EX•PRESS•ION

FROM THE PRESIDENT

Dear Colleagues,

Annual Convention

Very soon you will all be receiving the details of our 2012 Annual Convention to be held at Kingscliff Northern NSW. For Doctors and students alike, extremity adjusting is a valuable addition to your adjusting routine. Why not learn it from someone who does it for a living? Dr Jesper Dahl (UK) will present a hands-on weekend of workshops, covering all peripheral areas and their integration into the SOT practice.

SOT-International News

As the SOTO-International annual meeting is hosted by one of the Alliance members (2011 was held in Australia), this September the meeting will be hosted by PAAC in Tokyo. PAAC will also be celebrating the development of SOTO-Japan, a rebrand venture that brings the Japanese organisation of SOT contextually in line with the global image of SOT internationally. This will strengthen the presence of SOT in Japan and the SOTO brand in that region. It will also enable a smoother transition when sharing SOTO-International materials. I am excited to be chairing the SOTO-I meeting and I will report back on the discussed issues on my return.

SOT Seminars & Certification

I hope all who are attending the Seminar Series this year are being inspired by the passion of our Presenters and are enjoying the updated series material. Certification exams will be held in October (check the events calendar for details) in Melbourne away from the Annual Convention. This change in format frees up the Board and Examining team to prepare for the Annual Convention. It also provides an easier location for examinees to attend and also reduce the extra expenses involved. Next year it will alternate with Sydney as the venue for the exams.

Another project the Board has undertaken has been to review and rewrite the CMRT patient management notes. This process, in correspondence with the other International organisation's Boards will take time and a lot of international discussion. It is obvious to all however that that this process is necessary. DeJarnette was way ahead of his time in his understanding and knowledge

Inside this issue

SOT INTERNATIONAL

SOTO AUSTRALASIA

of the visceral systems but there is a need for current methods and supplements to be included in these sections. The trick will be to maintain the heritage of DeJarnette's notes but contemporise the material. I hope to have more to discuss regarding this next year.

We hope to see you in Bali!

For those attending the Mid Year retreat in Bali with Dr Geneveive Keating I look forward to spending time with you all then. I will next communicate with everyone else in the newsletter in September.

Cheers

Darren Little

SOTO- Australasia President

CERTIFICATION EXAMINATIONS

SOT Certification examinations will take place on Saturday 20 October in Melbourne.

Examinations begin at 2pm and conclude at 6pm.

- Basic Theory & Practical
- Advanced Theory & Practical
- SOT Certified Craniopath Theory & Practical

Download the guidelines and application form from our website or call Averil 07 5442 3322.

Product Feature - CMRT Pocket Reference Cards

A useful pocket reference guide for the practitioner that provides an easy-to-use item for your treatment room. Nine double-sided cards that provide a quick reference to:

- CMRT - Line 2
- T1 Corony Syndrome
- T2 Myocardial Syndrome
- T3 Respiratory Syndrome
- T4 Gall Bladder Syndrome
- T5 Gastric Syndrome
- T6 Pancreatic Syndrome
- T7 Splenic Syndrome
- T8 Liver Syndrome
- T9 Adrenal Syndrome
- T10 Intestinal Sydnrome
- T11 & 12 Kidney Syndrome
- L1 Iliocecal Syndrome
- L2 Cecal (Appendix) Syndrome
- L3 Glandular Syndrome
- L4 Colon Syndrome
- L5 Prostate / Uterine Syndrome

Available to purchase from the SOTO-A online shop or call Averil 07 5442 3322.

Kids' Healthy Brains

Dr. Genevieve Keating

Pan Pacific Nirwana Resort, Bali
4th and 5th August, 2012

Dr Genevieve Keating is committed to engaging health practitioners and the community in understanding, assessing and supporting neuro-development, ensuring that babies and children are given the best chance for healthy, happy lives.
Her presentations have been described as "professional, engaging and enlightening".

She has a referral practice in Melbourne and is incredibly inspired by the babies and children she works with.

Learn how to understand, assess and positively influence kids developing brains.

