SOTO AUSTRALASIA

AUTUMN 2011

EXPRESSION

INSIDE THIS ISSUE:

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PANCREAS PROCEDURE—T6

When you think of the pancreas, you think of diabetes. We also know from our C.M.R.T. notes that patients with acute pancreatitis will sit with their legs drawn up rather than lie straight out.

These are extreme conditions whereas the majority of your category patients will have some underlying measure of pancreas dysfunction. It is quite common. You are guided to it by occipital fibre line 2 area 4, trapezius area 4 and T6 transverse nodulation. If you have been following this series and have been viewing your T-S reflex points, you will note that there are two T6 areas marked T6 and T6B (Reminder: the CMRT charts from Marc Pick Creations are available from Averil) which provide another means of verifying the T6 condition and doing something to help.

Think of the basic functions of the pancreas and keep in mind that it has two types of tissues:

1) The Islets of Langerhans which secrete insulin. When this function is abnormal the T6A will be active and will 'ouch' to palpatory pressure.

2) The other type of tissue are the acini (from the Latin – acinus which means grape or berry) which secretes digestive juices and buffering fluid into the small intestine. When this portion of the pancreas is not normal in function then T6B will be active.

If the patient shows a T. S T6A and has not yet exhibited all four preclinical signs of

1) Hypoglycaemia

2) Sight problems

3) Dizziness, and

4) Frequency of urination;

then, you have an excellent chance of reversing the process with CMRT and bloodless surgery procedures.

The T6A is hypoglycaemic or is diabetic. They need to avoid sugars and refined carbohydrate foods and avoid alcohol intake. The post-ganglionic control procedure which is right shoulder hold contact and working the central gastric area is a procedure to be taught as home management to the patient.

If your patient shows a TS T6B then he is exhibiting the most common cause of abnormal digestion which is the failure of the pancreas to secrete its digestive juices into the small intestine. The preclinical signs are digestive problems, bulky and odorous stools and duodenal ulcers. Lack of pancreas secretion means that without these enzymic digestants, as much as three-fourths of the fat entering the small intestine and as much as one half of the protein and starches may go undigested. Then copious fatty stools are excreted as undigested, putrefied, bulky, foul-smelling mess. A lack of bicarbonate buffering secretion by the pancreas allows stomach

'...the majority of your category patients will have some underlying measure of pancreas dysfunction.'

(Continued on page 4)

PRESIDENT'S REPORT

Greetings friends,

Dr Darren Little

The new Board had their first Planning meeting of the year last weekend and we have some great events and ideas in store over the next few years. To kick things off, Peadiatrics is on the agenda for later in the year. The brilliant Steve Williams and Suzanne Seekins (who last time she was here presented the Pregnancy module), together tackle the challenging issue of developmental imbalances with the older child. Covering topics such as ADD, ADHD, allergies, food sensitivities, retained primitive reflexes and other common disorders, this will enable the practitioner to utilize and add to their SOT knowledge to maximise results with these issues. Those of you who have heard either of these speakers before will know how they make SOT easy to understand and apply the taught knowledge. They are a pleasure to listen to.

I hope you can join us at our first International Winter gathering in Fiji in August. This will be a fabulous family-based venture designed for maximum leisure time and minimal indoor structured learning and costed appropriately. More details to follow soon.

There is a strong campaign internationally to re-establish the distinction of Sacro Occipital Technic instead of Technique. These two terms, while often being defined as the same, actually do have a subtle but important difference. DeJarnette always made that distinction and for good reason. De Jarnette was a very logical, methodical and technical person. Technic pertains to a theory, principles or the study of the art or a process. A Technic works for everyone while a Technique may work for an individual. SOTO-International have proposed to reaffirm that SOT stand for Sacro Occipital Technic. CMRT and Cranial procedures are still Techniques. I have included comments by David Rozenboom, the head founder of the DeJarnette Library on this topic. There will be a resolution at this years AGM to formally clarify this distinction in our name.

