SOTO AUSTRALASIA

WINTER 2010

EXPRESSION

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EDITOR:

Samantha Culley

BUDDINA, SUNSHINE COAST

07 5444 3499

s.culley@hotmail.com

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Thoracic 3: Respiratory Syndrome

Welcome to SOTO Australasia's winter edition of the Expression newsletter. For those of you who may be new to "Expression," we offer a brief outline sketch of our publication. As previously mentioned in Expression SOT historical articles by Drs Parker, Leyonhjelm, Postles and Bastian, the newsletter commenced in 1974 and the association soon after. SOTO Australasia has presented continuing and unbroken lecture and workshop seminar series of the categories, CMRT and cranial work over the last four decades in spite of mishaps, especially in the early years, such as floods, air strikes, rail, bus and tram strikes and the like. We are proud to have developed the first certification programmes in SOT and currently the board is cooperating with other world-wide SOT organisations to achieve a standardisation process in the teaching of Major DeJarnette's work. Our SOTO Australasia coordinator, Averil Crebbin, has for many years ensured the newsletter has been published and available, and has spent endless hours behind the scenes, some of which have included a reprinting of the archival newsletters which are now available to all via the website.

For our part (John and Peter's), we have been able in these Expression articles of the last few years to forward some of the clinical methodology and knowledge we have gleaned from our instructors, conference guest speakers, authors and correspondents in the SOT community. The current series of articles are a re-introduction (rather than a re-invention) of the works of Dr. DeJarnette's colleague and good friend, Dr. Mel Rees. Dr Rees developed the Tempero Spehnoidal line work and we are sure many of our readers will find the work useful. A secondary purpose in writing this series is to expand and strengthen the usage of the CMRT work in our SOT field practitioners.

Here now is Respiratory Syndrome. Now, it is a maxim of the CMRT work that you adjust according to your triad of findings – occipital fibre, trapezius indicator and vertebral transverse process nodulation. It is too limited a view to have that: T3 work "well that's all about sinus troubles" and to thus proceed, blindly and without investigation. We are reminded of the thoughts of Dr. Terrence Bennett on the subject of sinusitis. By way of introduction, Dr. Bennett was a San Francisco chiropractor in the 1940's, 50's and 60's best remembered as the developer of the neurovascular reflex points which have become an integral part of Applied Kinesiology.

On sinusitis, Bennett stated that: "Ear, nose and throat specialists have treated sinus conditions for many years and their patients still have it, because they have treated it as a local disease. It is not. Suppose you drink a little too much and wake up the next day with a hangover. What has happened to your nose and accessory sinuses? There is congestion and swelling as though you had a cold. What produced it? Certainly, the alcohol did not get into the nose. Sinusitis is not a disease of the sinuses. It never was, it never will be. It is a condition of the second unit of digestion." The sentence applicable from our CMRT notes is "Sinusitis often means the body is retaining toxins."

The four units of digestion are listed in table one.

FIRST UNIT:	MOUTH, OESOPHAGUS, STOMACH
SECOND UNIT:	PYLORUS, DUODENUM, HEAD of PANCREAS, GALL BLADDER, and LIVER
THIRD UNIT:	SMALL INTESTINE
FOURTH UNIT:	APPENDIX, CAECUM, ASCENDING TRANSVERE, and DESCENDING COLON, SIGMOID FLEXURE and RECTAL POUCH

(Continued on page 4)

PRESIDENT'S REPORT

Earlier this month, SOTO-Europe celebrated their 25th Anniversary with a special gala event held in Windsor, England. I was honoured to represent SOTO-A at this International event, with an incredible line up of guest speakers and to be able to join in celebrating the growth and development of SOT throughout Europe over this time.

Dr Darren Little

I would like to congratulate SOTO-E on their success seeing that SOT has become the most studied Chiropractic technique outside the University system throughout Europe. Special congratulations to Jon Howat in receiving a Lifetime Achievement Award from SOTO-E and Steve Williams for his continued leadership of this organization.

The more I compare the teaching of SOT here in Australia with our sister organizations, I realize we are so blessed with a passionate group of educators who continue to strive for the best quality of SOT education we can offer. Be assured that our SOT education in Australia is truly revered and is a credit to our educators over the last four decades.

