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OCCIPITAL PALPATION

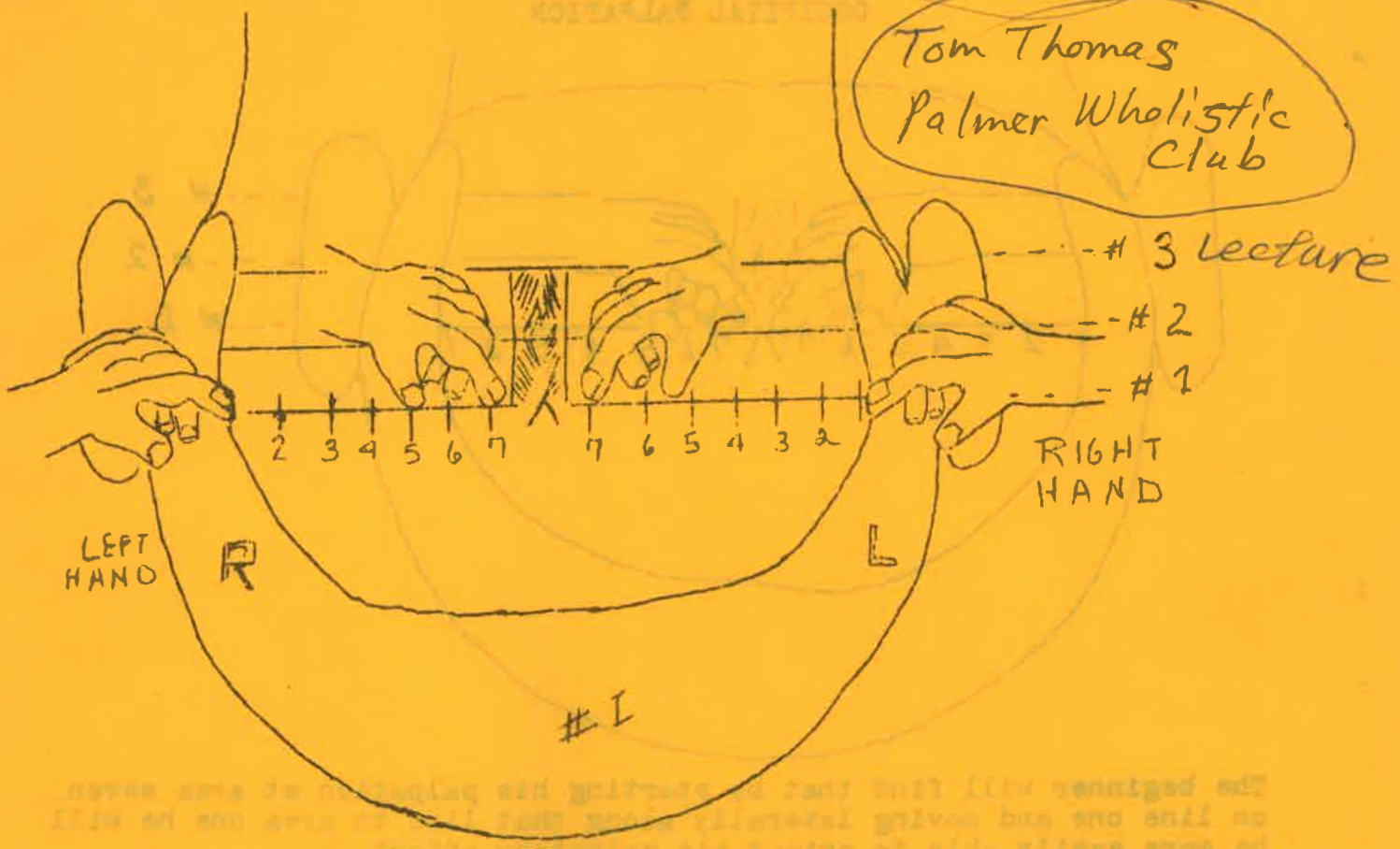


FIGURE #1. Sitting at head of table, facing patient's occipital region, your right hand index finger contacts left occipital area one on line one. Your left hand index finger contacts right occipital area one, line one. The index fingers are hooked, and the tip of the nail probes the occipital fiber.

Your middle and ring fingers perform a very important task as they follow the index fingers and serve to keep the tissues inferior of line one taut as the index fingers move from fiber to fiber.

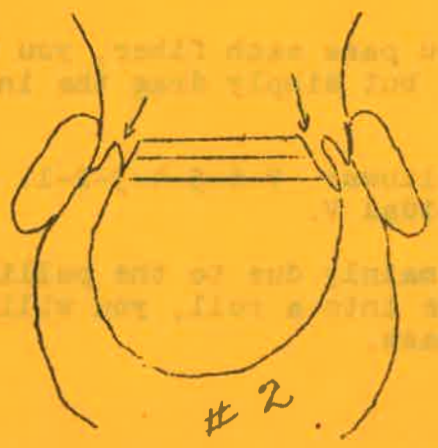
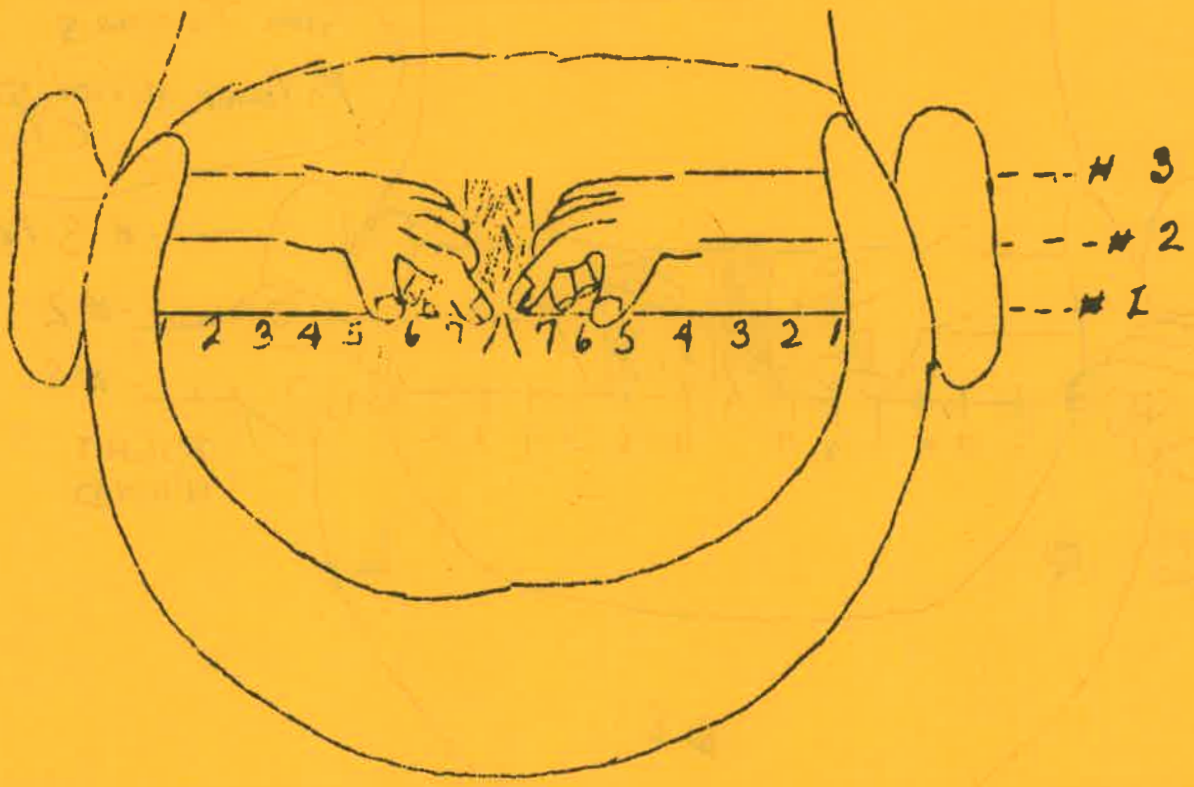