In follow up from our TMD conference in 2010, the Aqualizers are now in stock to be purchased from Averil. The aim of these appliances is to disengage the contact surfaces of the occlusion. This becomes very useful in determining if a patients bite is driving the cranial distortion and postural change. A persons bite can often change after a cranial or body adjustment and wearing this device at night can help these adjustments hold longer and prepare the person for appropriate dental co-treatment if desired. The waterbed also allows for a smooth sideways sliding action which destresses the TMJ's with retro-mandibles and night grinders. Whilst a temporary solution, it can be just the trick to allow healing of tissue and relaxation of muscles that contribute to a persons pain presentation.

While SOTO-A has done its part in proposing and driving the establishment of a new universal Brand Strategy for SOT, we expect the other organisations will come to an agreement soon. This should then be reflected in our new International notes and exams.

Our Seminar Series is about to begin and I am excited about the new passion and enthusiasm our Educators will bring to 2011. It is a great time to revisit the fundamentals of our great technic and reaffirm them with certainty by doing our Series again. Who knows, you may just learn something new.

Cheers

Darren Little
President

Technic vs Technique

Dr. De Jarnette used the word "Technic" in the title of all of his Sacro Occipital Technic books.

He used the word "Technique" in the title of his cranial and CMRT books and to describe most of the individual procedures in the Sacro Occipital Technic books.

Remember that Dr. De Jarnette was an engineer before he was a chiropractor. And in engineering, the words have specifically different meanings.

"Technic" is a set of procedures that can be done by anyone and applies to all situations. "Technique" implies an individuals' use of his own skill, knowledge and judgment, resulting in a slight variation of what he learned as a "Technic" that works for him.

"Technic" is never used in describing Chiropractic Craniopathy or Chiropractic Manipulative Reflex Technique. That is because they are an art more than a science and so are done by the individual doctor in their own manner. They really cannot be taught as a "Technic". There are too many variables.

I insist on using the terms as Dr. De Jarnette used them, not because Dr. De Jarnette wrote it that way, but because it is the only correct use of the two terms.

I express my gratitude Drs. Skip Saderlund, Ned Heese and Dave Beltakis for their contributions to my understanding of the difference of these terms.

David Rozeboom DC, CC

Dr Samantha Culley

'Take care of your body. It's the only place you have to live'

Jim Rohn

FROM THE EDITOR'S PEN

Hello to All,

Welcome all, to another amazing year. For so many it has been an interesting start with the floods in Queensland and Victoria, cyclones, again in Queensland and heat waves in Western Australia. Well I'm here to tell you that SOTOA has a heat wave of its own this year, its going to be hot.

Darren and Bec have been working extremely hard to get our seminar notes to be the first to international standard, the rest of the world is following in our foot steps. So thank you.

We have added an extra venue this year to include Adelaide and our Annual Convention and AGM will be held in South Australia's beautiful Barossa Valley with some amazing International speakers such as Steve Williams, John Howat and Susan Seekins and our home grown speaker is yet to be advised. (It's a great secret!). What a weekend that will be with the 'cream of the crop' all together for one amazing experience.

And let's not forget that our first international 'mid-year retreat' is being held in Fiji, yes that right, Fiji. Sun, sea, sand and *piña* coladas combined with talented all round speakers to tempt our taste buds. For the families it is a great opportunity for a family holiday and for those with no bambinos, don't panic we can party on and there is even an adult's only swimming pool!!!!!!

So cheers and here's to a fabulous year of SOT in 2011.

And enjoy reading.