Those of you who have attended the Series this year will agree the newly developed notes and PowerPoint presentations are fantastic and are a credit to the efforts of those involved in their development. The main aim of this undertaking was to enhance the learning experience of SOT in Australia, to make it clear, concise and respond to participant feedback previously received. All your comments regarding the organization are most welcome and encouraged to allow us to serve you better.

We have many new faces contributing as Assistant Table Educators or Table Educators this year. This is a great opportunity to hone your certified SOT skills, contribute to SOTO-A, and refresh the latest teaching and education. De Jarnette always said if your ever want to learn something properly then you should teach it. It is also the stepping stone for those wishing to become Primary Educators down the track. I thank all of you in advance for your time and commitment to serving SOTO-A and for helping make the SOT Series this year a success.

I would like to apologise to those people who were waiting for a midyear advanced module SOT holiday break this year. We were planning to combine a conference with a resort-style holiday offshore but due to time constraints and other priorities this has been postponed until next year. I will keep you all up-to-date with any progress we have with developing this so you can book your "holidays" in advance.

Until next time,

Darren Little
President

Current SOTO presidents Dr. Steve Williams (SOTO—Europe), Dr. Darren Little (SOTO Australasia), Dr. Suzanne Seekins (SORSI) & past SOTO-E presidents Drs. Jonathan Howat, Brian Gwilliam & Giles Courtis.

SOTO Europe celebrated 25 years at a dinner at the beautiful Beaumont House Chapel, Windsor

Congratulations to Jon Howat on receiving Life Member Award from SOTO—Europe!

FROM THE EDITOR'S PEN

Hello to All,

Well we have very exciting Expressions this quarter. With the CMRT module well under-way it is a perfect time to integrate the reflex work in with those categories. I would like to thank all the dedicated Chiropractors that spend the time to research and write for all of us to become more prolific Chiropractors serving the people that come to our offices/practices creating a much healthier and responsible nation.

With Thanks

Sam Culley

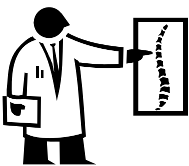
Editor

Dr Samantha Culley

UPDATES TO THE 2010 DIRECTORY

Since this year's SOTO Australasia Membership Register & Directory has been published we have had more renewals and new applications. Remember to regularly check our website for SOTOA members in Australia, New Zealand and Locums!

MORE OPTIONS THAN EVER WHEN ATTENDING SEMINARS!



If you register to attend the Full Series, or more than one session you have the option of attending at various centres! For instance, you may attend the Categories Session in Sydney, CMRT in Melbourne and Cranial back in Sydney. For those who have never completed the full series, remember that each session is a pre-requisite for the next! We look forward to hosting the Series in Adelaide for 2011.

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

Melbourne

Rydges on Swanston, 701 Swanston Street, Carlton — **Cranial**—July 16 & 17

Sydney

The Sebel Surry Hills, 28 Albion St, Surry Hills — **Cranial**—July 30 & 31

Perth

All Seasons Perth, 15 Robinson Avenue, Northbridge — **CMRT**—August 13 & 14; **Cranial**—September 10 & 11

Gold Coast Surfers Paradise

Legends Mantra Hotel, Cnr Gold Coast Hwy & Laycock St, — **Categories**—July 2, 3 & 4; **CMRT/Cranial**—September 24, 25 & 26

New Zealand

NZ College of Chiropractic — **Categories**—July 10 & 11; **CMRT/Cranial**—October 9 & 10

SOT Certification Examinations

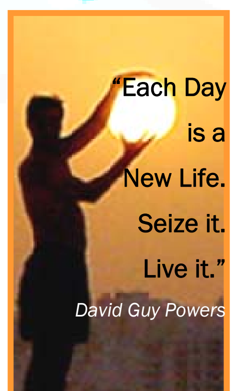
Melbourne — **November 12**

SOTOA Annual Convention & AGM

Melbourne — **November 13 & 14**

"The Power of Imagination makes us infinite."

John Muir



THORACIC 3: RESPIRATORY SYNDROME (CONT.)

