SOTO AUSTRALASIA

SPRING 2010

EXPRESSION

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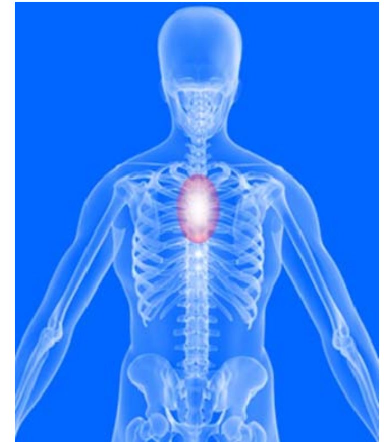
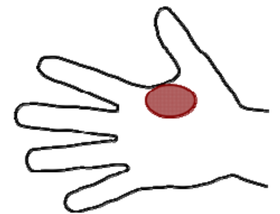
D4 Reflex—Gall Bladder



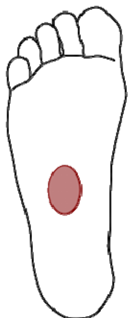
Welcome to this edition of the newsletter's article on the thoracic four reflex work involving the gall bladder, common bile duct and ampulla of vater. The bloodless surgery procedures in this paper are the observations of Dr. De Jarnette and his colleague, Dr. Mel Rees who developed the temporal sphenoidal reflex areas you see on your S.O.T. wall chart.

In clinical practice with a D4 reflex, CMRT and TS patient there are nine areas of pain reflex. Dr. Rees marked these with a skin pencil for pre and post comparison. In point form, these markings are:

1. The pain warning sign of bile system problems that brings in more patients than any other is knee pains. You will isolate the reflex pain to a small area on the medial inferior of both knees which is the bile duct sphincter of Oddi reflex. Mark these ouch areas with a skin pencil.
2. Mark the temporal sphenoidal T4 that is most painful. This will be the headache area that so many of these patients will present. This will extend to the superciliary arch then over the head to the occipital, commonly on the right hand side.
3. A common patient complaint will be pain areas on the right shoulder girdle. With a skin pencil mark the painful shoulder areas. These are on the right scapula as lateral painful nodules and on the top of the right shoulder meaning common bile duct abnormalities.
4. You will be surprised at how many patients will show you a pain area just above the right elbow on the inside of the arm which is the reflex area for the intestine area where the common bile duct empties. Mark this with a skin pencil.
5. Mark the painful – to – palpation third cervical transverse, commonly on the right hand side. This will be one of your contacts.
6. Mark the right hand web nodule which will be painful in gall bladder abnormalities.



7. Mark the right foot gall bladder area.
8. Mark the ampulla of vater reflex master area which occurs one and a half inches to the right of the umbilicus then three quarters of an inch down. In metric, this is roughly 40 millimetres to the right and twenty millimetres down. In some publications, a misprint gave this reflex point as three inches down rather than three quarters of an inch down, so please note this.
9. Mark the centre of the sternum painful area. This will be your final preganglionic area and is a region you have encountered previously in this series of articles.



There are several other areas that De Jarnette recommended you should note and test for before you begin your gall bladder and bile system CMRT work, including:

a) If the gall bladder is acutely inflamed, when you squeeze the right thumb index finger web there will be noted contraction of the abdominal muscles.

b) If the gall bladder is acutely inflamed when you squeeze the right foot gall bladder reflex area you will cause abdominal muscle contractions. This foot reflex area is usually more prominent than the finger – thumb web reflex.

c) If these two reflex areas are tender but no abdominal reaction is elicited then you have a chronic gall bladder disorder to contend with.

Here is a real dilemma for you to experience. You palpate and test these areas and suggest to the

(Continued on page 4)

PRESIDENT'S REPORT

Dear Colleagues,

Dr Darren Little

Thank you to all who responded to the online survey. Congratulations go to Eric Conti- the winner of the Annual Convention registration for completing our online survey and entering the draw. 45 % (110 members) responded to the survey and the Board will be closely analyzing this data at our next meeting together. Our aim is to represent you the members to the best of our ability and your feedback, both positive and negative will be use to improve the services we offer and create greater satisfaction within the membership.

I would like to comment briefly on a few points of note from this survey:

With 58% of you frequently using TMJ adjustments and another 35% sometimes adjusting the TMJ, our TMJ seminar topic for Annual Convention could not be more appropriately timed. It has been quite a few years since Temporomandibular disorders has been addressed by our organisation and now is a great time to hone your expertise in this area.