FIGURE #2. Line one is located by following the temporal-occipital suture V. The top of this V is the lateral limits of occipital line #1 and is occipital area #1 right and left.

The V is located by passing to the medial limits of the mastoid process. The medial margins of the mastoid ends in a depression, and this depression is the lambdoidal suture line.

2

OCCIPITAL PALPATION



The beginner will find that by starting his palpation at area seven on line one and moving laterally along that line to area one he will be more easily able to orient his palpatory effort.

Line one lies inferior of the tip of the external occipital protuberance. Place the index fingers together at that point and center them to the inferior tip of the external occipital protuberance. Move the fingers slowly laterally until you pass off the concavity of the nuchal ligament. Occipital seven lies in the lateral border of the nuchal ligament.

KEEP A VERY TIGHT SKIN CONTACT. This contact must be tight enough to force the index finger nail point into the tissues of the occipital bone.

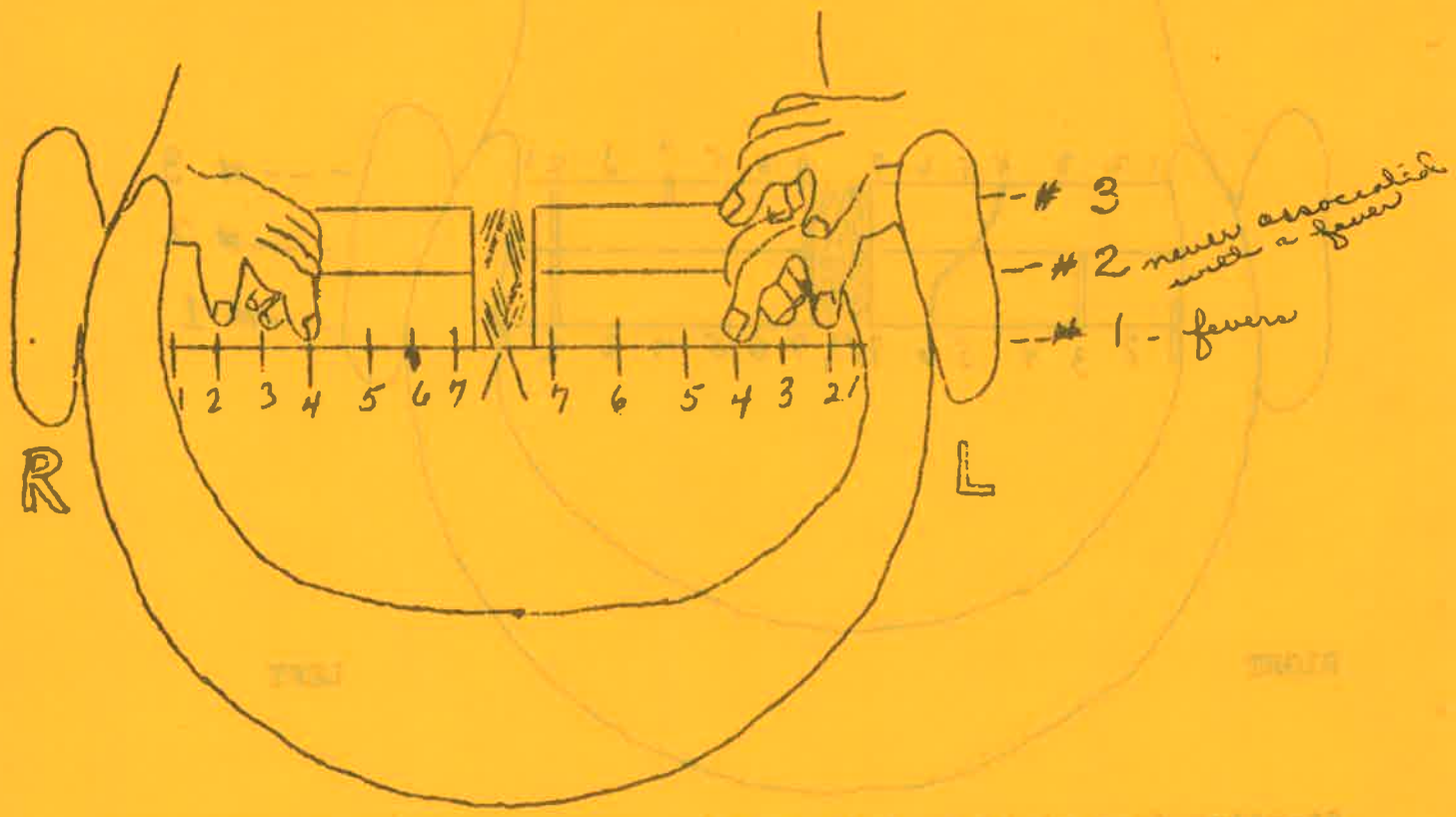
SLOWLY DRAW THE FINGERS LATERALLY and as you pass each fiber, you will distinctly feel it. Do not alter pressure, but simply drag the index fingers across the occiput.

You will count the fibers bilaterally as follows: 7-6-5-4-3-2-1. Area one will end in the peak of the lambdoidal V.

The objection to this form of palpation is mainly due to the pulling of the hair, and on women with the hair done into a roll, you will experience trouble in passing through the mass.

3

LOCATING THE OCCIPITAL MAJOR



Your index fingers travel across line #1 from fiber on area one bilaterally to fiber seven. The count is made to ascertain that you are accurately locating the seven fibers one line one.