(Continued from page 1)

Dr. Bennett recognised a strong interconnectedness between the respiratory and digestive functions and noted that the gall bladder and liver are always involved in the sinus process. Bennett observed that his sinusitis patients had soreness in the mid-thoracic region – specifically, fourth, sixth and eighth dorsals and further stated that: "you will find lumbo-sacral tenderness and low back pain among these people. It is the same, because it reflexes to the digestive area, to the upper dorsal region and to the lumbo-sacral articulations where it involves the portal circulation." The relevance of Bennett's writings to the CMRT work is that we do need to look at the D3 reflex work but also to pay attention to the underlying D4, D6 and D8 involvement. Now onto the Rees work of thoracic three with the description of his marking system, TS anaesthesia and step-by-step technique application.

When your temporal sphenoidal palpatory painful area identifies as T3, then you are alerted that your patient has a respiratory tract abnormality. You have one or a combination of problems to fix in the lung field, the bronchial field, the pleura, the diaphragm, the tracheal-pharyngeal-laryngeal area, the tonsils, nasal or sinus tracts, the Eustachian tubes and inner ear.

In respiratory CMRT, you must immediately think in terms of clavicular and scapular structure problems which have set up abnormal shoulder girdle function.

Man's respiratory function depends upon free shoulder girdle action; remember, the heaving clavicles are typical of the struggling asthmatic with insufficient lung filling capacity. In the partially destroyed lung fields of the emphysemic, shoulder girdle fixations mean death. When you find a TS-T3, mark the following body palpatory painful areas with your skin pencil.

1. The most painful temporal sphenoidal D3. This will be used to check progress and for pain control.
2. The most painful superciliary arch (about a quarter of a way out on the eyebrow from centre. Press – one side will be tender).
3. The superior clavicular areas that are painful.
4. The coracoid-clavicular union if painful (as it is in asthmatics).
5. The right and left abdominal sides in line with the umbilicus. These are the receptor block contacts.
6. The lung and bronchial diaphragmatic reflex which starts at the xiphoid and extends laterally along the costal arches for four inches.
7. The second and third inter-rib space, if painful. Found 2 inches lateral of the sternum just pas the costal chondral cartilage, these are painful in bronchitis on either or both sides.
8. The third and fourth costo-chondral interspaces at the sternal borders when they are painful to palpation.
9. The third rib at a point three inches lateral of the sternum which is painful in sinusitis.
10. The belly of the deltoid muscle which is painful in lung or bronchial abnormalities.
11. The painful area on the right gluteal which seems to radiate to the right iliac crest in sinusitis.
12. The painful anterior and posterior mid-femoral areas which are painful in sinusitis.
13. The pharyngeal-laryngeal reflex at the supra-sternal jugular notch. In severe laryngeal infections, pressure here will set up a cough reflex. Your bloodless surgery procedure for T3 is directed toward freeing shoulder girdle, rib and hyoid fixations, ventilating the lungs, then draining the sinus congestion and the respiratory tract lymphatics.

IN RESPIRATORY CMRT, YOU MUST IMMEDIATELY THINK IN TERMS OF CLAVICULAR AND SCAPULAR STRUCTURE PROBLEMS WHICH HAVE SET UP ABNORMAL SHOULDER GIRDLE FUNCTION

Bloodless Surgery T3 Technique – Step by step – patient supine.

1. Place a left hand finger on the marked TS.T3 and your right finger tips lightly on the marked abdominal receptor block area for two minutes. This is your pain control so you can do bloodless surgery without undue patient discomfort. One side alone will usually be sufficient to dull the painful marked areas so that bloodless surgery can be performed
2. You must now free the costal arch restrictions by working your thumb up and under the rib cage until the tissues relax. Patients many times will take a big breath as the diaphragmatic restrictions are freed.
3. Now sit the supine patient up and place a Dutchman's roll (you knew that thing you bought at the seminar series would come in handy, one day!) under the patient's dorsal spine. Repeated this three times. This frees a portion of the shoulder fixations.
4. Working one side at a time, take a straight arm by the elbow with one hand, working fingers of other hand under the clavicle from the top side. Go slowly, this is still painful even with T.S pain control. Bring arm back and down as you lift the clavicle ceilingward. Do this three times on each side. This frees the coraco-clavicular union and the clavicular-sternal junction taking pressure off nerves and circulation to the lung field.
5. With a flat hand, one hand over each lateral rib cage covering the marked inter rib areas, have patient take a great big breath and hold it, then you forcibly thrust against the rib cage three times to drive all air from the lungs. Repeat this cycle three times. This ventilates the lung field and brings immediate recall to reparable areas.
6. Nearly always this will clear all marked areas between the 2nd, 3rd and 4th rib spaces. If any reflex tenderness remains, work this out with deep massage and quick little thrusts to break up fixations (rib technique).
7. Now, if the supra-sternal jugular notch is still tender use a dou-

