SOTO AUSTRALASIA

SPRING 2009

EXPRESSION

INSIDE THIS ISSUE:

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D1 REFLEX WORK:

PART 2 (DR. REES' PROCEDURE)

Welcome to the second part of a 3-part article on coronary syndrome. Historically, DeJarnette's first written report on visceral work dates back to the first edition 1933, entitled "Reflex Pain." Six years later, "Technique and Practice of Bloodless Surgery," 1939, was produced and presented as a fairly complete work of the time. During the 1940s and 50s, two seminar series each year saw the publication of the DeJarnette Sacro Occipital work and the abdominal technique work, the latter being the forerunner of today's CMRT. For example, the publications of 1942 were entitled (a) Sacro Occipital Convention notes and answer series and (b) Bloodless Surgery compend – abdominal technic notes. This yearly 'twinning up' of the two areas of study continued until 1958. There was a break on the focus and study of 'abdominal technic' until the years 1965 and 1966 when two epic works were published: 1. T.S. Research Project, 1965 2. CMRT, 1966.

The 1966 notes are the gold standard and it is this work (reprinted in 1981) that is taught at SOT seminars around the world today, including at our yearly SOTO A/Asia seminars in the various capital cities. Incidentally, with the visceral work completed, DeJarnette turned to the teaching and publishing of cranial work. From 1968 to 1979, the "twinning" of publications each year were the SOT notes and Cranial Cranial Technique 1975. This practice continued until 1979 with the last pairing of publications. From 1980 to 1984 only the single SOT notes were published.

Do they do anything to enhance the CMRT work or are they procedures that burn up a lot more clinic time?

In this second part (of the 3-part article) we will add some procedures developed by Dr. DeJarnette's good friend, Dr. Mel Rees. Dr. Rees, you may recall, did further development of DeJarnette's T-S line from 1965.[1]

In 1965, DeJarnette held a seminar attended by 123 SOT doctors concerning the temporal sphenoidal analysis. DeJ had observed and reported something happening and invited the field practitioners to take part in this region. One practitioner (of the 123) took up the challenge to a great extent and that was Dr. Mel Rees of Sedan, Kansas.

One of this project's objectives in its avenue of investigation was "to determine and chart areas upon the temporal-sphenoidal perimeter that affected specific viscera[2] (Introduction CH. P2. 1965).

Dr Rees mapped the TS points, correlating them to the Dorsal and Lumbar spinal levels (there is a whole lot more work needed on the TS study. We have included DeJarnette's objectives for this work at the end of this article so you can gain an appreciation of the work).

Dr. Rees' TS and Bloodless Surgery papers were published in the 1972-74 editions of the SORSI despatcher.[3] We offer them as additional moves you may wish to include in your armamentarium of CMRT D1 procedures. Do they do anything to enhance the CMRT work or are they procedures that burn up a lot more clinic time? This question was posed in a Sacro Occipital Technic forum in 2006[4]. You be the judge. We have added another question – can Rees' procedure be applied without the use of glandulars (we discussed these in Part 1, suggesting the difficulty of using these in Australia or New Zealand, as they are not readily available here, amongst other objections)?

On the subject of D1 Bloodless Surgery and the coronary syndrome, Dr. Rees writes:

"Patient Presentation

"The impending doom is common to patients who present with the problem of constriction of the

(Continued on page 4)

PRESIDENT'S REPORT

Welcome all,

Dr Darren Little

Spring is upon us and our Seminars series across the country are coming to a close. I hope all who attended managed to take something new back to the office to start on Monday morning or now have a clearer understanding of how all the pieces fit together. For those attending for the first time don't be overwhelmed by the information, it may take a couple of revisits to get a proper grasp of SOT. And for the others, don't be deceived by its simplicity; SOT has a profound level of impact and the more you delve, the more doors that need to be opened.

We received excellent feedback regarding the Series this year, so well done to our current Seminar presenters. Thanks to Brett, Andrew, Linda, Ken, Paul and Sandy and all of the Table Educators who volunteered to assist this year. We had the largest attendance in Melbourne in 10 years, showing the keen interest the students have for SOT there.

SOTO-A invested in a new printer for Averil this year. With all our notes and brochures created in-house now this will reduce our costs considerably as well as making smaller print runs achievable now.