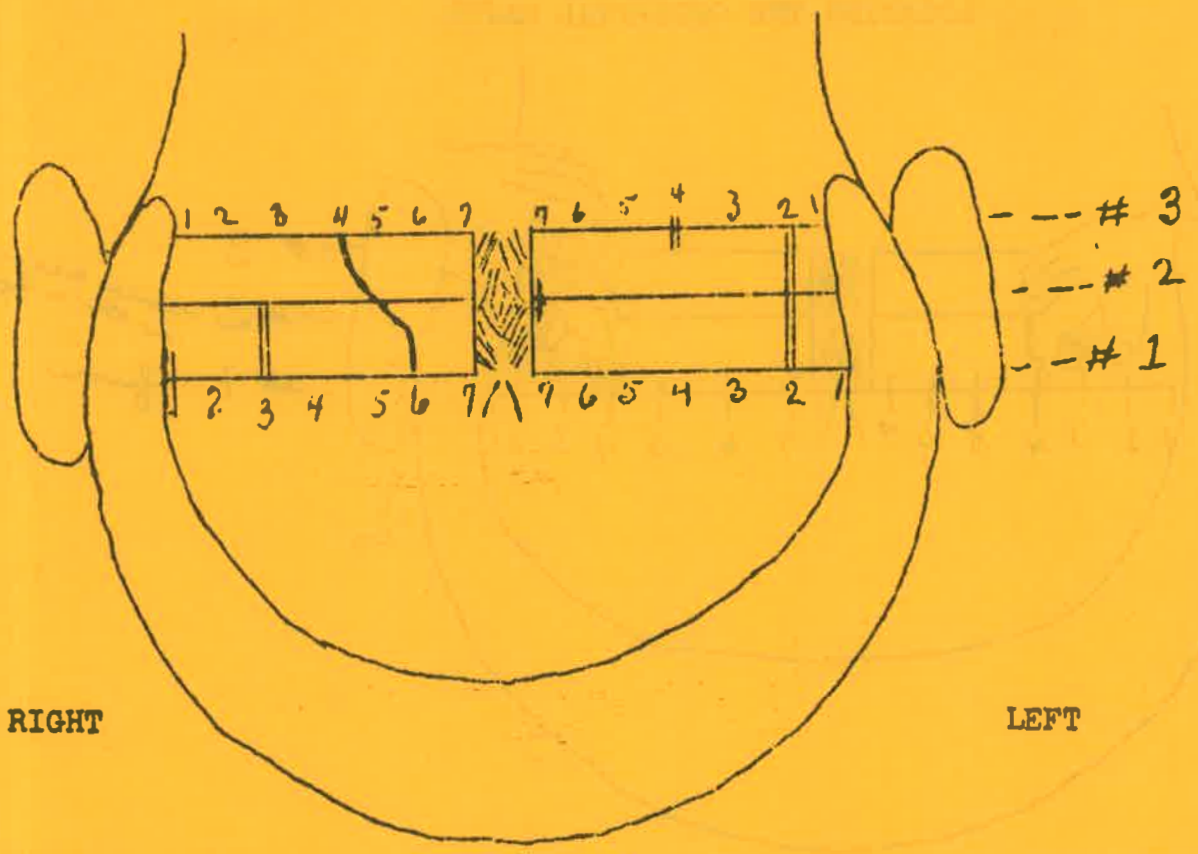
When this has been accomplished, your bilateral palpation starts on area one, line one, and as you proceed across the occiput the second time, you ask the patient to tell you when you contact a painful fiber. You stop at that fiber, and proceed to explore its inferior. If the fiber is one quarter of an inch or less in length, it will be a line one C fiber. If it is one half inch in length it will be an A type fiber, and if it is over one half inch, it will be a B type fiber. You move the complete hand inferior in this exploration, holding the skin taut with the middle and ring finger, and making certain you do not slip off the original fiber you are exploring.

In some B type fibers, you cannot travel straight inferior as the fiber will curve. You can easily detect this curve for as you move inferior, you find your finger coming into the side of the fiber, and then passing away from it.

You first locate the beginning of all fibers on line one. You cannot have a fiber involvement without having some degree of palpatory pain on line one. If the fiber increases in width as you progress to line two, and if the fiber narrows after passing line two, you have located a line two C fiber.

A B type fiber remains the same width for its full length. An A type fiber does the same.

TYPES OF OCCIPITAL LESIONS



Starting from right to left, we illustrate the types of occipital fibers possible to palpate.

AREA ONE RIGHT. This is a line one C fiber. Cerebro spinal fluid meningeal indicator.

AREA THREE RIGHT. This is an A type occipital fiber. Combination of the cerebro spinal fluid meningeal, plus viscus reflex. In the A type the viscus reflex produces the line one part of the A fiber.

AREA SIX RIGHT. This is a non-stabilized B type in which the fiber starts on line one at area six, transverses the occiput laterally through line two at area five and ends at area four on line three. This is a combination of the cerebro spinal fluid meningeal as indicated by line one, viscus reflex as indicated by line two and structural as indicated by line three.

AREA SEVEN, LINE TWO LEFT. This indicates a viscus reflex lesion.

AREA FOUR, LINE THREE LEFT. This indicates a structural lesion.

AREA TWO, B TYPE FIBER, LINES 1-2-3 LEFT. This is a vertical fiber and is termed a stabilized indicator. In this type fiber a specific distortion is its cause.