Topics covered:
- Hierarchy of brain development
- Functional assessment of development
- Advanced techniques to influence neurological function Growing brains at home

This course is designed in a "small group, hands on, use on Monday" way for your learning and enjoyment. This program has been assessed by the Chiropractors' Association of Australia (National) Ltd, an approved assessing body of the Chiropractic Board of Australia, and allocated 8 Formal Learning Activity Hours.

ILEO-CAECAL SYNDROME

Welcome to our winter edition write-up of the Bloodless Surgery, CMRT and TS line work. As stated in our last issue, we are doing the digestive in 2012 and are thus going T10, L1, L2 and L4. We have suggested that you will need your seminar notes; a reflex chart and preferably De Jarnette's 1966 CMRT manual (the latter two items are available from Averil; go to the website). This series of articles on the organ work has, in the main, been a presentation of the writings of Dr. M.L. Rees, that first appeared in the SORSI Despatcher, in the 1970s.

A warning you will find in your Lumbar 1 ileo-caecal seminar notes is: An incompetent or over competent I.C. valve may simulate appendicitis. The thing to do is establish the differences and we turn to Dr. Bennett's chapter, Ileocaecal spasm v. Appendicitis, from a long-forgotten volume from the 1970s (The same Dr. Bennett of Bennett reflex points that have been preserved by Dr. Goodheart in the Applied Kinesiology notes).

Bennett states: "If the case is an acute abdomen, and everything is sore, you cannot determine anything. First you want the white blood cell count. You check several hours later, or the next day, and it is not too acute. Then you find that the condition has localised itself in the area of McBurneys point, where there is point tenderness.

Spasms of ileocaecal valves will present the same symptom complex as appendicitis, sometimes; vague chest, abdomen and back pains. The difference with the ileo-caecal is that there is little or no fever nor will there be an increase in the white cell count." De Jarnette's observations about the signs and symptoms may be of help in that your frozen shoulder will be present with an I.C. valve, not so with L2 syndrome, generally.

Return to Dr. Bennett's observations, he further states: "In appendicitis, the point tenderness is at McBurneys point and there is spasm across the entire lower portion of the right rectus muscle. Where it is splinted, it shortens. The classic symptom is that the person cannot extend the thigh because when they do it pulls on this sore muscle. In order to seek relief they flex the thigh.

In the instance of the ileocaecal valve, the splinting is not across the belly of the muscle. It is the outer

margin of the right rectus muscle only. The middle portion of the muscle is perfectly free. In ileocaecal conditions you have a rope like tension of the outer border of the right rectus muscle. The mechanical pull of the shortening of the outer border would be just as painful if the extend the thigh, so that is no criterion.

As a practising SOT chiropractor you have one thing in your favour with the chronic lumbar one case and that is that you are not going to see one! These are past the point of no return types who will have already been hospitalised, given up as incurable degenerative disease cases who are 'made comfortable' only. In the last stages these cases are riddled with cancer. Gruesome.

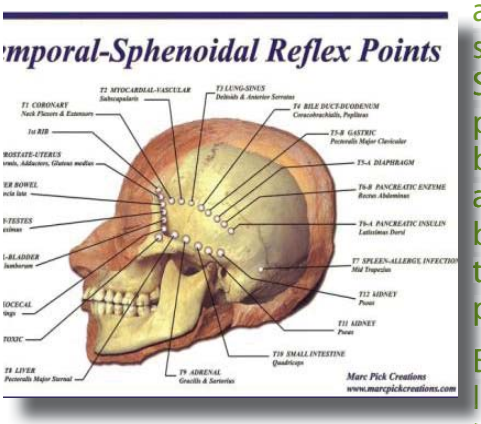
You are going to come across the acute and the sub chronic aplenty. If you find an L1 in the early stages, you have a good chance to help them recover. If you are unfortunate to come up with a sub chronic lumbar one patient, then you have a long haul 'vale of tears' in reversing this 'morbific' destructive syndrome and can only hope to save a partially destroyed patient, whom you must care for on a maintenance basis for the rest of their lives.