The top two seminar topics you would like to see presented again soon are Paediatrics, and CMRT/Bloodless surgery. Advanced Cranial/TMJ and Pregnancy followed closely after that. We hear you and intend to respond accordingly.

10% of responses stated they had not attended an SOT seminar Series in the last 10 years and 30% had not attended any advanced module within that time either. I know nowadays there are a plethora of fantastic seminars put on by other international and local organisations which you also attend. I encourage all members to continue to support SOTO-A and review their SOT knowledge regularly, Basic and Advanced. I am acutely aware of the task SOTO-A has to continue to present the SOT basics on a regular basis yet strive to keep up with current methods of our technique to challenge the regular SOT practitioners.

With this in mind, I encourage all of you who are interested in developing your SOT depth and scope further, to also look abroad for this inspiration and knowledge. SORSI holds their Homecoming Conference in St Louis in mid October and it is a pleasure to be taught SOT from those who were taught by DeJarnette himself. Please join myself and others representing Australia at this worthwhile annual event.

Along this same theme, several members were concerned with the apparent lack of further development of SOT in recent years. SOT developed rapidly year by year as The Major tested new theories and discovered new patterns. Each Homecoming, a new manual or set of new notes was added to the vast amount of information already collated. Indeed he was a genius with an incredible mind. Many current SOT pioneers have used DeJarnette's foundation of knowledge and adapted new ideas and theories from this. "Doctors sharing" is a very important part of SOT education, particularly at SORSI and SOT-USA and this allows for the expansion of the SOT technique. It is important though to ensure that a solid foundation of basic SOT principles not be lost with the teaching of streamlined tangent ideas and techniques. This is why we continue to teach the original DeJarnette SOT principles at our Seminar Series each year across the country and encourage all members to become certified in the technique. It is also the driving force behind standardizing the notes and presentations globally, as individuals have put their own slant on the way SOT is taught in other countries. Learn SOT as it was designed from the original teachings and then apply adaptations and advancements if desired. Changing SOT can be seen as natural progression or as dilution, and can lead to conflict as seen over recent years in the USA. My personal feeling is that neither is right or wrong. A solid foundation in conjunction with experience and innovation serves the profession and the community most effectively.

In response to comments made, we intend to create open forums with topic threads and chat rooms on our website in the near future. This will enable cases to be discussed and questions answered by our more senior practitioners. This also allows our membership to interact on a more immediate and intimate level. Stay tuned.

I am really encouraged by the responses and the general view of SOTO-A held by the members. This was a very worthwhile exercise and we hope to repeat this to gain feedback from all of you on a regular basis. Also, Averil or myself can be contacted via email at any stage to hear your concerns or comments. I am excited about the current direction SOT is taking in Australia and I am sure the membership will strengthen and grow as a result.

Cheers

Darren Little
President

FROM THE EDITOR'S PEN

Dr Samantha Culley

Hello to All,

Hello and welcome to anther exciting edition of Expression. With our Seminar Series coming to an end many of you will be implementing some of the extraordinary work by DeJarnette into your practices. For some it is still a challenge as there is soooo much information to take in, in such short time frames.

I applaud you all for making so much of an effort and spending the time to improve your knowledge in order to improve the health of your people. Thankfully, there are many great articles, such as the one in this issue regarding the Gall Bladder reflex that is a fabulous expansion on what is already taught. For those who attended the CMRT series you will find these articles interesting and welcoming as they start to increase your basic knowledge and place it into a clinical application.

Thank you so much to John and Peter Kyneur for all your hard work in supplying us with this information for us all to grow and have many BFO moments.

For anyone from any of the seminar series please remember that you are more than welcome to contact us with any questions that may arise though out the year. (My e-mail s.culley@hotmail.com).

Enjoy reading.

Sam Culley

Editor

To see more of DeJarnette's articles visit the DeJarnette Library

http://www.dejarnettelibrary.com/

SOTO Australasia

Annual Convention & AGM

13 & 14 November, 2010

Mercure on Spring Street, Melbourne

SOT Certification Examinations

2pm Friday 12 November

SOTO Australasia—Events 2010

Surfers Paradise

Legends Mantra Hotel, Cnr Gold Coast Hwy & Laycock St, — **CMRT/Cranial**—September 24, 25 & 26

New Zealand

NZ College of Chiropractic — **CMRT/Cranial—**October 9 & 10

SOT Certification Examinations

Mercure on Spring Street, Melbourne — **November 12**

SOTOA Annual Convention & AGM

Mercure on Spring Street, Melbourne — **November 13 & 14**

Man does not live by words alone, despite the fact that sometimes he has to eat them.