In a recent Board meeting it was decided to increase the number of face-to-face meetings to four per year instead of two. Although in previous years two had been adequate, we now find ourselves making more group decisions and topical discussions can only be taken so far via email without the need for personal meetings. This should improve the organization of our seminar logistics and also communication between Board members. Our next meeting is in early October in Sydney.

Annual Convention is just around the corner and is at Bondi Beach this year. Save yourself a trip to Homecoming in the USA as we have brought the best from SORSI to our shores. Come and reinvigorate your passion for SOT amongst peers and why not introduce a friend to the intricacies of SOT by inviting them along. This will be fantastic event- "advanced concepts in Bloodless surgery and extremity techniques"; something for everyone!

Till next time, keep on changing lives.

Darren Little
President

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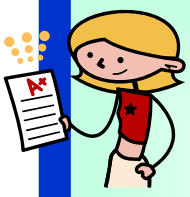

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FROM THE EDITOR'S PEN

Dr Samantha Culley

Hello to All,

So the end of another seminar series. I hope you all had as much fun as I did, it was my absolute pleasure in sharing my knowledge with you and I very much look forward to doing it all again next year.

As stated at the seminars if anyone has any questions on anything that they learnt this year or any cases that you are being challenge with please do not hesitate in contacting me s.culley@hotmail.com.

Talking of cases, we are always looking for new research and new areas to show the world how great Chiropractic is, so please write up those case studies and send them into Gerald.

We are going to have an amazing time in Sydney this year at the AGM so get booked in and avoid disappointment. Remember to bring you best party clothes and those dancing shoes to boogie the night away.

See you all in Sydney.

Sam Culley

EDITOR'S QUIZ

Here are the answers to our last quiz. If you have interesting facts, then we'd love to hear them!

QUIZ 3—WINTER 2009 NEWSLETTER

In 1924 what did DeJarnette do to relieve one of his classmate's of pain"

First he got a very hot pan of water and a heavy Turkish towel. The hot towel was applied to his shoulder and upper dorsa spine, 3mins later colleague fainted. A pitcher of cold water was thrown over him to bring him back . With also most of his pain.

In 1926 what hypothesis did DeJarnette conclude?

Hypothesis, when the muscles of the spinal column showed very red areas due to pressure, those muscles contained blood vessels in a state of dilation. When the spinal muscles would whiten, I assumed that they contained blood vessels in a state of constriction

In 1928 what was the name of the system DeJarnette announced?

Vasomotor Control Technique.

In 1929 what technique did DeJarnette name?

Sacro Occipital Technique.

In 1930 what did DeJarnette construct to view the sacrum?

Distortion Technique.

In 1931 what part of the body did DeJarnette seriously investigate?

Excessive painful fibres on the occipital bone.

In 1932 what technique did DeJarentte discover?

5-10-2 Technique.

These questions and answers were taken form 'the history of SACRO OCCIPAL TECHNIQUE 1958. (Thankyou to Mark Postles for the loan).

More interesting questions about the life and works of DeJarnette!

QUIZZ 4

1. *How many basic articulations does the cranium have?*
2. *How many articulation do the facial structures have?*
3. *Who first pronounced cranial motion in the early 1900's?*
4. *In which year did his hypothesis 'in which neural function within the cranium could be altered'?*
5. *In which year did DeJarnette further advance cranial analysis?*

Why not submit your questions to be published? Contact me directly at s.culley@hotmail.com.

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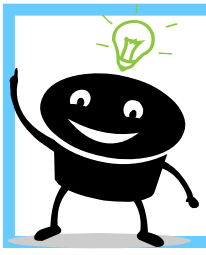


Nothing great was ever achieved without enthusiasm.

Ralph Waldo Emerson

D1 REFLEX WORK (CONT.)

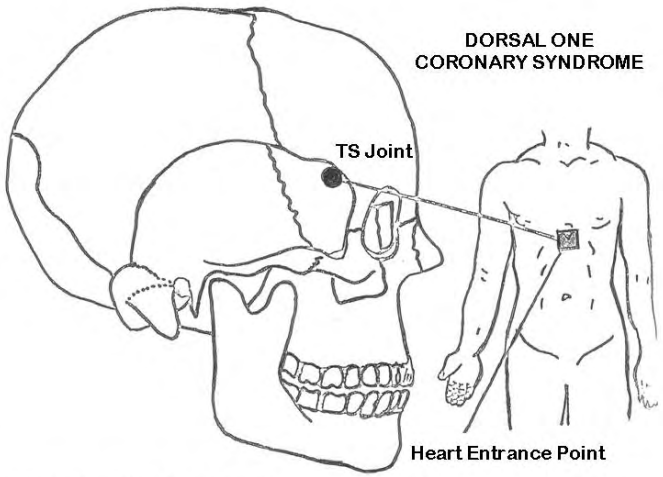
coronary arteries. This patient's thought pattern is: 'I'm scared something is going to happen to me.'"