CHARACTERISTICS OF THE OCCIPITAL FIBER

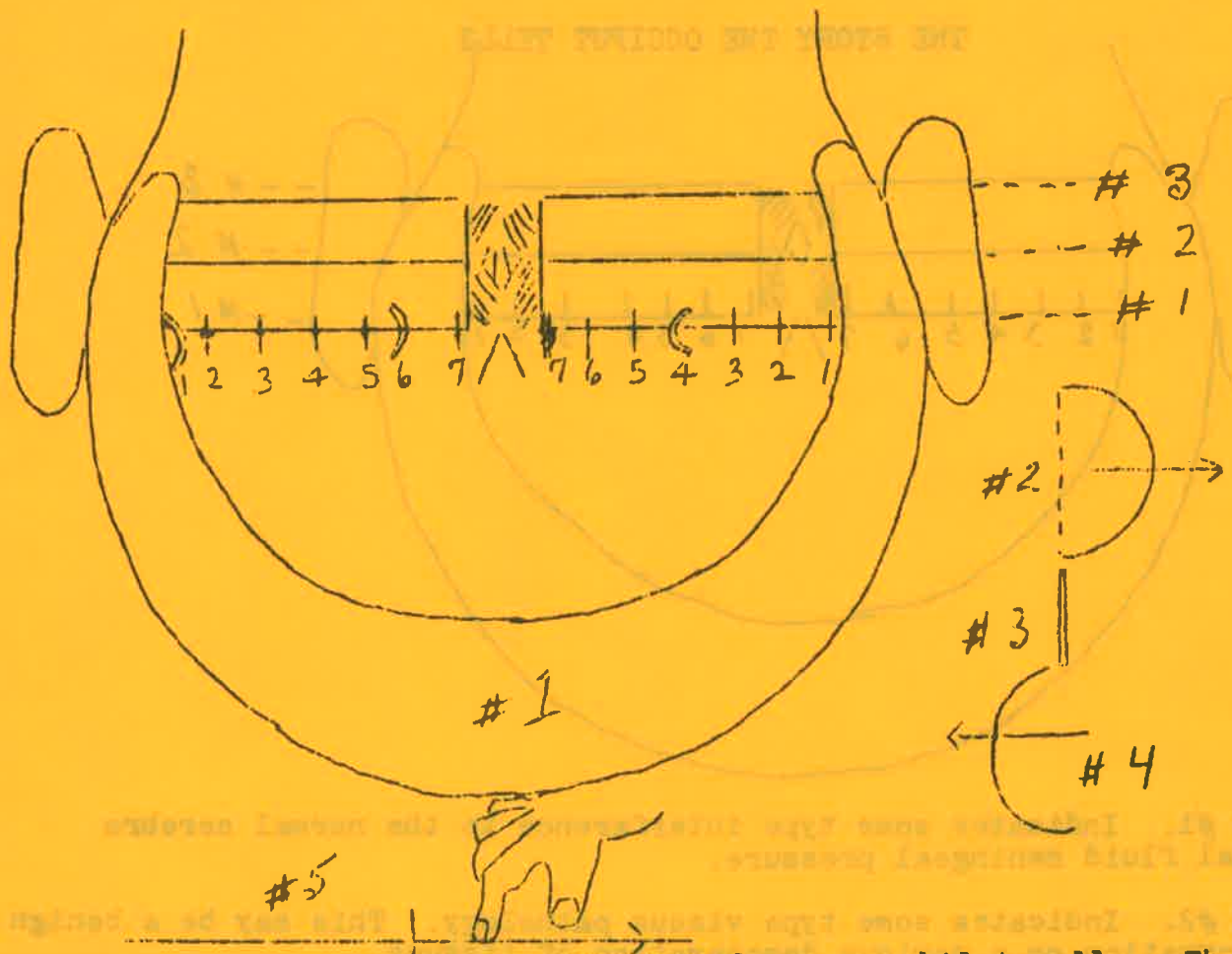


FIGURE #1. Illustrates seven count on line one, bilaterally. There are two reflexly affected fibers on the right and one on the left.

The normal fibers are straight, the abnormal fibers are moon shaped with convexity toward the medial.

Occipital fiber number one on the right is the most outstanding as it completely fills the lambdoidal area and can be very easily missed as it obliterates the lambdoidal V.

FIGURE #2. Illustrates in magnification the medial convexity of a right occipital fiber.

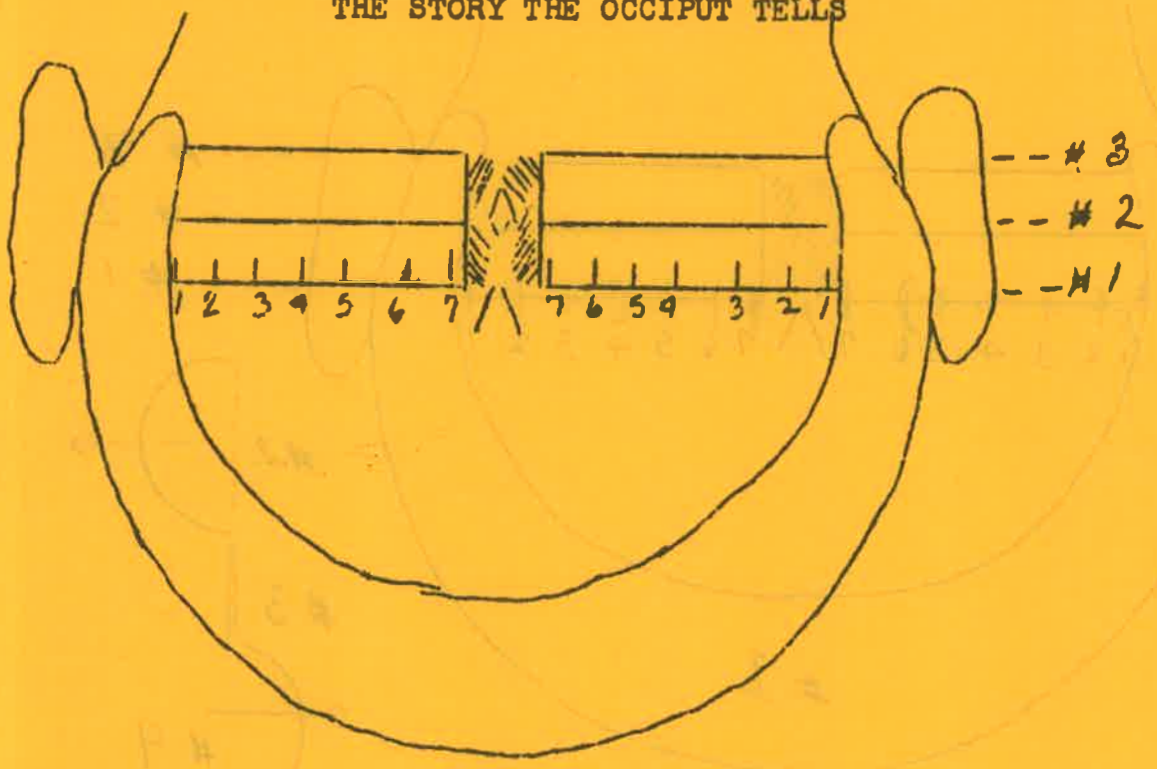
FIGURE #3. This illustrates how the normal straight fiber would appear and how it has been reflexly lesioned as in figure #2.

FIGURE #4. Illustrates the direction of index finger pull to produce a concavity of the convex fiber.

FIGURE #5. Illustrates a left normal straight line one fiber and a convex lesioned fiber, and shows medial position to index finger in relationship to fiber to start its lateral stretch. Your mail point contact must be medial of the belly of the fiber before you can contact it for the stretch. This moon shaped fiber may not be painful until stretched.

6

THE STORY THE OCCIPUT TELLS



LINE #1. Indicates some type interference to the normal cerebro spinal fluid meningeal pressure.

LINE #2. Indicates some type viscus pathology. This may be a benign inflammation or a serious degeneration of tissues.

LINE #3. This line is our serious structural change line and indicates a breakdown of tissue in the parts affected.

AREA ONE. This is the cardio-vascular indicator area. Heart, pericardium, great blood vessels, Blood pressure regulatory systems.

AREA TWO. Pulmonary, bronchial, kidney system.

AREA THREE. Gastro intestinal systems.

AREA FOUR. Pancreatic, cecal system.

AREA FIVE. Lymphatic-glandular systems.