Broderick Crawford

D4 Reflex—Gall Bladder (Cont.)

(Continued from page 1)

patient that they have a gall bladder problem. They say this can't be possible as they have had their gall bladder removed some years previously. Here is what has occurred. Because the surgery was done under anaesthesia, the brain did not fully record this and is not aware that the gall bladder has been removed and thinks the gall bladder is still there and in trouble. Part of your CMRT work is to handle this neurological confusion. It is a bit like the organ equivalent of phantom limb syndrome, in which a person loses a leg but still feels a need to scratch a perceived itch or feels pain or par aesthesia in that limb.

A patient can exhibit any one or all of the following symptoms of gall bladder and bile system abnormality.

1. The lower G.I. tract distended by gas.
2. Gastro enteric distress.
3. Gastric vertigo.
4. Pain over lateral scapula.
5. Right shoulder girdle pains.
6. Knee pains.
7. A right frontal sphenoidal headache.
8. Nausea.
9. Irregular bowel action.
10. Bowel movement yellowish and with an oily appearance.
11. Jaundiced whites of eyes.
12. Nervous to extremes.
13. Pain between xiphoid and umbilical.
14. A tension over McBurneys point.
15. Occipital pull described by the patient as 'headache in back of head'.

In the procedure for the T4 reflex patient you are dealing with bile stasis. You are endeavouring to do the following seven things:

1. Anaesthetise the very painful common bile duct so you can work in that area.
2. Relax the sphincter of Oddi.
3. Relax the spastic common bile duct.
4. Relax and empty an inflamed impeded gall bladder or convince the brain that a surgically removed gall bladder is no trouble.
5. Drain the liver of impeded bile backup.
6. Adjust the occipital side slip which will be found.
7. After this has been completed you then remove the anaesthesia with the preganglionic technique.

T4 Technique

Your patient is supine and you are seated to the patient's right. All reflex areas to be worked on have been marked with a skin pencil and the following seven steps are then performed.

Step One: As soon as the patient is turned from the prone to the supine the doctor applies TS pain control anaesthesia. The doctor's left hand finger contacts with light pressure the active TS T4 on skull. Doctor's right hand holds a light contact over the ampulla of vater abdominal reflex. This is a one to two minute hold being enough time to block the pain receptors so that the following steps can be more readily performed.

Step Two: Now move your left hand under the patient and contact the T4 transverse process major—its held there under the patient's body weight. Your right hand begins at the soft tissue under the xiphoid and works its way down to the ampulla of vater area, in sweeping circles. This is to relax the common bile duct. If you have done your TS pain control sufficiently, this should be well tolerated by the patient.

In earlier times, thus in the development of CMRT when it was still termed 'bloodless surgery', this step was known as post-ganglionic clearing or neutralisation of the postganglionic exciter. Simply, you are clearing out the pain-causing signals that the viscera are sending to the brain. Now, with the spasmodic calibre narrowing visceral reflex neutralised you can proceed to drain the bile ducts and the gall bladder.

Step Three: Now you must relax the gall bladder and use palpatory pressure so that it will empty its contents. If there has been gall bladder surgery this will relax the 'stub' by clearing lace adhesions and thus convincing the brain that the gall bladder area is normal. If the right hand web reflex is more painful than the foot gall bladder reflex, then you contact the marked nodule in the web between your left hand index finger and thumb with a squeezing pressure. Your right flat hand is placed over the bile duct area with the fingers over the gall bladder just under the liver. The rest of the flat hand will be over the bile duct and ampulla of vater. This hand contact presses floorward and then headwards as the left hand contact uses rotary moves over the web nodulation. Do this for one minute or until you feel the gurgling sensation as relaxation occurs.

Step Four: If the foot reflex is more painful than the thumb web, then the foot contact is used for this step. The right foot area where you find this gall bladder reflex is just to the inside of the colon hepatic flexure reflex foot area. Flex the patient's right knee and bring his right foot up to rest over his left knee so you can readily reach the reflex. Use a right hand double finger reinforced contact to the foot reflex as your left hand contacts over the ampulla of vater. No vigorously manipulate the marked foot contact as the bile duct soft tissue contact is pushed floorward and then headward up under the liver. Repeat this for one minute or until you feel the gall bladder bile duct areas relax.