Sam Culley

Editor

SOTO Australasia—Events 2011

Month	Dates	Categories	CMRT	Cranial	SOT Retreat / S.O.T. Certification Examinations / Annual Convention
April	16 & 17	Melbourne			
	30 May 1	Sydney			
May	21 & 22		Melbourne		
June	4 & 5	Perth			
	11 & 12		Sydney		
	25 & 26	New Zealand			
July	9 & 10			Melbourne	
	16 & 17	Adelaide			
	23 & 24			Sydney	
	30 & 31		Perth		
August	5—7				SOT Retreat—Fiji
	20 & 21		Adelaide		
September	3 & 4		New Zealand		
	17 & 18			Perth	
	24 & 25			Adelaide	
October	8 & 9			New Zealand	
November	10				S.O.T. Cert Exams—Barossa Valley SA
November	12 & 13				Ann. Conv & AGM Barossa Valley, SA

PANCREAS PROCEDURE (CONT.)

(Continued from page 1)

acids to eat ulcers into the duodenal walls. As this T6B condition becomes chronic, a very dangerous condition called pancreatitis can occur. The pancreatic enzymes start digesting the pancreas itself. This patient is now dying from malnutrition with a diabetes mellitus complication

In all T6 patients, a common thing overlooked is the anterior thoracic. The anterior thoracic is an important aspect of the category two patient and you will have addressed this usually in the healing Category two. (Newer readers and practitioners may wish to refer to an earlier article on the anterior thoracic! Averil has loaded all of the newsletters from 1974 to present as a valuable research tool for SOT scholars on our SOTO Australasia website www.soto.net.au.)

Now let us look at the Rees pancreatic procedure. You may wish to refer to your Thoracic 6 seminar notes for comparison and integration with CMRT protocol, as currently taught by SOTO Australasia.

Dr. Rees was fond of using a skin pencil to mark areas for pre and post comparison. Many of these areas are the reflex areas in your CMRT notes, so hope you are comparing as you read this series.

Step 1 of procedure, then is to find and mark the ten areas listed below:

1) TS T6A and/or 6B. This determines whether an insulin or digestive major.

2) TS T4 suggests there is a common bile duct involvement (and there usually is).

3) TS L2 means caecum is involved as it many times is.

4) At the posterior and superior of the charted TS lines, Rees found another region of reflex points. The area of concern for the 6th thoracic level is called TS H.3. To find H3, place three fingers on top of your earlobe. Move up three spaces, of half a centimetre and you will land on H3. TS H3 means muscle vasomotor involvement at the 6th thoracic level.

5) On the right anterior rib cage mark the tender tops of the 6th and 7th ribs.

6) Palpate under the left costal arch mid-diaphragmatic line and mark the tender nodules found.

7) Find and mark the tender belly of the triceps muscle on the posterior of the arm.

8) Find and mark the posterior 5th and 6th rib cage tender areas between the 5th and 6th ribs, near the rib heads.

9) Mark the mid-clavicular tender areas.

10) On the right hand thenar pad, find the painful nodular area and mark with the skin pencil.

Step 2. Now find the receptor block area, mostly between the 5th and 6th intercostal space about four inches from the sternum (sometimes between 6th and 7th intercostal spaces). This will be a tender area to the touch, about the size of a twenty cent piece.

Step 3. Now with one finger of your left hand you hold the most painful TS T6A or T6B with light contact. With your right hand finger tips you hold the right rib cage marked receptor block area lightly. Hold both areas for two full minutes. Now, if your anaesthesia worked, your triceps marked area, right rib tips and left costal arch should be painless and you are ready to proceed.

Step 4. Continue to hold TS T6 with your left hand. Contact the marked areas on the patient's right hand and squeeze firmly. Have the patient open and close their hand slowly twenty times. This prepares the pancreatic duct for the next procedures. (This is a procedure we find useful on the thoracic one constriction patient, as well. The regular procedure is to manipulate the left thenar until the left pulse gains in volume. In this alternative, you have the patient squeeze open and close their fingers as you are contacting the thenar – nice.)