AREA SIX. Liver-colon system.

AREA SEVEN. Intestinal-prostatic or uterine reflex center.

7

ALLERGY REACTIONS

Allergy reactions assume many forms. Allergies are usually associated with pollens, but nothing could be further from the truth.

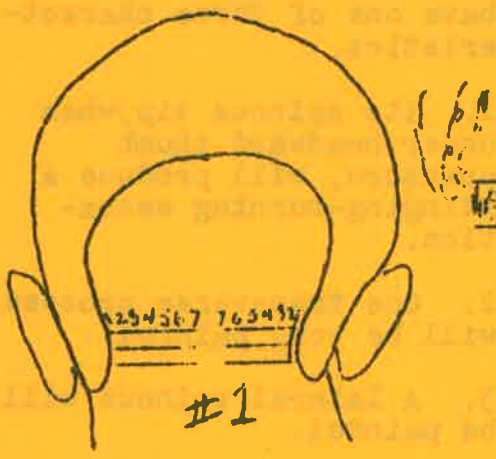


FIGURE #1. We have a B type fiber on area one, right. There is a dorsal one spinal major. The patient is a heavy cigarette smoker. We normalize the spinal major by use of the spinal pump. The patient them smokes one cigarette, and if within five minutes the occipital B fiber on the right increases in intensity, this patient is specifically allergic to cigarette smoke or tars.

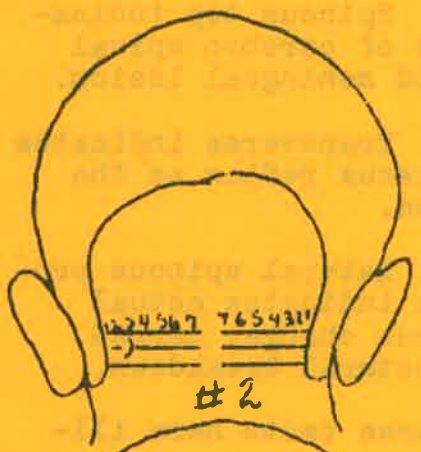


FIGURE #2. An occipital C fiber line two, area three left. Dorsal four is the spinal major. We suspect a dietetic cause. The patient is adjusted, then immediately eats a portion of food most eaten. If occipital three, line two left increases in intensity within five minutes there is a specific food allergy. Each food must be tested separately. This is a laborous process, but proves accurate even after all types of skin tests have failed.

FIGURE #3. We see an occipital A type fiber on the left, involving lines one and two at area 4. Specific nutritional aids are indicated, but which one or ones will be specific? Adjust the spinal major as indicated. Give one tablet of the type under consideration. Wait five minutes. If the fiber intensity increases, that vitamin or mineral is not indicated.

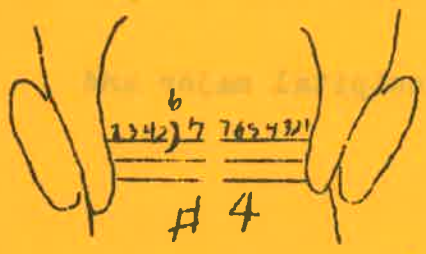
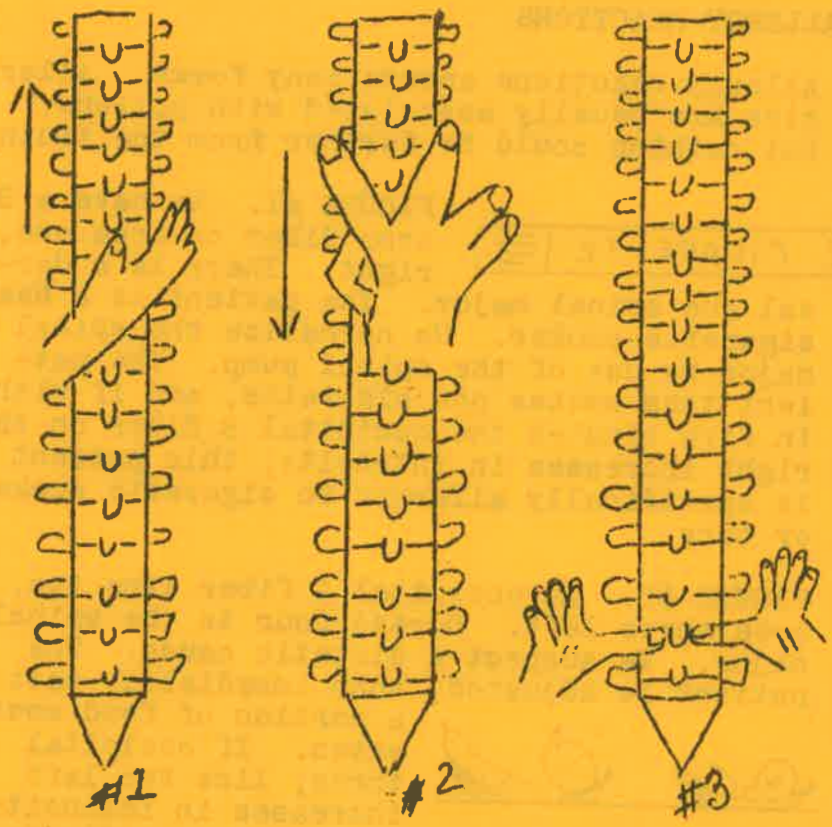


FIGURE #4. WHAT ADJUSTMENT WILL BE SPECIFIC? You have selected what you believe is the specific vertebra. Palpate the occiput and locate its most active fiber. Give your adjustment. Repalpate the occipital fiber in five minutes. If its intensity increases, your specific was in error or your adjustment was in error.

THE SPINAL MAJOR



The spinal major will have one of three characteristics.

1. Its spinous tip, when under headward thumb pressure, will produce a stinging-burning sensation.

2. One transverse process will be very painful.

3. A lateral spinous will be painful.

#1. Spinous tip indicative of cerebro spinal fluid meningeal lesion.

#2. Transverse indicates a viscus reflex as the cause.

#3. Lateral spinous process indicates actual tissue change, termed structural breakdown.

In learning occipital-spinal technic, make the three tests here illustrated.

FIGURE #1. Palpate all dorsal-lumbar spinous tips with thumb point, and in a headward direction. Make contact, give pressure, and hold for five seconds. If indicator of cerebro spinal fluid meningeal lesion, patient will observe a burning-stinging sensation.

FIGURE #2. Starting at dorsal one, draw index and middle fingers across lateral transverse processes. Make firm pressure. Go slow, hold equal pressure. Painful area indicates viscus reflex at that level.

FIGURE #3. Using thumb lateral of spinous process, make pressure to left with right thumb, and to right with left thumb. Painful spinous side indicates area of structural reflex.

The spinal area thus found must agree with the occipital major and its fiber.