Step Five: This is the third cervical contact. The third cervical on the right hand side is contacted with left thumb anterior, fingers to the posterior. The right hand contacts those tissues to the right and inferior of the umbilicus. You lightly stimulate the cervical while lower hand moved floorward then headward. You continue until you hear and feel the gall bladder, common bile duct and intestines move with a gurgling sound. If gall bladder surgery has been performed you will still get the gurgling sound. Remember with this step you are normalising gall bladder to brain reflexes. It is telling the brain that the gall bladder which isn't there but should be is returning to normal function – as you proceed with this technique.

Step Six: This is now a pump out and emptying technique. You reach under the patient with your left hand and make firm contact with the painful dural port area at the fourth dorsal. The right hand vigorously carries the bile duct tissues up under the liver and rib cage to the right and then to the left as headward pressure is maintained.

If the gall bladder is still intact it will discharge its contents. If surgical removal has been the case, it will produce ease in perception of the gall bladder troubled reflex.

Step Seven: You only use this step when you are certain that all the bile duct reflexes are normal. In practise you would have 5 or 6 visits before adding this, the pre-ganglionic step. A good suggestion is to go to the CMRT 1966 step of De Jarnette's, thus, the postganglionic. De Jarnette used the holding contact over the right shoulder and mildly stimulated two areas in postganglionic procedure, the rib or duct area and secondly, the ampulla area, we have already worked on. The preganglionic has these same contacts, duct and ampulla, but whereas the postganglionic is a soothing hold contact for the spinal accessory nerve, the preganglionic involves contacting that central sternal exciter area (after visit five); found at the sternum at the mid – nipple line. This area is painful to touch and you tell the patient so. You then perform 10 vigorous circles as the other hand is on the duct reflex area and then 10 vigorous circles as the other hand is on the ampulla area.

(Continued on page 5)

(Continued from page 4)

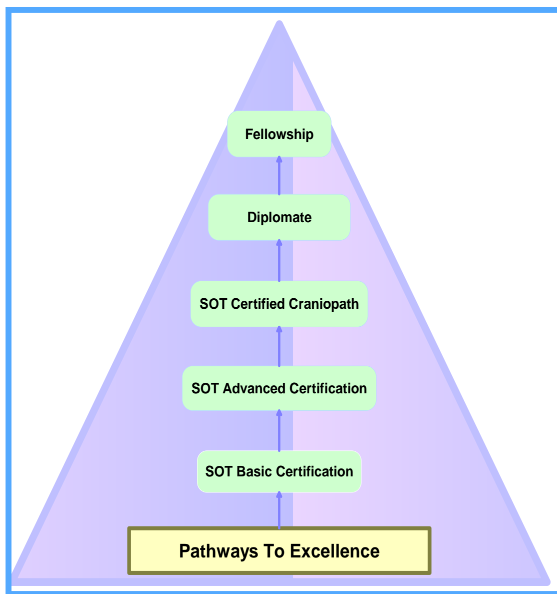
Effectively, you are putting a force into the nervous system to stimulate a previously troubled viscous, either inflamed or chronically sluggish into activity.

As with all of the articles in this series, the information is there to flesh out your CMRT procedure that you have learned in your basic series and which you have read about in the definitive work, De Jarnette's CMRT Manual, 1966. This volume and the charts you will need are available from Averil at SOTO Australasia headquarters. As well, don't forget that wonderful resource, the Rose Ertler memorial library, which is maintained by Dr. Rozeboom and has generously been made available to SOTO Australasia members. Bye for now.

John S. Kyneur — Haberfield, Sydney, NSW

Peter J. Kyneur — Toronto, Newcastle, NSW

S.O.T. Certification—Examinations 12 November, 2010



The 2010 S.O.T. Certification Examinations are scheduled to take place to coincide with the SOTO Australasia's Annual Convention and AGM. Examinations will be conducted in both theory and practical for Basic SOT Certification, Advanced Certification and SOT Certified Craniopath. Reserve your place by calling Averil.

A guidelines handbook that is available to download from our website, has all the information as well as a registration form.

Some of last year's successful candidates have been part of the educating team at this year's Seminar Series. Their help and enthusiasm has been well appreciated by both Primary and Table Educators as well as the participants.