Rees' initial procedure has two contact points:

The TS contact point – in the side skull picture, you see the dorsal one coronary indicator pointed out on the temporal-sphenoidal ring.

On the mannequin, you see the temporal sphenoidal contact area for cybernetic control of the coronary syndrome. You will recognise this as your post-ganglionic hold contacts area from CMRT, also known as the receptor block area or the heart entrance point. (DIAG 1)

Diagram 1: T.S. Technic First Contact points



In this side skull picture you see the dorsal one coronary indicator pointed out on the temporal sphenoidal ring.

On the mannequin you see the temporal sphenoidal contact area for cybernetic control of the coronary syndrome—The receptor block area or heart entrance point.

Dr. Rees' procedure was to use a felt pen and mark the reflex areas. It is fairly subjective when you are working with painful or tender reflex areas. Rees suggested to make certain both you and the patient know the areas are tender as both you and the patient must know when these areas are controlled.

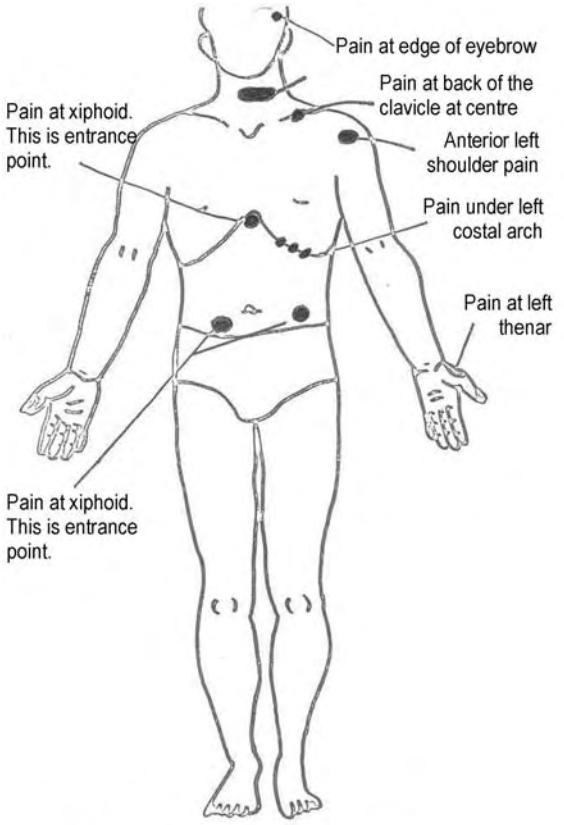


Diagram 2: Cardiac Insufficiency Complaints

PROCEDURE:

The first action is to palpate the TS ring on both sides, at the D1 point. If the TS ring is active on one side only, it is likely that a nutritional correction will clean up the coronary, but even if it is a bilateral T.S. dorsal one, the first step is a specific nutrient to see if the coronary is so controlled.

Now, if chewing up a tablet of *Cardio-plus* (see glossary) cleared up the reflex areas in twenty seconds this is a mild coronary, so you proceed directly to the last step which is known as the *REM Alpha Wave enhancer step.*

The Coronary insufficiency reflex areas, you will recall from your CMRT studies, are: pain at the edge of the eyebrow, a throat constriction that won't clear up, pain at the back of the central clavicle, anterior left shoulder pain, pain the xiphoid entrance point, pain under the left costal arch, pain at the left thenar and pain below the umbilicus and to each side that radiates to the low back. Some or all of these areas will be present. (DIAG. 2) We know from Chiropractic lore about the story of the patient who goes to the doctor for a physical and gets a clean bill of health and dies of a heart attack the next day. The point is that the patient may not always present as a classic coronary patient, but may present with a left shoulder problem or a low back pain.