(Continued on page 5)

(Continued from page 4)

ble thumb contact over the notch and with a quick little thrust drive footward. This will clear the pharyngeal-laryngeal reflex.

8. Drain the sublingual and cervical lymphatics (same as T.S. T7 technique).

9. You must now free the hyoid bone restrictions to the Eustachian tube, inner ear and styloid process. Grasp the hyoid bone from both sides with a finger and thumb. Move the hyoid from side to side twenty times or so which will usually free its restrictions.

10. Sit the patient up (with Kleenex handy). Have patient remove any dentures they may be wearing. Glove both hands. To open right sinus cavity, have the patient open his mouth wide and push his left cheek between his teeth. Warn him if he bites, he will bite his cheek. Now with right index finger, quickly enter the mouth, follow gum line past soft palate, then quickly go up in the sinus-eustachian tube cavity to open up the restrictions, then come out fast. The patient will spit out an astonishing amount of impeded drainage. Repeat on the opposite side.

11. Lay patient back down supine after he quits coughing up phlegm. You are seated at the head of the table. Cradle occiput with one hand and contact the molars with the other hand. Raise the occiput ceilingward as you pull the molars toward you. Repeat three times.

12. The pre ganglionic work is not done until the third visit.

Until next issue, Yours in Health,

John S. Kyneur
Sydney

Peter J. Kyneur
Newcastle

WELCOME

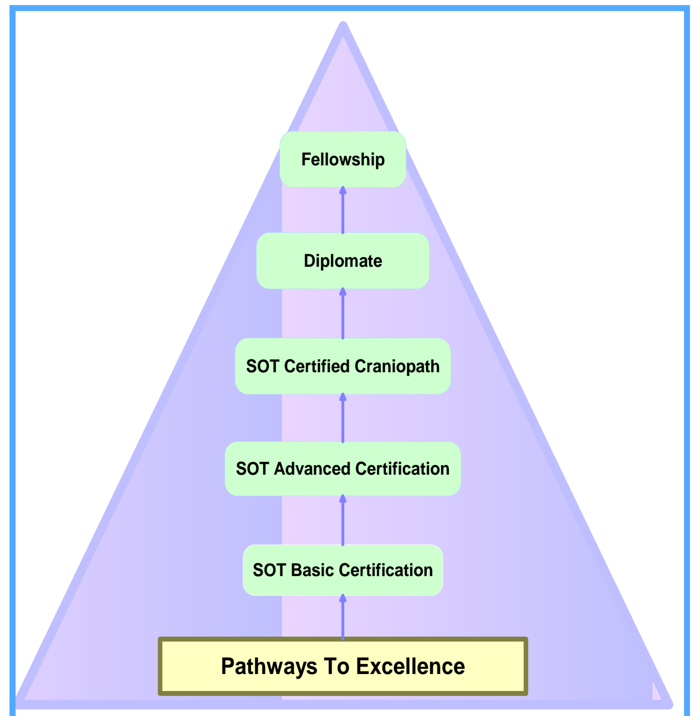
To Our new members!

Leisa De Kauwe, Cottesloe, Perth, WA
Ashleigh Franke, Victoria Point, Brisbane, Qld
Brett Grant, Chatswood, Sydney, NSW
Joseph Iemma, Rouse Hill, Sydney, NSW
Kim Lie Jom, Chatswood, Sydney, NSW
Steve Klymovich, Karrinyup, Perth, WA
Rod Le Coz, Mackay, Qld
Stephanie Le Coz, Penshurst, Sydney, NSW
Corina Piltz, Budgewoy, NSW
Anna Pratten-Shields, Kempsey, NSW
Alexander Rodwell, Locum, New Zealand
Meredith Ruby, Woollahra, Sydney
Lisa Sullivan, Caloundra, Sunshine Coast, Qld
And Academic members -
Clive Farrelly, 3rd Yr, Macquarie
Alain Frabotta, 5th Yr, Macquarie
Daniel Gilmore, 4th Year Murdoch
Matt Hamilton, 5th Year Murdoch
John MacPhee, 5th Year, Murdoch
Jane Yuan Ren, 5th Year, Macquarie,
Brooke Talbot, 5th Year Murdoch,
Emma Zappia, 5th Year Macquarie

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.