To be eligible to sit the Basic and Advanced Certification examinations a candidate must have completed the SOT Seminar Series at least twice, be a financial member of SOTOA, be a registered chiropractor and have had at least 1 year of practising as a chiropractor. To be eligible to sit for SOT Certified Craniopath a candidate must have completed 140 hours post graduate SOT Seminars or SOTO International sponsored programs(equals 4 Basic Seminar Series), be a financial member of SOFOA & a registered chiropractor.

Diplomate status is available to a practicing SOT Certified Craniopath who has submitted a written thesis for consideration by the Board of Directors.

Fellowship status is achieved following Diplomate status by having a research paper published in a peer-reviewed journal.

Asthma—by DeJarnette

Asthma is reaching epidemic levels. So I thought I would do a word search in De Jarnette Craniopathy. In just one book, the 1982 Craniopathic Instructors Manual, I found the following. I copied the paragraph where "asthma" is found. Imagine if this were done for all of the SOT™- Craniopathic manuals.

David Rozeboom

Start of reproduction.

The following are cranial procedures not indicated by categories:

The Cranial Bowl Lift.

The Cranial Rhythm Impulse Technique (C. R. I.). Respiratory

Temporal Rocker Technique (R. T. R. T.).

Temporal Reciprocating Technique (T. R.T.).

TMJ Malocclusions

Deafness.

Ventricular Compression Bulb Technique.

The Sphenobasilar

Symphysis Technique.

Sphenobasilar Asthma Technique.

Sphenobasilar Occipitofrontal Approach Technique.

Craniosacral Approach To Sphenobasilar.

Spheno-Basilar Flexion And Extension Technique.

Cough Test To Determine Flexion Or Extension Of The Sacral Base.

Sacral Pussy Footing Craniosacral.

Inhalation Exhalation Sacral Balance Technique.

C.S. F. Balance Technique.

Mastoid C. S. F. Balance Technique.

Inhalation Faults Technique.

Accelerator Bulb Technique.

C.S. F. Control Technique.

Sutherland's Uncle Tom Sacral Pussy Footing.

Asthma Cruciate ,

Technique. Eustachian Tube Technique.

Epilepsy Technique

Directing The C. S. F.

The Cranial Antidote Technique.

Cranial Membrane Flexion And Extension Technique.

The Frontal Fruit Jar Technique.

Craniofacial Lift.

Coronal Suture Technique.

Frontal Headache Technique.

Continued on page 6

ASTHMA—BY DEJARNETTE CONT.

Continued from Page 5

Pterygoid Testing.

Temporal Balancing.

Maxillary Technique.

Vomer Technique.

The Sphenopalatine Ganglia.

Infant Cranial Technique.

Tongue Depressor Test For Mandibular Vertical.

Page 8

The adjustment for respiratory cycling is as shown in the manual.

The lateral plate fingers simply lift and pull backward on inspiration and loosen on exhalation. Play like your fingers are magnetized and the parietal is lifted by this magnetic contact.

The parietal is a key cranial bone in that when it is depressed, the entire skull locks. All of the above is table practice.

This particular technique is found to be useful in asthma, strokes, epilepsy, pressure headaches such as menstrual headaches, prestrike syndromes. This is a useful part of the Category Three parietal lift technique.

Page, 9, 1982 Craniopathic Instructors Manual

Page C, C. T. 79-80

R. T. R. T. (respiratory temporal rocker technique), this technique is a universal cranial application and is needed as a finishing part of any type cranial correction. The technique has a built-in safeguard, the forehead. When the technique is being applied, you stop the second you see the forehead area blanch. If this occurs on inhalation, stop. If on exhalation, stop, do not go past the time of frontal blanching (turning white).

The temporal bones are likened to the timing mechanism of your automobile and by reciprocating action, they balance the body by balancing the equilibrium mechanism. This is one cranial correction that every person can benefit from

because most persons, especially after fifty years of age do have an imbalance of the temporal bones and thus an imbalance of the reciprocal respiration mechanism and the righting mechanism. A vestibular imbalance not only causes you to be dizzy, but may be the cause of asthma or high blood pressure. Those are but two instances of many that may be benefitted by this R. T. R. T. application,

The contact must be drilled by actual workshops as the basic thumb contact into the mastoid of the temporal bones is the important step. The elbows are the tools in the manner of operation. With the bilateral contact in position, the elbows are spread apart on inspiration and brought together on exhalation. This creates a fulcrum action on the mastoids and reciprocates the temporals. When the forehead blanches, stop. It doesn't matter if the elbows are all the way out or in, stop at the blanching point.