There is a second outcome to the 20-second test with the cardio-plus glandular and a further procedure to do. Thus, if chewing up a tablet of cardio plus cleared only part of the body reflexes in twenty seconds then you must balance the central nervous system by re-zeroing it through the entrance points (those two we described at the start i.e. TS D1 point and xiphoid point).

To restore the central nervous system's "base line", two additional steps are performed before proceeding to the last step, alpha wave REM enhancer. *(Diagram 3)*

Step One: Have the patient hold their right arm up with a clenched fist (similar to the arm fossa test position). You hold down pressure on the right arm of your patient as you pull headward at the coronary entrance point. This "re-zeros" the nervous system.

Step Two: Now hold the master point on the T.S. ring with the left index finger and push footward on the arm. If the arm gives, you pull headward to re-zero the nervous system.

This is probably a new concept to our "Expression" reader so we will describe it some more with the two steps and some simple neurology rationale for the procedure.

Article continued on Page 5

Preview next year's Seminar dates

http://www.soto.net.au/calendar.asp

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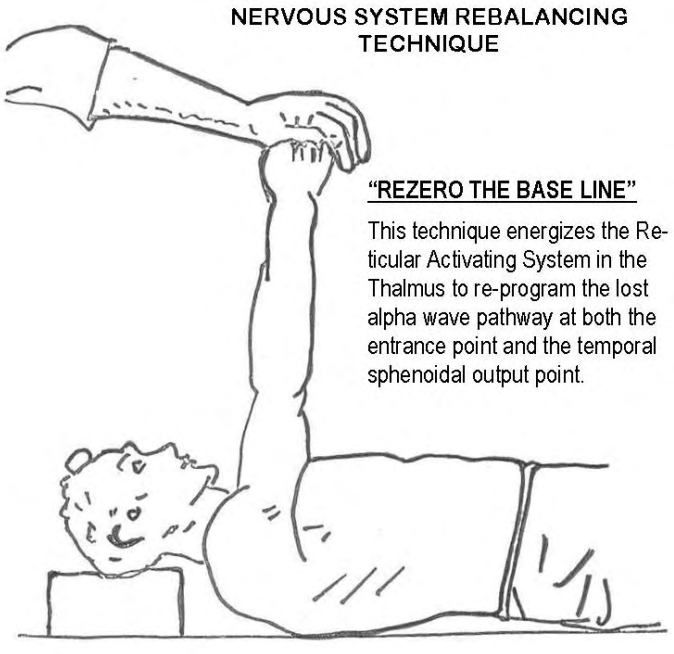
Dr Rees had a formal name for this technique which was the "Temporal Sphenoidal Central Nervous System Balancing Technique." Dr Rees commonly called this "re-zeroing the base line," the idea being that the chiropractor was performing a similar action to someone pressing the trip meter button in their car and bringing it back to zero. This is a technique which energises the reticular activating system in the thalamus to re-programme the lost alpha wave pathway at both the entrance point (xiphoid) and the tempero-sphenoidal output point.

The patient is supine, head on pillow. Either arm can be used but the right arm is best. The patient holds the stiff arm straight up toward the ceiling with the fist closed. Doctor tests arm strength for comparison by pushing patient arm footward (DIAG 3). If the



arm is weak, you have the patient chew up one *neurotrophin* to strengthen it so it can be used in the energizing technique.

The steps again:

Step 1: Sitting (or standing) to patient's right at the head of the table. With your left hand push footward on the patient's extended arm as your right hand uses deep contact at the entrance point (xiphoid) and pulls the tissue headward.

Step 2: Right hand pushes footward now on the patient's extended arm as your left index finger contacts the master point on the T.S. line. This reprograms the upper pathway. If the arm weakens, you then reverse the footward push to a headward pull on the arm. A little bit of practice is needed with this one.

REM ALPHA WAVE ENHANCER:

Just as the Temporal Sphenoidal central nervous system rebalancing technique proved too much of a mouthful and became known as "re-zeroing the base line", the temporal sphenoidal REM alpha wave enhancer technique was simply called "the biological shunt."

The biological shunt is the last step in the temporal sphenoidal technic (short form) and is a retraining step to teach the circuits how to find a lost path from the TS output point to the abdominal entrance point (brief physiological notes: the four types of brain waves are, slowest to quickest, delta (deep sleep), theta (drowsiness), alpha (relaxed, conscious, alert) and beta (adult, waking consciousness – most of the time).