SELECTING THE SPINAL MAJOR

FIGURE #1. We have an occipital four left. A type occipital fiber. This occipital four area indicates that we are to palpate dorsals 6 and lumbar 2.

OCCIPITAL	1	2	3	4	5	6	7	
DORSAL	1-2	3	4-5	6	7	8	9	
DORSAL	9-10	11-12						
LUMBAR			1	2	3	4	5	
CERVICAL	1	2	3	4	5	6	7	

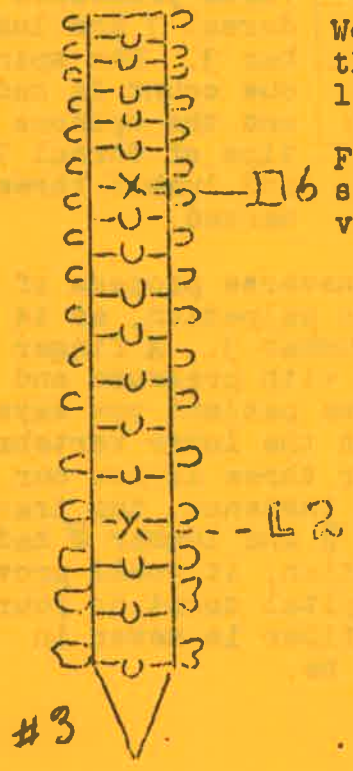
#2

The spinal major is based upon specific spinal segments that reflex to specific occipital areas.

FIGURE #2. This is the occipital-spinal reflex chart that is used in determining spinal segments to palpate in all occipital A type fibers, B type fibers, and lines one and two C type fibers.

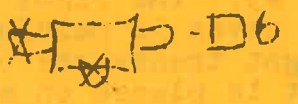
Knowing the occipital major and the type fiber involved, you consult the chart and immediately know which vertebra to palpate.

FIGURE #3. Start your count at dorsal one spinous. In above illustration of an occipital 4 fiber, we wish to palpate the transverse processes of dorsal 6 and lumbar 2 because this is an A type fiber.



We count spinous processes as dorsal 1-2-3-4-5, then mark dorsal six. Continue count as 7-8-9-10-11-12, L 1-2 and mark spinous of lumbar two.

FIGURE #4. Having marked the spinouses of dorsal 6 and lumbar 2, we can now palpate their transverse processes without confusing the patient.



We note that the left transverse of dorsal six is painful, as is the right transverse of lumbar 2.

We now hold a contact on the left transverse of dorsal 6 and the right transverse of lumbar 2. The one the patient feels is the spinal major.

#4

#10

TYPE A FIBER TECHNIC

1 3/0

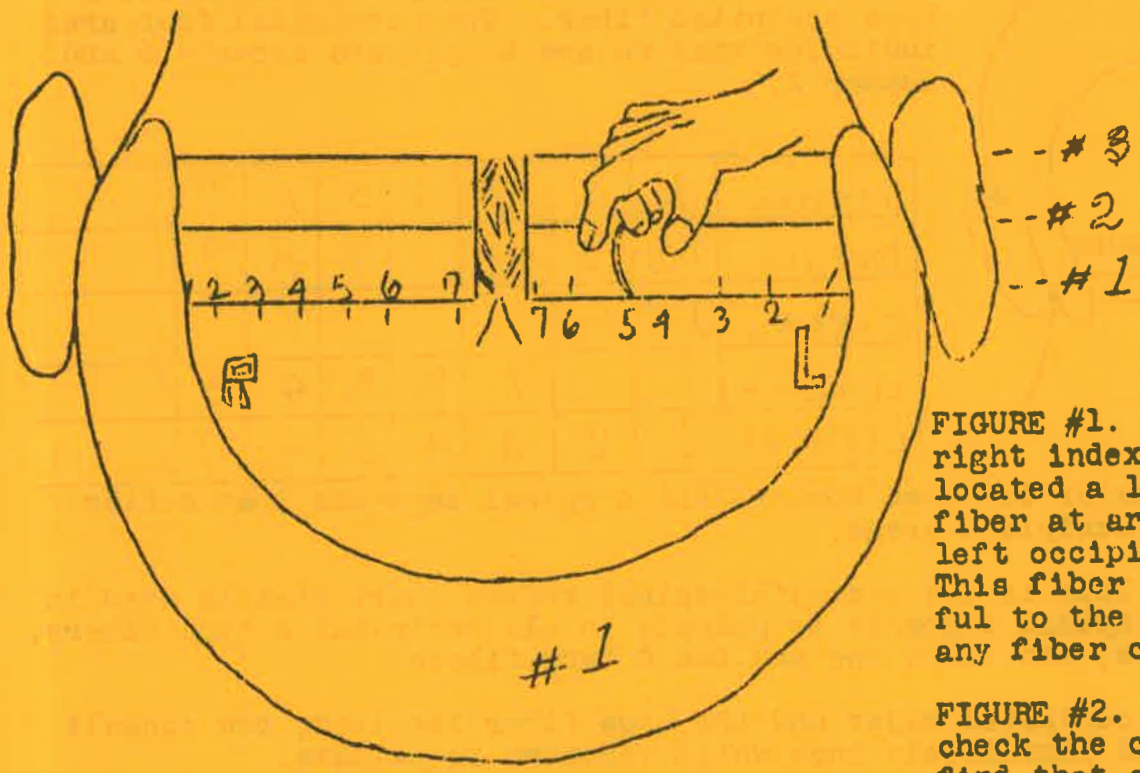


FIGURE #1. Operators right index finger has located a line 1-2 fiber at area 5 on the left occipital ridge. This fiber is more painful to the patient than any fiber contacted.

#2

OCCIPITAL	1	2	3	4	5	6	7
DORSAL	1-2	3	4-5	6	7	8	9
DORSAL	9-10	11-12					
LUMBAR			1	2	3	4	5

FIGURE #2. We now check the chart and find that occipital 5 A type fiber indicates that we palpate the transverse processes of dorsal 7 and lumbar 3. The spinous count is made and the spinous tips of dorsal 7 and lumbar three marked.

#3

FIGURE #3. The right transverse process of dorsal seven is painful to palpation, as is the right transverse of lumbar 3. A finger contact is placed on each with pressure and held for five seconds. The patient now says that she feels the pain on the lower vertebrae, which is lumbar 3. Lumbar three is now our spinal major. If in this instance, the transverse processes of dorsal 7 and lumbar 3 had not been painful to palpation, it would prove you in error on your occipital count or your spinal count. Occipital fiber is never in error, but your count may be.

#11

A TYPE OCCIPITAL FIBER TECHNIC

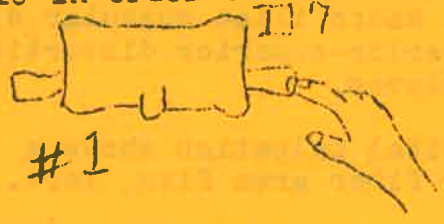
In this illustration lumbar three became the spinal major because its right transverse was more painful than the transverses of dorsal 7 or the left transverse of lumbar three.