When we teach this page we must be ever mindful that a book can never be written that totally and absolutely outlines everything you do as a Craniopath. Craniopathy is a science that must oftentimes be improvised because the cranium does not act according to specific rules. A person may appear to inhale normally but its effect upon the cranium may not be felt as am elevated C. R. I. Exhalation may appear normal but its effect upon the cranium may be nil as far as extension of the membrane is concerned. Research in craniopathy is constant because you never do exactly and precisely the same hand movements on any cranium twice. There is always the need for the variable and that variable is you meeting circumstances as they rise.

A surgeon may open an abdominal cavity with the intention of doing a specific technique but he must be versatile enough to vary his approach.

The terms given on this page are important to memorize and this should be done. You memorize by repetition. The terms we use to express ourselves cranially are defined. The sagittal suture of the parietal bone is not only a pain control area, it is the area that is elevated to control epilepsy, strokes and asthma. There is not much difference between the paralysis of a stroke and the convulsion of epilepsy and the choking convulsion of an asthmatic attack. All are produced when the sagittal suture sinks due to a flattening of the parietal bone and pressure on the straight dural sinus of the brain system.

Inspiration sees the sacrum normally move superior at the base and anterior at the apex. Exhalation causes the sacral base to move anterior and the apex posterior. When the above movement does n t occur we then have a reciprocal imbalance and this must be corrected. Basically lesions of the sacrum cause the parietals to tighten and sink, causing

strokes and seizure and asthma. Two cranial lesions are causative of asthma...sacral imbalance and sinking of the sagittal suture, along with bulging of the cruciate suture back of the hard palate.

Page 20, CT 79-80

This page must be studied and the landmarks remembered. The hard palate basically forms the anchor point for the sphenobasilar so it does play a prominent part in craniopathy. A shift in the hard palate is often the culprit in TMJ problems. Basically the cruciate part of the posterior hard palate is the area we use in respiratory problems, asthma, etc. The hard palate proper is specific for Category One crest and dollar sign indicators. Oftentimes the pterygoids shift due to improper denture construction and they can be the cause of many types of facial and cranial neuralgias. Tension in the occipital bone area is suspect in any type hard palate shift.

The first cranial development that Major De Jarnette made as the connection between the shift of the hard palate and the continuing dollar or crest in the Category One. The parietal dome is the mystery bone of the cranium. This is perhaps the one area where craniopathy is weakest because so many so called craniopaths try to use the hard palate as the

panacea for the skull. Pretend for a moment that you are made to wear a tight skull cap and there is no way you can loosen it. Pretend you have your head in a mould and someone is applying constant pressure onto your skull. Pretend you are the meningeal artery and you are trying to carry the essential load of arterial blood and someone is stepping

on you. That is the thing which underlies the parietal.

Everyone is adjusting the TMJ or the occiput or the frontal but the parietal is the one bone that might be the cause of the other bones complaining. Tension in the back of the head and neck always brings to mind parietal pull or pressure. Epilepsy, asthma and many of the chronic problems that make life miserable may be caused by the parietal.

Read this page, explain it and discuss it.

When you see a hypertensive person, think of the parietal before you think of any other therapy. Palpate around the perimeter of the parietal. Palpate the sagittal suture. Feel of the center of the parietal for a soft spot. Think of the parietal as the roof of the skull. Think of it as a hat you wear. Think of it as overlying the great straight dural sinus. Think of the parietal when you adjust the epileptic, the asthmatic and of course the hypertensive. Think of the Parietal when you see the cerebral palsy victim going through his or her spasmodic gyrations. Think of the parietal when you see

someone with a severe pressure headache, because this person will point to the parietal as being a great height on top of the head.

Think of the parietal when you adjust a Category One temporal or occipital or frontal and the adjustment does not hold, when you see a hyperactive child. Remember that pressure on top of the head excites the motor center just as it does when an epileptic seizure occurs, or a cardiovascular accident happens. Think or the parietals when someone complains that suddenly the leg or arm goes numb while sitting quietly.

(Continued from page 6)

The skull gets too heavy to bear and the patient has to lie down for relief...think of that flat iron bone as being too tight. The parietal lift is perhaps one of the most important adjustments we know, yet it is seldom used because the doctor feels that he is not doing anything, because nothing pops or coughs or otherwise makes a noise.

In this adjustment you simply have to use your imagination and think you have glue on the tips of your fingers and the glue sticks and you are lifting the parietals off the skull. In doing the parietals it quite often helps to go around the perimeter of the parietals and simply use your fingertips to pry the parietals up and forward. In going along the perimeter of the parietals, you pass the labroid suture, the coronal suture and the squamosal and the parietomastoid suture.