The supine patient is asked to close his eyes, then to look upward inside his eyelids like he was trying to see inside his forehead. This quickly sets up a rapid eye motion. When the eyes flutter, alpha wave production has started. This REM part of the technique is simply a reproduction of what happens during sleep when the body produces alpha waves. (If you hooked up the patient to an oscilloscope it would show an alpha wave production build-up to about eight times amplification during this simple manoeuvre.) The doctor places his left hand index finger on the T.S. output point that he is concerned with and his right hand finger tip on the corresponding entrance point. As REM occurs and alpha wave production builds up, the doctor can feel it. Doctor's finger contacts feel stingy hot; his face and ear lobes feel hot, he is a biological shunt for alpha waves from T.S. output to abdominal entrance point. At this time the patient is advised to continue to look upward, the doctor then removes his finger contacts and leave the room. Two minutes is sufficient to retrain innate as to the location of the lost entrance point pathway. This completes the preparatory work.

The Full Rees Series of D1 Procedures:

In the procedure we just outlined, one would find three stages of coronary insufficiency. The patient who chewed up a Cardio-Plus and had all the reflex areas as marked clear up, is a mild coronary patient. Go straight onto the 'biological shunt.' Dr Rees then suggested this patient take 2 tablets of Cardio-Plus with meals over a four week period. This is the easy-outcome patient with a very positive prognosis.

Then a second presentation you will see will be the person who only partly responds. This patient requires a 're-zero the base line' and a 'biological shunt'.

The third type of patient is the one who does not respond to the glandular and this person needs to receive the full series of Rees adjustments which we will now discuss. It is a 15-minute procedure, so, yes, if you are time-conscious as most SOT practitioners become, it may be an issue. Let's first list each of the 10 steps and then we will discuss their procedure and merit.

T.S. Cybernetic feedback.

Thenar Squeeze dilation.

Left Costal arch technique.

Push-pull diaphragm technique.

Phrenic-vagus Clavicular technique.

P.A.S. (pulmonary artery segment) ventilation technique.

Costal Sternal constriction technique.

Aortic throat constriction technique.

Cardiac McBurney point technique.

(Continued on page 6)

(Continued from page 5)

Pre-ganglionic technique.

T.S. Cybernetic Feedback

This is a holding contact which is similar to the procedure we have just discussed (of holding the TS point and receptor area) except we do not have the patient's eyes closed invoking REM and alpha waves. Here, the doctor holds the T.S. major with one finger and the other contact made is the receptor block area. The effect the doctor is going for is a slowing, calming hold. The holding is a pain control procedure that enables you to make the following procedures more comfortable.

Now you do the Thenar Squeeze Technique to dilate the coronary artery constrictions. You squeeze the patient's thenar tightly while he opens and closes his hand at a slow cadence as your other hand is placed over the heart. This brings an anterior coronary soft pulse picture to normal in one minute or less. A posterior coronary is much more difficult to normalise (remember from your CMRT notes, proximal thenar = posterior coronary insufficiency, usually due to physical exertion. Distal thenar = anterior coronary insufficiency brought on by emotional stress).

The left Costal arch technique is now used to remove emotional stress. All coronary insufficiency patients are scared – they sense impending doom. You now remove the costal arch tension set up by emotions before it aggravates the heart problem. You contact up under the arch with both hands, break up nodules you find (1 min).

Known as the Push-Pull technique, this procedure works through the diaphragm to the apex of the heart to resuscitate it. You have just finished relaxing the tissues under the left costal arch. You now push your right fingers up under the left costal arch tissues as your left hand is placed over the patient's left shoulder. Your shoulder contact pushes tissues toward the first thoracic as your costal contact pushes those tissues towards the left shoulder. You repeat this slowly for one minute (1 min).

The Phrenic-Vagus clavicular technique is used to free circulation to the lung field. This step is a must if you have a posterior coronary causing back pressure in the P.A.S. – pulmonary artery system. Stand at the head of your supine patient. Work your fingers under the clavicle from the top side so you have a good purchase on the bone. This is painful – so slow and easy. Now grasp the same side arm at the elbow. Now you pull the clavicle with about five pounds pressure toward the ceiling as you make five complete circles with the arm and shoulder girdle. Repeat on the opposite side (1 min).