Sacro Occipital Technic 1964

Dr. M. B. DeJarnette.

The Basis of Sacro Occipital Technic

Page 2.

Figure No. 1. Disease and pain are caused by a vertebral subluxation, which overactivates (exactly as written-DLR) and acts as a source of continuous bombardment of stimuli to muscles that are receptive. Figure No. 2. Lateral view of the subluxation, which probably has not altered the foramina or may enlarge its diameter. Figure No. 3. The source of stimuli is chemical and is the product of mechanical failure of protective mechanisms which control muscles. Figure No. 4. The subluxation creates overmotion (exactly as written-DLR) for IT IS emphasis added-DLR) symbolic of motion, not fixation...fixation is a power exclusively owned by muscles, not cartilage or tendons or ligaments or fascia. Figure No. 5. Man's overmotion may bend him forward or backward, or sideways. Figure No. 6. You can stop motion with supports, or even hand pressure...this proves the subluxation to be a product of mechanical failure with resultant stimuli to motive parts of the body. Figure No. 7. The chiropractor alone has the knowledge and skill to differentiate between a mechanical subluxation and the effects of that subluxation, which are distortions, by trapezius palpation and identification. Figure No. 8. The occiput when properly palpated identifies disease and pain sources. Figure No. 9. The distortion analyzer lets you look (visualize).

Page 4

The trapezius muscular fibrous areas are indicators of distortion patterns, while ligament and osseous indicators as here shown are connected with subluxation patterns and not distortions. The trapezius identifies distortions.. .major trapezius indicates distortions will respond with a true M. S. Multiple trapezius means distortion is cause of pain and must be overcome by SOTO, or COTI (Cross Over, Turn In) and 1B.A. Plus pattern adjustments. Subluxation Pattern Indicators All true subluxation patterns, whether following the "movement subluxation" neutralization, or appearing with a multiple trapezius, have indicators which become active when the pattern becomes active.

Innominate activity indicator is the left mastoid. Fifth lumbar inferiority indicator would be the styloid process of the temporal bone on the side of fifth lumbar inferiority...all pain from indicators elicited by palpation, not verbal complaint from patient. Sacral indicators are the nuchal ligaments from occipital bone through the second cervical vertebra. Right nuchal palpatory pain anywhere on its continuous area indicates either a sacral crest rotated toward that side or an inferiority of the sacral base on that side.

Left nuchal palpatory pain exact opposite of above...

First rib palpatory pain indicates a disturbance of balance between pelvis and fifth lumbar and is an indicator of an acute meningeal tear from any area arising at lumbar three through five. Cause is usually found in subluxated innominate, this type patient cannot elevate his legs in the supine position...extremely acute lumbosacral syndrome. Fifth lumbar rotation is indicated by atlas transverse process palpatory pain...fifth lumbar rotated right with its right transverse process anterior would produce palpatory pain over the right transverse process of the atlas...a fifth lumbar rotated left with its left transverse process anterior would produce palpatory pain over the left transverse process of the atlas.

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David L. Rozeboom, D. C., C. C., B. A., Librarian.

Special Symptoms

Technic and Practice of Bloodless Surgery, 1939 : chapter 28

Dr. M. B. DeJarnette

Page 461

The object of this chapter is to briefly outline the major symptoms complained of by patients with gastro intestinal disorders. This chapter deals with both the diagnosis and treatment of these special symptoms. The diagnosis concerns preoperative analysis and the treatment concerns itself with postoperative care. These subjects are combined into this chapter to make them more easily assembled and to be more workable for the reader of this book.

Anorexia

Loss of appetite may mean many things. This is noted during the incipient stages of acute disorders. In chronic disorders the picture is changed. The lack of proper vitamin reserve in the body causes this disturbance.