When you look at the T-S reflex points charts, you will see a zone called 'toxic'. Often this is active and tender along with the T-S L1 palpatory tender area. Remember, a patient with an incompetent ileo-caecal valve is a fast ageing patient where all of the vital organs are wearing out fast fighting poisons.

The ileo-caecal patient will complain of a pain like a broken rib on the right anterior rib cage at the tips of the 11th and 12th ribs. But the one to look out for is that condition that is printed in capital letters in your seminar notes: FROZEN RIGHT SHOULDER. Be suspicious of inflammation of the ileo-caecal valve if your patient complains of a right shoulder problem that resembles a rotator cuff tear.

Dr. Rees suggested another condition to observe which was a pseudo-gouty arthritis in both big toes. In your seminar notes are two diagrams of pain and signs and symptoms of the ileocaecal syndrome. Of note are the head and neck indicators that we need to bring to your attention. These are the areas around the side of the head, the cheeks and the ears.

What will occur is that your L1 patient will lie prone on your table and feel an undue pressure from the headpiece. The other thing that occurs is violent headache spasms coming from subluxation of the atlanto-occipital articulations often with vertebral artery occlusion. This sets up the tinnitus aurium and vertigo symptoms of the eighth cranial nerve by circulation starvation. Tinnitus is considered a condition with multiple and sometimes unknown cause. As SOT, CMRT and Cranial trained practitioners, we have the basic cranial procedures in our armamentarium. There is no better place to start than with the Basic One and Basic Two procedures.



Marc Pick's CMRT Reflex Charts are available at our online shop!

www.soto.net.au/all-products

Before going to procedure, we will list out the clinical picture of the ileo-caecal valve in the stages you are going to see, namely; a) the acute attack and; b) the sub chronic.

A. Inflammation of the Ileo-caecal Valve (Acute)

1) These people will have migraine headaches that are sub-occipital starting at the pain reflex line just below the occipital three and extending over the ear on the temporal bone through T-S D4 and D5 with extreme posterior eye pain and upper teeth pain. They will be nauseated and when they vomit, bile will be present resembling a bilious attack. Many of these people will have been through the barrage of tests and scans and may even have been hospitalised. They are coming to see you with headaches for which they are often taking multiple pain killing drugs.

2) They will have tinnitus aurium as the petrous portion of the temporal bone is pulled into distortion.

3) They will have higher level low back pain around the level of the first lumbar and check for the palpatory pain at the transverse processes. This is often the pain that drives them in to see you.

4) They will have pain resembling broken ribs at the tip of the 11th and 12th ribs on the anterior rib cage.

5) In these acute cases, the area on your wall

chart – the temporal sphenoidal tonic area (slightly medial and anterior to the L1 and actually on the zygomatic) may not yet be painful.

6) Another observation that didn't appear in the 1966 CMRT notes is that the metatarsal-phalangeal joints of the big toes will be painful to pressure palpation as inflammatory material is being deposited.

B. The Incompetent Sub Chronic Ileo-Caecal Valve

1) They will have painful but hardened tissue at the right anterior humeral head which will be felt in the rotator cuff musculature. This is the frozen shoulder type patient. Note in your seminar notes, under signs and symptoms that frozen right shoulder is in capital letters. This is the frozen shoulder that does not have 'rotator cuff tear' or 'supraspinatus problem' reports from the radiologist. In advanced cases you will note that the patient cannot raise the right arm and keep the neck straight. Your true indicators for this type of frozen shoulder is occipital line 2 area 3 is active; TS L1 and the hardened feel of the shoulder.

2) As previously mentioned, the metatarsal phalangeal joints of the big toes have become like a toxic dumping ground. The pain will resemble gouty arthritis. Hallux valgus develops.

3) The 10th rib costal tip on the right side becomes acutely painful. A chest x-ray will show a calcified costo-chondral cartilage.