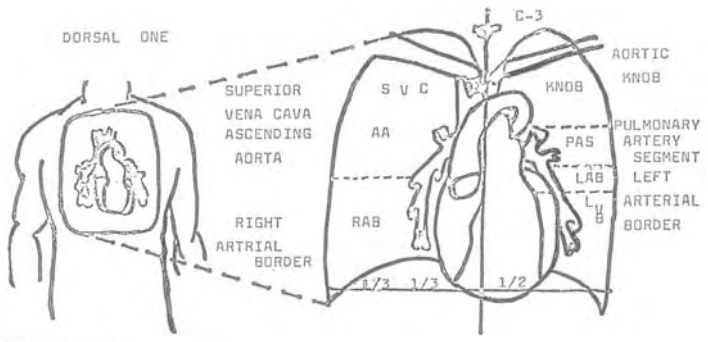


Diagram 4: Heart

Phrenic-Vagus P.A.S. ventilation technique is applied to free up the pulmonary artery segment and free the flow of the right atrium of the heart. Lay both hands flat on the upper chest covering as much rib cage as you can. Have the patient take a deep breath and exhale all the way out. As the patient exhales, you do a series of sharp little thrusts on the rib cage in the direction of the patient's buttocks (1 min).

Costal sternal tension xiphoid technique. This relieves the heart at the costal sternal border. Here you press inward and headward at the receptor block area for a slow count of ten. Then relax. Repeat this performance five times for the total time of one minute. This relieves the heart at its costal sternal border.

The Aortic throat constriction technique is also known as the common iliac technique or the left psoas (upper) technique. This is used in a line from the umbilicus to the anterior iliac spine; your contact point is on this line four inches from the umbilicus (it is like McBurney's point, but on the left, an area that older anatomical nomenclatures termed the "Valves of Houston"). Using both your hands at this point, go in deeply with your finger tips using gradually increasing pressure. This contact once gained is now moved toward the left shoulder as if to tuck it under the costal area. You repeat this manoeuvre five times.

Cardiac McBurney's Point reflex technique. This is a holding technique. You simply hold a left hand contact over the left shoulder as you hold a flat hand contact over McBurney's point for two minutes.

Preganglionic Technique

We should say, modified Preganglionic technique. Rees' approach was to contact that tender embryological point in the middle of the sternum and do ten quick clockwise circles to re-establish the motor arc.

And there you have it! None of the procedures of the work are too complex. You can say this is the case with all of the TS work and CMRT work. The procedures are not complicated but there is a lot to remember. It appears overwhelming to the neophyte.

Conclusion

We have introduced the Bloodless Surgery and T.S. work of Dr. Mel Rees of Sedan, Kansas. The techniques were Dr Rees' variation. He learned the older Bloodless Surgery work from Dr. Brian Surtees when he was at Chiropractic college, so some of the procedures may have been developed or adapted from the earlier methods of DeJ. In the next part of this article, we will discuss some DeJarnette procedures that don't receive a lot of notice in the modern era (and we mean to change that).

Until then,
We remain,

John S. Kyneur
Haberfield, NSW

Peter J. Kyneur
Toronto, NSW

The Glandulars Used

There are 3 types of Standard Process glandulars.

(Continued on page 7)

(Continued from page 6)

Protomorphogens

Cytosol extracts

Whole gland concentrates.

The protomorphogens are extracts of the nucleic acids from the cell nucleus. Many doctors use the terms "protomorphogens" and "glandular" interchangeably. Although not strictly accurate, the protomorphogen is the fundamental type of glandular product. They end in –trophin, thus the product you would use with a D1 patient is Cardiotrophin and, as we described, Rees suggested Neurotrophin to strengthen the arm and shoulder. Cardio-plus is a cytosol product, cytosols being extracts from the cytoplasm of the cell.

The general principle is that the cytosol products are more for the acute patient, the 'trophins' for the ongoing administration.

Cardio-plus is also known as GEC, being the food source of lipotrophic "B" factors as found in calf's brain (Vit G), a synergisic phospholipid food found in beef chromatin material (Vit. E2) and the extract of beef heart muscle (food source of cardiotrophin).

Once again we refer our readers to www.becomehealthynow.com and www.centralbirdanimal.com because the vets have found that glandulars work very well in the animal kingdom, and there is no placebo effect there!

DeJarnette's T-S Research Project Objectives[5]

To determine the reflex potential of the temporal-sphenoidal bone in the control of pain.

To use this skull area in the control of specific regions of the body which have been predetermined to exist in certain viscus disorders and in the presence of specific vertebral subluxations.