(Continued on page 5)

S.O.T. Manuals & Books

- Chiropractic First Aid (De Jarnette)
- Extremity Technique
- Chiropractic Manipulative Reflex Techniques (De Jarnette)
- Philosophy, Art & Science of S.O.T.
- '79 De Jarnette S.O.T. Manual
- '84 De Jarnette S.O.T. Manual
- Cranial Participants Guide
- A Practical Guide to Cranial Adjusting (H. Getzoff)
- Line 2 Occipital Fibre Technique with Advanced CMRT Methods (N. Heese)
- Neurological Reflex First Air (J. Unger)
- Pregnancy & Paediatrics: A Chiropractic Approach (S. Williams)
- The Anatomy & Physiology of Sacro Occipital Technique (J. Howat)
- CMRT Reflex Charts (M. Pick)

Available from SOT Supplies—
To order, contact the Co-ordinator.

(Continued from page 4)

Step 5. Now, place both your thumbs under the right rib cage arch and slowly gently work thumbs under ribs in the direction of the right shoulder. Do this until the tissues relax.

Now move the left hand to a right shoulder contact (post-ganglionic style – in fact, this is post-ganglionic). Your right hand contact is all fingers under the right rib cage. Rather than the circular vibratory move of a 'work' portion of a regular post-ganglionic procedure, this is more of a gentle slow push of the tissues up under the right rib cage. This clears any impediment in the common bile duct and pancreatic duct that is always present in D6 reflex cases.

Step 6 is clavicular technique. You have moved to the head of the table. Have the supine patient bring the arm around to ninety degrees. Your left thumb is on the mid clavicle with your right arm making a wrist hold on the patient's right arm. Go slowly and easily. Push the thumb into the clavicle as you move the patient's wrist an inch or so. Repeat five times then do the equivalent on the left mid-clavicle. This is a technique to free up vagus nerve impingement.

Step 7. This involves working the related T4 area. You contact the TS T4 areas bilaterally and rub them out with twenty firm circles. This is for relaxation of Oddis sphincter which is that contraction of the outlet of the common bile duct at the neck of Vater's ampulla.

Step 8. You must free the pancreas of visceral impingements. Patient supine, doctor stands to the right of the patient. Doctor places hands along the abdominal midline with fingers and thumbs spread out to be able to gather up a handful of abdominal soft tissue. The thumbs and fingers of both hands make deep pressure down toward the spine grasping all abdominal tissue possible. Now squeeze to build up abdominal soft tissue into a mound and carry superior toward the left costal arch. This is the freeing up of pancreas adhesions.

Step 9. Now, visualize the pancreas position with its left tail at the spleen and its head tucked in the duodenal coil. You must now free the mesenteric apron so that circulation can normalise. For this bloodless surgery you simply gain deep access to the mesentery along the pancreas then let go suddenly with a flip of the fingers. Effectively, there are three types of adhesions which occur in soft tissues:

A) Lace

B) Fibrous, and

C) Spider-web.

This was called 'breaking up lace adhesions' in the older De Jarnette bloodless surgery notes of the 1940s and 1950s. You do this beautiful manoeuvre across the surface of the pancreas, beginning at the liver and ending at the spleen.

Step 10. This is the final pre-ganglionic portion of pancreas procedure. The pancreas pre-ganglionic is a double-hand action. Your right flat hand contact is over the pancreas as the left forefinger fingertip makes ten quick vigorous circles over the mid-sternum. This starts the normal reflex arc and takes the pancreas out of anaesthesia so to speak.

In the modern, post 1966 CMRT notes, we find usage of the fibre neutralizing, vasomotor adjustment and reflex work for the right thenar pad and costal arches. The receptor block area is noted but not utilized (now you can do something with it!) and the TS fibres and pre-ganglionic from the late 50s and early 60s have been discussed. As previously stated quite a few of your category two patients will have an underlying pancreas involvement.

Review this paper, look at your reflex chart and read over your seminar notes and you will have some very useful procedures you can integrate into your practice.

Until next issue, we remain

John S. Kyneur
Sydney, NSW

Peter J. Kyneur
Newcastle, NSW

2011 S.O.T. CERTIFICATION EXAMINATIONS

- **Basic**
- **Advanced**
- **SOT Certified Craniopath**

The 2011 S.O.T. Certification Examinations will be held on **Thursday, 10 November** commencing at 10.00am.