Background Thoughts and Rees' Marking

Two factors in correction of the ileo-caecal incompetency are of note. First, you must think in terms of mesentery correction. The apron-like folds of the mesocaecum must be lifted back to normal position and all lace adhesions that restrict the freedom of ileo-caecal movement must be broken up.

A second factor is that you must think in terms of the entire digestive tract with ileo-caecal fault. One common cause of this syndrome is back pressure of colon gas causing the valve to open the wrong way. Trace it back to the person's stomach not producing enough stomach acid. Remember with insufficient acid there is difficulty digesting proteins and iron.

With this background information covered let's now look at information on the Rees' marking system and then we will cover the Dr. Rees procedure for correction. Once again, for those who may be reading this article separately from others in the series, the Rees procedure was developed from his 1950s study of the De Jarnette Bloodless surgery notes combined with the 1965 Temporal Sphenoidal Research. We have found that reviewing DeJarnette's early work as presented by Dr. Rees has helped us understand the reasoning behind the 1966 work that is presented yearly in the seminar series along with providing some additional, effective procedure.

Rees' Marking points

1. The basic receptor block area for the ileo-caecal syndrome is located 5cm inferior of McBurneys point. This area is quite tender to pressure palpation.

2. Find an mark the tender area on the right shoulder.

3. Find and mark the tender area found at the fifth level interspace (this is an area marked in your seminar notes that you probably wondered about. It is a tender area that vanishes with L1 CMRT procedure.)

4. Find and mark the 11th and 12th rib anterior rib cage. These will be quite painful and are easily located.

5. Find and mark the tender metatarsal phalangeal joints.

6. Find and mark the TS lumbar one points and the tonic point.

7. Now palpate the neck motor unit at cervical 5 and 6 which is your Lovett brother relationship.

8. Another indicator not included in the 1966 CMRT notes is the temporal sphenoidal meningeal irritation area. If this area on the interior of the T-S line is palpatorily painful, then you also have a disc problem at lumbar one level which must be corrected with annular ligament technique before the work will be effective.

9. If sacral one is painful to palpation, then you have a dural port closure at lumbar one and a need for the fibre neutralisation work.

Technique

In modern times (from 1966 on) CMRT lumbar one technique has consisted of a) neutralisation of sacral one and occipital fibre, b) receptor reflex area and shoulder contacts, c) postganglionic. In going over Dr. Rees' procedure you can see some inclusions and exclusions of the work of DeJarnette. This is the case in all of the thoracic and lumbar syndromes and L1 is no different. Here now is the bloodless surgery technique for a lumbar one major, by the number.

1. As soon as the patient is turned from prone to supine, you apply the following temporal sphenoidal pain control. Dr. Rees found the

CALENDAR OF EVENTS

JANUARY 2012

Happy New Year!

FEBRUARY 2012

MARCH 2012

Certification Examination Re-Sits

12 March

APRIL 2012

Easter Sunday
8 April

Introduction & Categories Seminar Melbourne
Saturday & Sunday 14-15 April

Introduction Categories Seminar Sydney
Saturday & Sunday 28-29 April

MAY 2012

CMRT Seminar Melbourne
Saturday & Sunday 12-13 May

CMRT Seminar Sydney
Saturday & Sunday 19-20 May

JUNE 2012

Study and exam weeks all colleges
2-17 June

Introduction & Categories Seminar Perth
Saturday & Sunday 23-24 June

Introduction & Categories Seminar Gold Coast
Saturday 30 June - Sunday 1 July

JULY 2012

Cranial Seminar Melbourne
Saturday & Sunday 7-8 July

Cranial Seminar Sydney
Saturday & Sunday 21-22 July

CMRT Seminar Perth
Saturday & Sunday 28-29 July

AUGUST 2012

SOT Retreat (TBC)
4-5 August

CMRT Seminar Gold Coast
Saturday & Sunday 18-19 August

Advanced Module - 'Suturals', Melbourne
Saturday 25 August

SEPTEMBER 2012

Cranial Seminar Perth
Saturday & Sunday 15-16 September

Cranial Seminar Gold Coast
Saturday & Sunday 29-30 September

OCTOBER 2012

Certification Examinations
Saturday 20 October, Melbourne

NOVEMBER 2012

Annual Convention and AGM
Kingscliff NSW
Saturday & Sunday 10-11 November

DECEMBER 2012

Merry Christmas!

combination of the TS work at the start of the procedure and the use of the preganglionic to 'switch on the motors' again to be a successful action in many of the syndromes (not all). Note, with L1 there is a warning about when and when not to perform preganglionic technique.