Take your disarticulated skull and hold the parietal in your hands and study it totally. You will be glad you did.

Spend as much time as you can learning the feel of the parietal lift...the first cranial contact you see in the cranial technique 1979-80 manual.

Page 26.

Page 79. CT 79-80

This is a different version of the sphenobasilar symphysis technique we have just described. This has been one of our asthma standbys for many years. Here is where you need the cough test because this version of the sphenobasilar is constructed to take care of the S. B. Minus type sphenobasilar. The asthmatic is caught with air that cannot be expelled and this is associated with cranial flexion. With this type flexion it is impossible for the mechanism of respiration to go into extension or exhalation.

The contact is fully explained. Your table leader will read this page and discuss it and that will be followed by a workshop session. When you begin palpating the borders of the frontal bone, you will find many abnormalities and they will lead you into improvisation of remedial techniques. That is true cranial Research. This is a modified sphenobasilar symphysis technique. This contact is especially indicated for some types of asthma in which the sphenobasilar is caught in flexion. This would be indicated by an S. B. Minus cough test. This basically influences the phrenic nerve and that is why it is sometimes preferable to relieve an asthma attack.

We find this contact also helpful in many nervous problems in which the solar plexuses are irritated and in which spasms of the diaphragm are causative. Many times the diaphragm is a trouble spot without diagnosis. When the arm is weakened by an opposite hand contact over the solar plexuses, this sphenobasilar is helpful. In working from the patient's left side, patient supine, the right index and middle finger contact just inferior of the occipital protuberance,

the left hand with its thumb contacts the right sphenoid and the middle left finger the opposite sphenoid.

Upon exhalation, the sphenoids are lifted upward and forward. On inhalation, lightly hold the sphenoidal contact and rotate the occipital contact right or left, whichever offers the more resistance. Rotate into the resistance.

Page 80. CT 79-80

This is the occipitofrontal approach to the sphenobasilar. You are facing the patient's skull and basically you are correcting the frontal in relationship to the sphenoid. We personally use this contact more in lifting the skull to free orbital pressures. You will find this especially good in certain types of migraine where nothing seems to be effective. Your sphenoid contact is not for the purpose of feeling the cranial pulse, but is a bony contact to relate the sphenoids to the frontal. Many eye problems will be helped by this procedure. You simply make your contacts and then. Move the

sphenoids and frontal until you find a comfortable position for the patient. This is another procedure where you improvise to meet a situation and that you must learn to do if you are to become a Craniopath. This is a workshop page.

Page 99. CT 79-80

This mastoid-contact is basically for those patients with respiratory problems. In this cranial technique we deal with the mastoid process as it does seem to have a major influence on primary respiration. This is the cranial contact you would use on all respiratory problems as a supportive measure.

During an asthmatic attack this procedure would do very little good. You would use the sagittal lift or the cruciate suture elevation during an attack. This is the cranial procedure we use on all anemic and so called run down patients. Iron does them very little good, liver and B-12 seem to fail, but this mastoid process procedure does seem to help This cruciate correction does help asthma sufferers and should always be given a trial run. Remember that asthma is often an allergic problem and you of course must try to find the substance to which the patient is allergic. The cruciate suture technique is used on emphysema patients and does help. You must use an intramouth contact and be sure and hold the mandible so you will not be bitten, especially by youngsters.

The cruciate suture is back of the hard palate and close to the gag center so be ready to withdraw your finger in am emergency. The instructor will read or have this page read and then demonstrated. The table group can take this

contact on themselves and see how it feels. Go along the hard palate until you feel the posterior ridge and you are then on the cruciate suture. The nasolabial furrow is often present on the side of external maxillary movement. We prefer the index finger as the intramouth finger. This technique should be given slowly and held until the patient can exhale freely and that means you may have to apply the contact several times at one visit. Be sure and stay off the gag center. When

you have your cruciate contact turn the face toward the left and then wait for a deep breath and then turn the face to the right. This is a demonstration and workshop page.

The Category One may be an asthmatic or a person in good health, but whatever the state of health, you must be conscious that a Category One develops problems with his primary respiratory system, and those problems may be totally without embarrassment to a person's breathing.