The venue—Novotel Barossa Valley

Applications close Thursday 13 October, 2011.

CHAPTER VIII 'REFLEX PAINS'

As a rule the site of the pain corresponds with the site of the lesion. In other Instances the area causing the pain may be at a great distance from the actual area of pain that is complained of by the patient.

Pain from the top of the head to the occiput may denote a liver con-dition. Pain directly on top of the head in the female may mean uterine or ovarian pathology. Sometimes bladder irritations cause a throbbing on top of the head. A pain over the eyebrows may be caused by defective eyesight or decayed teeth. A pain back of the ear may be caused by otitis media or mastoiditis. Do not confuse this area with Occipital Area 1, as it Is higher than Occipital I area. A pain over the bridge of the nose may be the result of gastritis. A pain over the clavicular groove may be caused by disorders of the diaphragm. A pain in the breasts and at the wrist on the same side as the breast pain, usually means uterine and ovarian disorders. A pain in the groin means urethral disease and oftentimes is associated with ovarian inflammation or tubal pregnancy. Pain at the knee joint makes one think of hip joint disease, possibly tubercular in nature.

We recall a patient observed some five years ago. This boy was 16 years of age and in apparent good health. He was suddenly seized with a pain in the knee which radiated to about the middle of the femur. In two days the boy was running a temperature. We were called into see him and suggested an X-ray of the hip, although no history of hip Injury could be obtained. The boy's parents refused the X-ray and we refused the case. This boy was under medical care for six months and the diagnosis was RHEUMATISM. At the end of that time, this patient was confined to a wheel chair. An orthopedic sur-geon was called in on the case and made a diagnosis of tuberculosis of the hip joint. An operation was performed, the boy remained in a cast for many months and today walks with a stiff Leg.

A pain at the nape of the neck formerly was a sure sign of neurasthenia, but today we know that it may be the result or the cause of anything. Pain under the right scapula makes you think of liver trouble, and If the eyes are yellow, you are sure of jaundice. In a case of this kind of pain, be sure tuberculosis does not exist. A pain over the lower back formerly Indicated uterine disease. A burning sensation in the soles of the feet is usually accompanied by prostatic disorders in men, and a pain In the heel region of women means ovarian disease. A pain-ful parietal bone may mean middle ear disease. Trigeminal pains are often the result of sinus or antrum infections. A tendency to cough without results may be due to an auditory canal disturbance. We saw a patient some months ago that had a very persistent cough. The cough was non-productive, but was practically constant and much worse when lying down, Examination showed very little wrong and three treatments absolutely produced no improvement. We examined the right ear and found a bur like substance in the canal. This was removed, and with Its removal the cough stopped Immediately. A pain in the larynx often means tuberculosis. We saw a lady 27 years of age in 1927. A very distressing cough was the main complaint. This patient had complained of a constan.t sore throat for some years. The tonsils were removed and afforded relief for a short time'. The sinuses were then operated upon without any relief. Examination of the throat showed little pathology. X-ray examination showed tuberculosis of both lungs. The patient took treatments, but would not rest as we instructed her to do. Results of the treatments were only moderate.

A pain in the left arm is usually accompanied by some disorder of the coronary arteries. A pain of a constant and burning nature, extending from the fourth to the ninth dorsal, usually is associated with gastric disturbances. Tickling In the nose means intestinal worms.

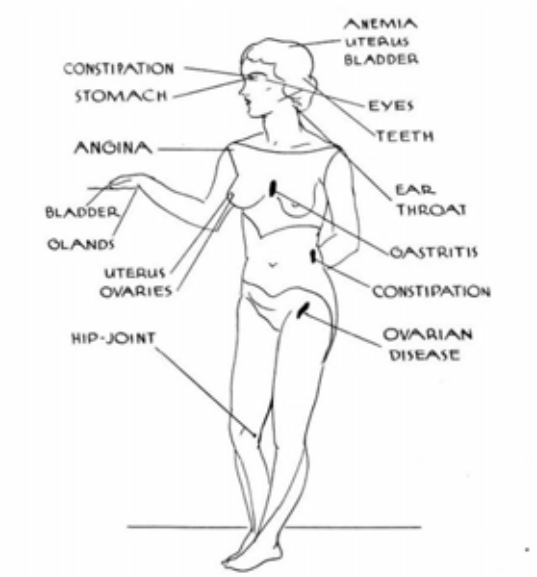

ILLUSTRATION 23

Body areas of pain produced by visceral and joint reflexes. Anterior view.