FIGURE #1. Occipital-transverse process reflex.

Take your position at side of prone patient. Place one finger over the occipital fiber on area five.

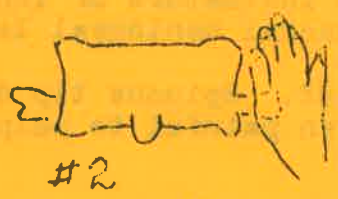
Place index finger of free hand over right transverse of lumbar three. Hold this contact lightly.

Stimulate occipital fiber at area five very vigorously and continue to do so for two minutes or less. The adjustment is made when you feel heat and slight moisture over your third lumbar transverse contact. You must irritate this occipital fiber as vigorously as possible in order to break this viscus reflex.



If your transverse contact does not develop warmth and slight moisture in two minutes, break contacts. Wait three minutes and reapply. Do not proceed past this point if warmth does not develop. Use pre or postgangalionic technic. Described later.

FIGURE #2. When warmth over the spinal contacts develop, it indicates that the reflex has been broken and that you can proceed with your chiropractic thrust.



A left hand pisiform contact is made in this case over the right transverse of lumbar three. This is supported by your right hand. A fast recoil is delivered obliquely through the vertebra so it will transverse its central axis. Your thrust must not be anterior-superior or inferior.

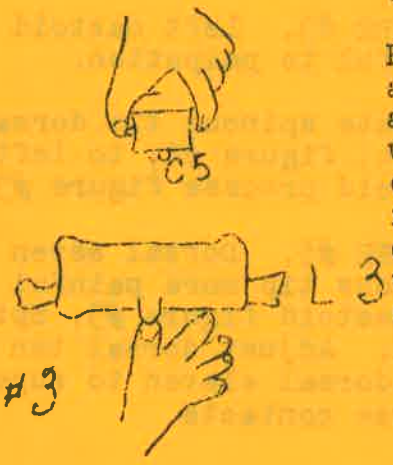
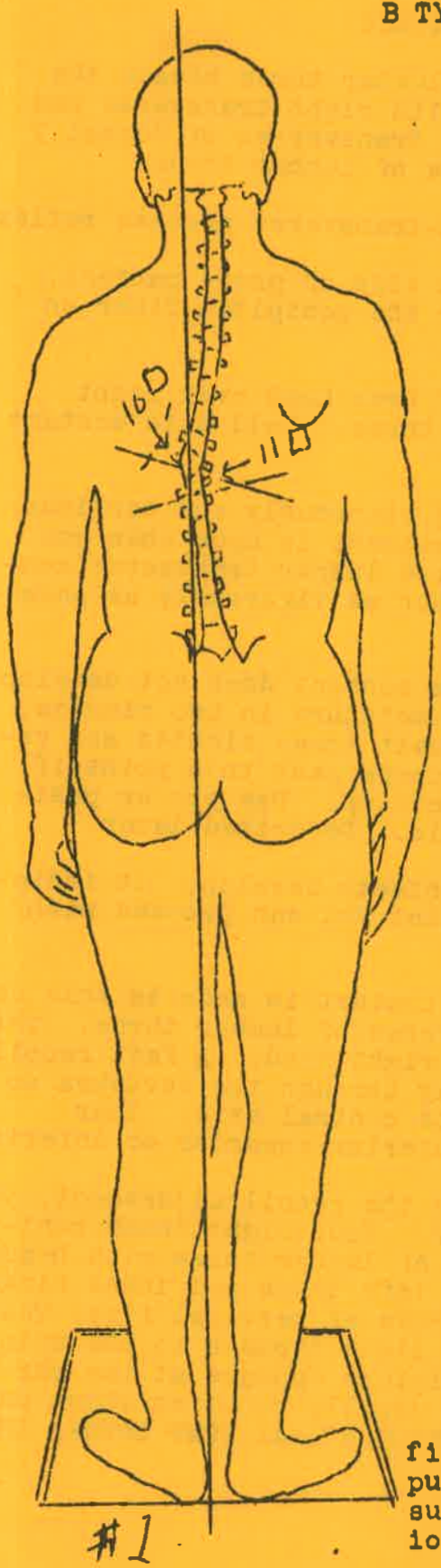


FIGURE #3. Following the recoil adjustment, you apply the SPINAL PUMP. Your right thumb contacts the spinous tip of lumbar three with headward pressure. Your left thumb and index finger contacts the transverses of cervical five. Your right thumb delivers light thrusts to the spinous contact until moisture appears at the cervical contact. This usually requires about one minute. DO NOT CONTINUE SPINAL PUMP LONGER THAN TWO MINUTES.

#12

B TYPE OCCIPITAL FIBER about 84% of all cases



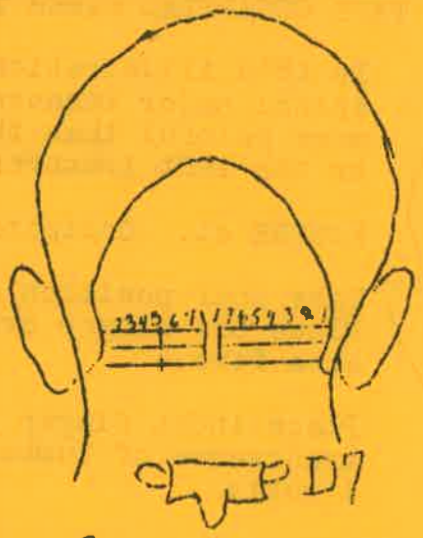


FIGURE #1. Right sacro iliac muscular distortion, plus inferior-superior distortion dorsals ten and eleven.

FIGURE #2. Occipital palpation shows a stabilized B type fiber area five, left.

FIGURE #3. Left mastoid indicator of innominate lesion.

FIGURE #4. First rib tubercles as indicators of innominate-sacral meningeal lesion.

FIGURE #2. Spinous tip dorsal seven painful to palpation.

FIGURE #3. Left mastoid painful to palpation.

Compate spinous tip dorsal seven, figure #2, to left mastoid process figure #3.

FIGURE #5. Dorsal seven spinous tip more painful figure #2, than left mastoid figure #3. Spinal pump technic indicated. Adjust dorsal ten to superior on right and dorsal eleven to superior on left. Transverse contacts.