The lack of vitamin B produces anorexia because of poor muscle action of the gastro intestinal tract, and lowered output of digestive juices. The lack of vitamin C may predispose to anorexia through the resultant disease of the gums and degeneration of the glandular system. Vitamin C, unlike vitamin B, has no direct relationship to carbohydrate metabolism. An insufficiency of Vitamin A produces a lack of assimilation, which results in autointoxication. A deficiency of vitamin D results in lack of motility of the gastro intestinal tract, which produces loss of assimilative functions.

Disturbance of the vagus nerve (1) is a definite cause of anorexia, as hypofunction of the vagus interferes with normal digestion and a normal craving for food. Disturbance of the sympathetics produces congestion of the mucous membranes of the gastro intestinal tract and a reflex to the taste buds, which results in a loss of appreciation for food.

The chronic anorexias are associated with cancer, in which instance the patient has an aversion to meats. In ulcers of the stomach and duodenum, the patient craves food, but due to the pain it produces, soon becomes obsessed with fear, which in turn produces a loss of digestive power and a resultant aversion to food. Nervous disorders produce loss of appetite in many patients, in others a phobia for certain types of foods. This results in food faddism.

Bulimia or excessive craving for food results from endocrine disturbances. Hypothyroidism is a typical example of this disturbance as also is hypo ovarian and gonadal action.

The Treatment

Lesions of the vagus must be corrected. This is explained under vagus contact. Lesions involving the fifth and sixth dorsals, as well as the eighth dorsal must be cared for. The gall bladder will need draining.

Vitamin deficiencies must be regulated. The diet needs adjusting. Environment must be studied and corrected when abnormal. The colon must be kept normal.

Vegetable juices will in most cases create a normal appetite. Vitamin B, through its ability to normalize nerve impulses, is a valuable adjunct. The loss of appetite is a symptom and not a cause. When the cause is removed, the appetite becomes normal. Forced feeding seldom needs to be employed. When vagus hypotonia is present it is well to have the patient lie prone immediately after eating, with a pillow under the epigastrium. This pressure helps to contract the stomach walls so that the food may be worked into a proper bolus.

(1) All spastic conditions of the gastro intestinal tract with the exception of the colon can be instantly relaxed by this vagus contact lateral to the lobe of the thyroid. (Page 357, Technic and Practice of Bloodless Surgery, Dr. M. B. DeJarnette)

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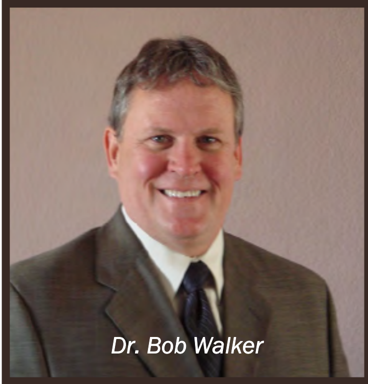
The Chiropractic Dental Patient: A Combined TMD Approach


Dr. Bob Walker

Multi-Disciplinary Concepts for TMD Treatment

Get into 'Spring Fever & the Melbourne Cup Racing Carnival' and join us in Melbourne on November 13 and 14 as Dr. Bob Walker presents this year's SOTO Australasia Annual Convention.

Since graduating from Chiropractic in 1987, Dr Walker has taught over 200 courses on Multi-disciplinary care, focusing on the Chiropractic and Dental professions. He has written the series of courses known as "Chirodontics" which develops this concept into a workable system for the Chiropractic/Dental co-treatment of chronic head pain and TMJ patients.

He is currently the Co-director of Global Health Consultants and Co-Instructor for the Exceptional Dental course series as well as the Chirodontics course series.

He has also written a series of courses on Applied Nutrition, called "Nutrition for Life", which explores the clinical nutrition approaches to patient care and healthy lifestyles.

Dr Walker has been a keynote speaker at over 50 International symposiums including; The Australian Chiropractic Association, The British Chiropractic Association, Sacro-Occipital Research Society International, Sacro-occipital Technique Organization- USA, Sacro-occipital Technique Organization- UK, Sacro-occipital Technique Organization- Australia, The International College of Applied Kinesiology, The American Association of Functional Orthodontics, The American Academy of Head, Neck and Facial Pain, Australian Dento-Facial Symposiums, BioResearch International Computer Diagnostic Symposium, The Korean Institute of Cranio-Mandibular Disorders, as well as numerous Dental and Chiropractic study groups throughout the world.