The left hand holds light contact over the most painful T.S, L1 area as the right hand finger tips hold light contact over the ileo-caecal receptor block area. Hold these contacts for two minutes with no motion. The ileo-caecal patient will have a very alive occipital area 3 and the valve area may just be screamingly tender to the touch. So, your two minute TS contact is for pain control to first calm down the abnormal pain oscillations in the reflex arc between the hollow viscus and the spinal cord pathways before you can successfully do the deep tissue work. In two minutes this reflex arc pain oscillation will be neutralised so that you have anaesthetised your patient, locally, or blocked his pain interpretation pathway from the hollow viscus, so now you can go deep into the soft tissue without discomfort. If you wish to make sure the pain pathways are blocked you can re-palpate your marked areas and you will find them absent or with only a faint remnant of pain. Be sure and remember this is not a correction. You have only anaesthetised the warning signs. This is a regional visceral receptor block anaesthesia that will last about ten minutes. This gives you sufficient time to painlessly accomplish your bloodless surgery to the involved hollow viscus.

2. The receptor area and right shoulder work. Your left hand is over the right humeral head; your right two fingers contact the ileocaecal area. Your work both areas. This procedure is continued until you can feel the tension resistance at the ileocaecal release.

3. Using a double hand reinforced contact just below McBurneys point, you have the patient flex their leg. The patient moves their flexed leg medial then lateral eight times.

4. In the same position, with both hands you squeeze an expanse of abdominal tissue into a mound. You lift this soft tissue ceiling-ward like you were going to raise the patient off the table. Carry this tissue headwards then away from you then towards you. Repeat this complete manoeuvre eight times. This puts normal motion back into the ileocaecal valve.

5. Now adjust the metatarsal – phalangeal joints of both big toes. This is done by traction and then a quick thrust.

6. In subsequent visits when the pain rib areas are not present; when the right shoulder pain, the 5th rib intercostal pain and the other indicators of L1 toxicity do not return, you can be rest assured that you have removed this patient from his tendency towards carcinoma.

7. If there were 8th cranial nerve indicators, you clear this with your upper cervical work and with Cranial Technique Basic One and Basic Two. The 2nd or 3rd office visit after the initial L1 is a good time to do this.

8. You do not do preganglionic technique until you are ready to have this patient on maintenance visits.

As a final word, there is a right / left brain dysfunction as a key problem in many of these patients. There are often resultant immune related problems such as sinusitis, influenza and colds. L1 has the associated C5 which is part of the neurological rod of the phrenic nerve to the diaphragm. These people are very sick and the liver pump and hiatal technique will also be of help.

With the Expression newsletter every three months, we hope that this allows you time to study and incorporate the TS, bloodless surgery and CMRT work. Remember as SOTO Australasia members you also have access to the Rose Ertler memorial library which has a very large selection of DeJarnette's works including the 1965 Temporal Sphenoidal research project notes.

Until spring, we remain,

John S Kyneur
Haberfield, Sydney
New South Wales

Peter J Kyneur
Toronto, Lake Macquarie
New South Wales

ADVANCED MODULE*

SUTURALS

with -
Dr. Brett Houlden

When -
Saturday 25 August, 2012 1pm - 6pm

Where -
Mantra on Russell, 222 Russell Street, Melbourne

*Completion of the Basic Series (Categories, CMRT and Cranial Sessions) is a pre-requisite for this course.