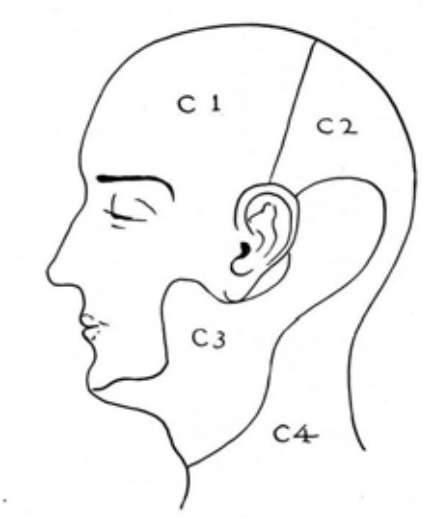

ILLUSTRATION 22

Painful head, face and neck areas and their corresponding spinal areas.

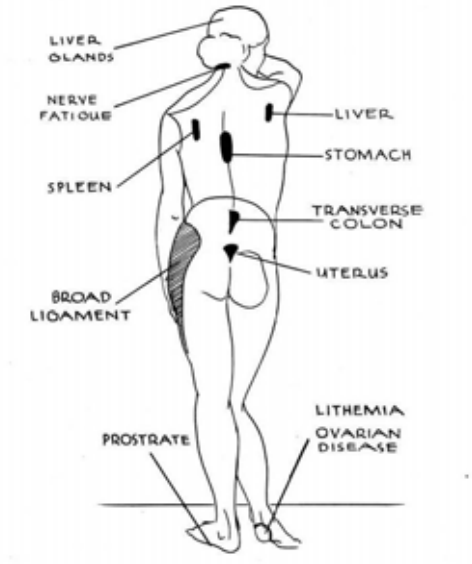

ILLUSTRATION 24

Body areas of pain produced by visceral and joint diseases. Posterior view.

REFLEX PAINS (CONTINUED)

Due to the inaccuracy of visceral pain manifestations, It sometimes Is quite difficult to know exactly what a peripheral pain means. Cutaneous skin areas, when stimulated, project exact areas of pain. A spinal seg-ment when diseased may manifest a variety of peripheral area pains, but in such Instances the spinal pain will accurately locate the seg-ment Involved.

VERTEBRAL TENDERNESS

The Spinal Therapist has in his own domain of diagnostic and therapeutic procedures one of the most elaborate technics for determination of visceral disease by vertebral tenderness.

A research worker by the name of Mannkopff ascertained that when an area of pain was contacted that the pulse rate became faster. In our work we have used this sign to some extent. In examining your patient for the true areas of peripheral pain, before your spinal local-izations start, you will on some patients have difficulty in determining which of two or more areas are the most painful. In such instances we would count the patient's pulse rate, then make pressure upon the painful area and recount the pulse rate, and if this were a true area of pain the pulse rate would be increased. We would wait about two min-utes, recount the pulse and make pressure upon the other controversial area and then recount the pulse, and the area that caused the greatest Increase in pulse rate would be selected. This has proven of value in some very difficult cases. However, we find that it is not necessary to count the pulse rate, as pressure upon these areas Increases the pulse tension and the area that produces the most marked Increase in ten-sion is selected as the major skin area for localization.