In addition, Dr Walker has been published in numerous professional journals, including; The Journal of Cranio-Mandibular Practice –(UK), The Journal of the American Association of Functional Orthodontics and The British Chiropractic Journal.

The weekend's learning will include:

Understanding the Ascending and Descending Components

Learn to look at the body, and TMD issues, from both a structural and dental perspective.

Dental Terminology for the Chiropractor

Learn how to communicate with dentists, in their terms!

Cranial Distortions Related to TMD

Learn to recognize the most common cranial distortions that set up TMD issues.

TMJ Timing Pattern Analysis

Learn why "when the TMJ event occurs", is the most important diagnostic TMJ finding.

SOT TMJ adjusting techniques (including workshops)

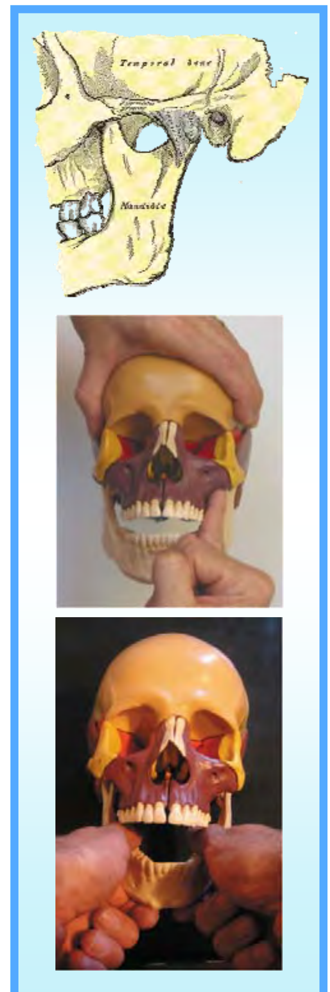
Advanced Differential Diagnosis of TMD Issues

Learn to differentiate between Cranial, Cervical, TMJ and Occlusal issues.

Setting up the TMD Treatment Team

What else can Chiropractors bring to the TMD "team", and how do you set them up?

Nutrition and Adjunctive Therapies



CLASSIFIEDS

Locums

LISA BARDY 0412 301 465 lisabardy@hotmail.com

JASON HENDERSON 07 5536 4249 thenewfarmer@hotmail.com

DOMNA LOVATT domnalovatt@hotmail.com

WAYNE JENNINGS 0457 931 377 (From January 2011)

JONATHAN LUBETZKY MELB AREA ONLY 0401 038 871 jlubetzky@gmail.com

CATHERINE METCALF sam.cath@mac.com

TROY MILES 0407506612 chirotroy@yahoo.com.au

KATE STEWART 0402 423 212 katemcraestewart@gmail.com

ALEXANDER RODWELL (New Zealand) 0432 071 363 dr.ajrodwell@gmail.com

MARCUS SOANE 0429 625 615

BRIONY TEMPLER 0419 517 860 btempler@hotmail.com

Locums Available

Practicing for 13 years (RMIT graduate). Techniques—SOT, Diversified, Some Drop Piece. Availability—Brisbane/Gold Coast and Melbourne. Available for short and extended periods. Contact Dr. Domna Lovatt, domnalovatt@hotmail.com - 0423 777224

Experienced SOT Locum. Dr Kate Stewart. Already registered QLD, NSW, ACT, VIC and SA. SOT Advanced Certified, Currently completing ICPA Certification. Referees Available. Please contact via email on katemcraestewart@gmail.com or 0402423212.

From August, 2010. Willing to travel nation-wide. S.O.T. Basic Certified (undertaking Advanced level in Nov, 2010). N.E.T. Certified. References Available. *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. 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

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

Practices for Sale

Caloundra - Excellent opportunity to purchase a well established (18yrs) family wellness practice on the beautiful Sunshine Coast. Techniques include SOT, activator, diversified, NET, ABC. Trained CAs, efficient operating systems. Please e-mail Christine at clang.ccc@gmail.com for further information.

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