THE CLASSIFIEDS

Locums

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MARCUS SOANE 0429 625 615

BRIONY TEMPLER 0419 517 860 btempler@hotmail.com

Locums /Associates Available

Practicing for 14 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 777 224

Wayne Jennings Locum Service. Now resident in Brisbane. Available Australia Wide. 30 years private practice. SOT Certified / Diplomate. Entrust your patients to experienced hands. 0457 931 377 wyrox@bigpond.net.au.

Dr. Jeffrey Mathews, SOT Advanced Certified requires full time associate position in Sunshine Coast region, Qld. Committed practitioner with over 20 years' experience specialising in family wellness. Returning to the Sunshine Coast to live. Call 0413 903 092 or email jeffmath52@bigpond.com

Associates / Locums required

An excellent position has become available in a rapidly expanding, well presented, family wellness practice in the Sutherland shire. We are looking for a part-time position to take over an existing patient base with an opportunity to go full-time towards the end of the year. Must be self motivated love paediatrics and pre-natal care and be willing to learn, principal chiropractor of 10 years' experience keen to train/mentor. Send CV to admin@chfc.com.au.

Associate needed for well established SOT practice in inner west Melbourne. Come join the team of 3 other DCs, 3 massage therapists and TCM practitioner at Williamstown Chiropractic Centre. Steady flow of new patients and access to extensive patient base and great team mentality. Williamstown is an exceptional place to work and live. Bayside suburb with great cafes, shopping and quick drive or public transport to city. Call Greer 0424 147 725 or email greer.watson@gmail.com

Newcastle. We are looking for an energetic and motivated chiropractor to join our multi-disciplinary centre. We are an SOT based practice, so a knowledge and interest in using SOT in practice is important. It would also be advantageous to have an interest in paediatrics and neuro-development. Some experience preferable but new grads may apply. Email vjclinic@bravo.net.au

Gold Coast SOT based practice, with focus on pregnancy, paediatrics and family health care. Friendly, nurturing clinic in a lovely location in Burleigh. Contact Jana 0421 285 822 or jana@handsonhealthchiropractor.com

Locum Required: Limestone Coast Mount Gambier Practice. Position for September+ 2012. Techniques primarily SOT, low force compatible. Must love taking care of families and all ages. Call Linda on 041 780 4741 Or email: manormail@optusnet.com.au

Locum Required - Sep/Oct, Mt. Gambier. SOT locum required for Monday 17th September to Fri 19th October inclusive for family based low force wellness practice. Contact Liana 0403 585 615 or harmon88@bigpond.com.

Position/s available in two long standing clinics in Perth Western Australia. One clinic is in the city CBD and the other in the southern suburb of Wilson, 15 minutes from the CBD. Positions available for full-time/part- time work in both or either practice. SOT technique preferred but good manual adjusting techniques required also. For further information contact pam@citychiro.net.au

A wonderful opportunity exists in Brisbane South for a two week locum position, followed by the option to stay on as an associate. Friendly family clinic. SOT, Diversified, NET, some AK would be an advantage. enthusiastic caring nature required. Ph Marguerite 0409183815, email info@rochedalechiro.com

Practices For Sale

Limestone Coast Mt Gambier City centre Practice for sale. Over 30 years established we need a chiropractor committed to providing quality care: SOT/Low force skills desirable . Wonderful patient base; heaps of families; good PV; fully equipped office. Excellent staff, Front Desk & efficient systems; low overheads. The region encompasses Coonawarra, Coorong, the stunning Blue Lake, World Heritage listed features & borders Victoria. Make the change, enjoy great wines, wildlife, caves, Arts, coast & rivers. Genuine opportunity priced to sell; serious inquiries only. Contact Linda +61 417 804 741 or E: manormail@optusnet.com.au

General Notices

SOT Advanced Module - Saturday, 25 August, 2012, Mantra on Russell, Melbourne. 1 - 6pm. Dr. Brett Houlden presents 'Suturals'.

Advertising Rates

Qtr Page – $165.00

Half page – $275.00

1 Page – $495.00

A4 tri-fold insert – $165.00

Free classified advertising for members!

Contact the SOTO Coordinator Averil Crebbin at: sotoa@bigpond.com or by phone on: 07 5442 3322