These tests consume time, but at times it is advisable to consider well the skin area for localization, for upon that area depends the outcome of your localization procedures. In some instances, due to vasomotor reflexes, this test would be inaccurate. For instance, if the pressure would cause the reassimilation of carbon dioxide gas in the presence of a strong heart, the pulse rate would decrease and if this procedure eliminated carbon dioxide gas In the presence of a weak heart, the pulse rate would increase.

Another simple little test is to watch the pupils of the patient's eyes. If your skin area is on the right side of the body, watch the patient's left eye in particular, and if pressure upon the skin area dilates the pupil it denotes a true area of skin pain. The area that causes the greatest pupil dilation, of course, is the area of choice for localizations. This sign will rarely be needed, but we wish you to be familiar with them, for the unexpected may happen in any practice, and it is always well to be WELL PREPARED.

The Spinal Therapist must be prepared at all times to detect actual pathological diseases of the spinal column or cord proper. In briefly reviewing the major symptoms, we note the following:

In neuroses the spine is not rigid at the point of greatest sensitive-ness.

In Potts dise.se reflex muscular spasms are associated with pain. In disease of the cervical column the head Is held rigid or is supported by the aid of the hands.

In disease of the dorsal column the pain may radiate to the chest and produce painful and difficult respiration. This causes groaning and night cries.

In lumbar column disease the pain is referred to the abdo men or legs.

In Potts disease there may be no local pain on pressure, but spasms of the spinal muscles occur on movements or when pressure is directed onto the diseased area of the spine.

Some years ago a few writers claimed that areas of vertebral tenderness associated with disease were due to vasomotor disturbances, which caused Impeded circulation in the spinal cord. We can not agree with this statement, because in our opinion the vasomotor nerves have very little to do with detection of sensation, their chief function being to control the caliber of all arterial tubes. It is perfectly true that areas of vertebral tenderness correspond to vasomotor centers in the spine. Associated with these areas of vertebral tenderness we have spinal muscle tenderness and we know that these spinal muscles have a compensatory circulation with the cells of the spinal cord. How-ever, we do not believe that this disturbed sensation is due to vasomotor sensory effects, but rather is the result of vasomotor inactivity causing the sensory nerves of the spinal muscles to detect the pain stimuli.

Irritation of the sensory portion of the spinal nerves conduces to the sensation which Is projected into the periphery innervated by the nerves of the spinal segment. The same Law that Hilton laid down for joint pains applies to the vertebral column, and we, therefore, say the muscles, ligaments, joints or the vertebral column are innervated by the same segmental division of nerves that innervate the skin over these spinal joints.

For complete vertebral and body areas see other parts of this book, which completely cover the vertebral and body area's and list diseases associated with those areas.

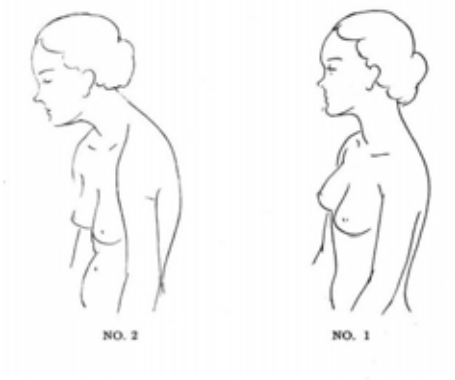

Illustration Number 1 shows a normally balanced spinal column. This column is free from muscular tension. Illustration Number 2 shows a spinal column that is under tension. The cervical spine is rigid, due to disease of the cervical veterbrae.

(Article provided by Dr. Joe Unger, USA)

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Dr. Steve Doig. Available July 2011. SOT Advanced Certified and NET Certified. Experienced as a locum and associate. Ref. Available, happy to travel nation-wide. *Contact* Steve Doig 0401 012 873 hdoige@hotmail.com.

Experienced Wellness SOT Locums available. Sam Lowe & Catherine Metcalf available for locum cover in South-East Queensland from start of February 2010. 14 years locum and practice experience throughout Australia & England. Please email & we will be happy to contact you to discuss your needs. Email: sam.cath@mac.com

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