To develop a comparative study between the temporal-sphenoidal area and the post-ganglionic shoulder contact for pain control in depth.

To determine the total extent of cerebrospinal influence on disease and pain as it may relate to specific vertebrae and specific visceral symptom syndromes.

To establish, if such exists, exact temporal-sphenoidal perimeter areas that are directly related to specific vertebral subluxations at specific levels of the spine.

To determine the relationship between the painful spinous process in line one occipital disorders and direct visceral involvement.

To determine the perimeter control of temporal-sphenoidal reflex points on the spinous process pain?? as above described in relationship with occipital line one.

To determine the influence the cerebrospinal fluid has upon skeletal muscles in relationship to known viscus reflex areas on the anterior body.

To determine accurately the possibility that the production of cerebro-spinal fluid is more of a problem in pain than is the control of its movement.

To determine the relationship that exists between the temporal-sphenoidal perimeter in relationship to the twelve cranial nerves.

To determine the relationship between pain and blood pressure and the effects both may have upon the temporal-sphenoidal reflex perimeter.

Comparative studies to determine if pressure upon normal areas of the temporal-sphenoidal perimeter will produce definite changes in the viscus reflex patterns known to exist.

Comparative studies to determine whether or not stimulation of normal temporal-sphenoidal perimeter areas will produce instant palpatory changes in vertebral spinous and transverse processes.

Comparative studies to determine whether or not temporal-sphenoidal perimeter areas may be pressed upon to excite the production of cerebro-spinal fluid in excess and by such pressure and excess produce direct pain signs in an otherwise pain free viscus.

To determine and chart areas upon this temporal-sphenoidal perimeter that affect specific vertebrae.

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ibid. pg. 2

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Associate required for immediate start-WA. You will be taking over a growing client base of 40-50 per week from the current new graduate Doctor, who is leaving to become a full-time mum. Growing Family Practice uses mainly SOT, AK but all techniques considered! Interest in sports, rehabilitation and nutrition a plus. SOT teaching clinic, regular W.A. SOTO club meetings. Clinic doctors work together to share knowledge, discuss difficult cases and from this synergy expand all of our knowledge. For a new graduate doctor, a structured support and mentoring from principal with 15 years experience is available. Busy multidisciplinary clinic in affluent area, close to city and walking distance to Cottesloe beach and train station. A FUN clinic that encourages team growth, personal development and supports everyone to reach his or her highest potential. If you have a dream to be the best chiropractor you can be and would like to join us then contact: Diana 0431 636 154 or dischwelm@optusnet.com.au

Associate Chiropractor(s) Required. Chiropractor(s) required to replace existing associate who is leaving to travel in January 2010. Currently seeing 120-130 patients per 4.5 day week, and turning away new patients daily, in a low-force mainly SOT wellness based family practice in Mount Gambier. For more information or any queries please contact Liana Ruggiero on harmon88@bigpond.com, or call 08 87256291 or 0403 585 615 after 6pm.

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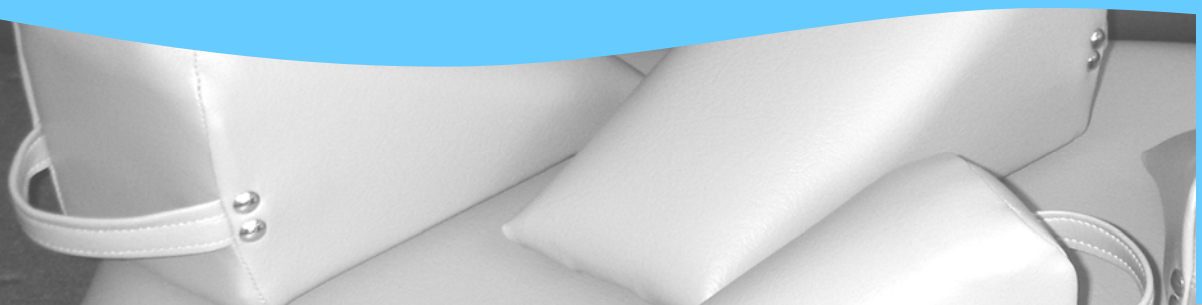
Locum Available

Available from Jan 2010. Dr. Troy Miles. SOT Advanced Certification. chirotroy@yahoo.com.au or 0407506612.



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