Page 190, CT 79-30

Category Three: the instructor will remind you that you saw this sagittal suture adjustment on page A at the beginning of this seminar. This is also the same basic contact we use for some types asthma in cranial specifics and epilepsy. This same type sagittal technique is demonstrated for hypertension and stroke victims. It will be shown under the Category Two sutural technique under the Vee spread for the frontal. The management of Category Three is covered in the S. O.T.

manual for 1982.

While the sagittal spread is not specific as cranial goes for the supposed disc problems, it is a basic control for the straight sinus and the sagittal, sigmoid and lateral sinuses and the falx cerebri and a corner of the tentorium. The Category Three patient is after all a combination of many incorrectly positioned parts of his mechanism, and this sagittal

spread is worth a try. In trying to help the Category Three patient with this sagittal spread, you will be surprised at how many other problems it does help clear up.

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Category Three- sagittal spread: this is a study page. The instructor will demonstrate and the table group may go through a workshop with actual contacts. You saw this cranial on page A and later on for asthma and epilepsy cranial. This Category Three sagittal spread does help in selected cases of gross sciatica and even when surgery fails.

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Experienced Wellness SOT Locums available. Sam Lowe & Catherine Metcalf available for locum cover in South-East Queensland from start of February 2010. 13 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

S.O.T. Locum Available. Dr. Troy Miles. SOT Advanced Certification. Available Australia chirotroy@yahoo.com.au

Wayne Jennings Locum Service. Commencing January 2011. 29 years private practice. SOT Certified / Diplomate. 0457 931 377.

Dr. Ali Postles. Passion. Integrity. Commitment. Techniques SOT, NET. References. Available Now! Contact alipostles@gmail.com. 0420 233 577.

Spring is nature's way of saying, "Let's party!"

Robin Williams

Associates / Locums Required

Baulkam Hills, North West Sydney. An exciting position awaits an enthusiastic and motivated chiropractor to join our established and busy SOT practice. The successful applicant must be competent and confidant in SOT and or NET. Complete training and support will be available for new team member. All interested parties should e-mail their CV to gerald@ehchiro.com.au

15 Minutes from Adelaide CBD. A wonderful opportunity exists for a self -motivated Associate passionate about Chiropractic, in a well established Multi-Practitioner Clinic 15 minutes from the CBD. Successful applicant must be able to communicate well with patients, have good adjusting skills and be a team player. SOT would be a great asset. Other techniques used in the Clinic include AK, Diversified, Activator, Drop Piece, NIP, A.B.C., Foot Levelers, Posture Pro and Auricular Therapy. New techniques are welcome; however we require competence with Manual Adjusting. Interested parties please forward resume to: Practice Manager, C/- 34 Hawker Avenue. Belair SA 5052

Associate position available at well established SOT based Practice in Lakes Entrance Victoria. Flexible hours and an opportunity to develop own patient base in a relaxed seaside rural environment. Contact Dr Richard Howden 03 5155 4400 (BH), 03 5155 2562 (AH) or email lakeschiro@bigpond.com

South Australia - Limestone Coast. Associate or locum opportunity in busy CBD family practice commencing 2011. Experienced Chiro. or new grad. proficient in SOT &/or low force techniques is invited to take care of a well-established patient base 4.5 day week. Your chance to Practice with Passion not pressure in this great Mt Gambier location! Contact Linda P: 041 780 4741 E: manormail@optusnet.com.au

Vibrant SOT based practice Balance Chiropractic in Waiuku (50min south of Auckland CBD New Zealand). Flexible hours and start date with potential to work a ´family flexible´ timetable and build a bustling practice. Waiuku a lovely rural/coastal town with a population of 7000+ and at present only one Chiropractor. The practice is full to capacity and has easy systems and procedures to follow a good retention rate and most new clients are through word of mouth. We have a high family and child active wellness focus and have good relationships with other local health practitioners. We are expanding and currently looking to upgrade the premises to a more central location in town with the potential to work with other holistic health practitioners in the one location. We are looking for someone to join our team anytime before December 2010 and we are open to a Chiropractor continuing with us in a potential partnership. We would love another SOT based Chiropractor who has had some practice experience and is confident to establish their own client base and manage their practice procedures. (A willingness to learn is also welcomed) To find out more and meet our team please call Dr Samantha Haitsma 021 244 0276 or email sam@balance-chiro.co.nz

A great opportunity exists for Chiropractor(s) to work in a busy practice. Replacing existing associate who is leaving to travel in January 2011. Currently seeing 120-130 patients per 4.5 day week, 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 403 585 615 after 6pm.