#13

B TYPE OCCIPITAL FIBER

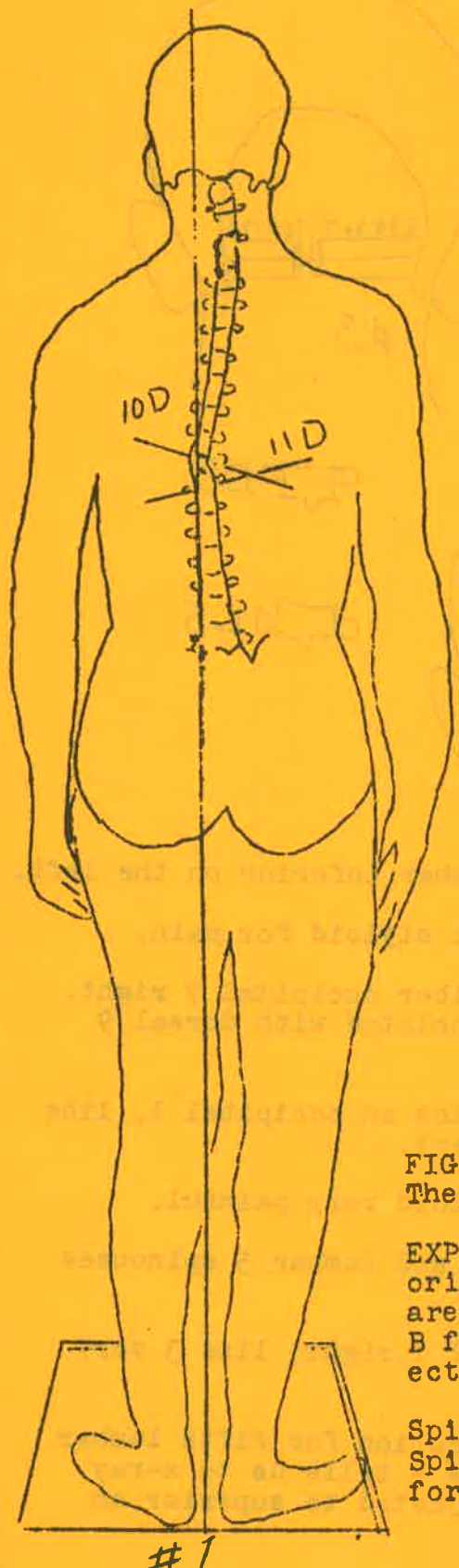


FIGURE #1. Right sacro iliac muscular distortion, plus left inferior eleventh and right inferior tenth dorsals.

FIGURE #2. Occipital 2 line one left is origin of B fiber which transverses occiput, passing through line two and ending at area 5 line three. This is an unstable B fiber.

Palpate spinous tips dorsals 3-11-12.

FIGURE #3. This is a right sacro iliac muscular distortion, so we palpate left mastoid. It is negative.

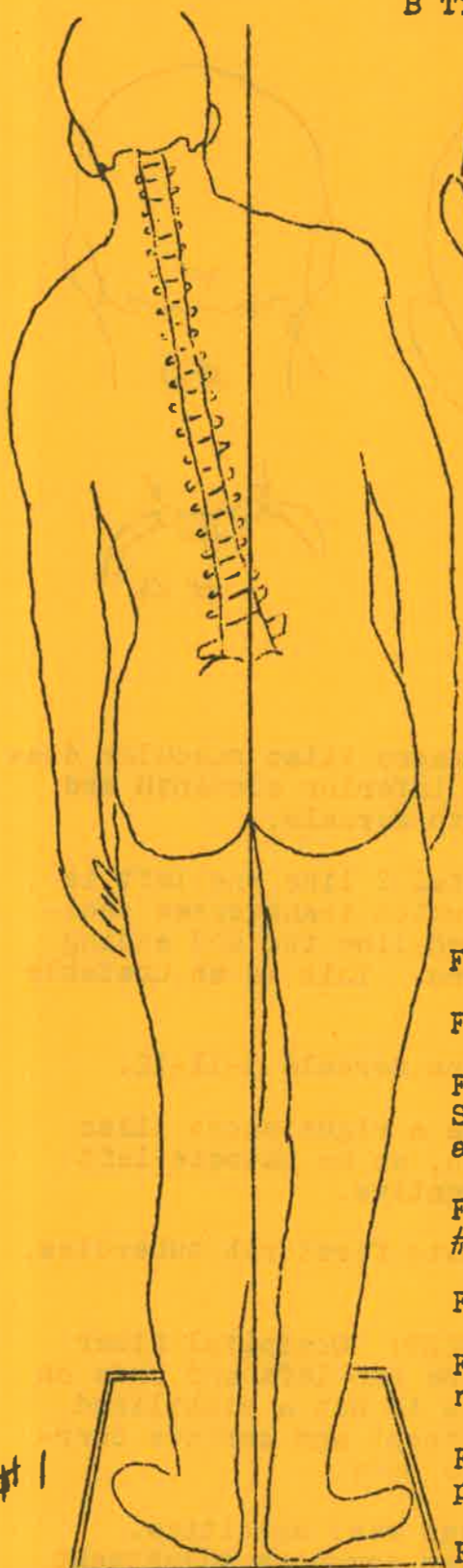
FIGURE #4. We now palpate first rib tubercles. They are negative.

EXPLANATION AND ADJUSTMENT: Occipital fiber originates on area 2 line one left and ends on area 5 line three. This is not a stabilized B fiber so we do not attempt and osseous correction before x-rays are made.

Spinous tip dorsal eleven very sensitive. Spinal pump dorsal eleven completes adjustment for today.

#14

B TYPE OCCIPITAL FIBER



PD9

L5

FIGURE #1. Fifth lumbar inferior on the left.

FIGURE #2. Test left styloid for pain.

FIGURE #3. B type fiber occipital 7 right. Straight fiber. Associated with dorsal 9 and lumbar 5.

FIGURE #4. Illustrates an occipital 1, line # 3 fiber, same patient.

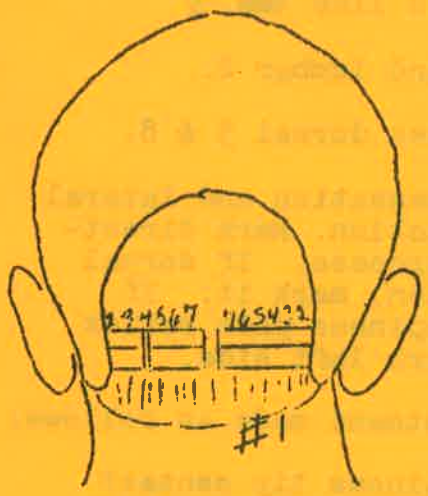
FIGURE #2. Left styloid very painful.

FIGURE #3. Dorsal 9 and lumbar 5 spinouses negative.

FIGURE #4. Occipital 1 right, line 3 very painful.

FIGURE #2 gives indication for fifth lumbar adjustment to superior on the left. Figure # 4 tells us to x-ray fifth lumbar. Found free of pathology. Adjusted to superior on left. Complete relief.

B TYPE OCCIPITAL FIBER



The B type occipital fiber is a three line fiber of many characteristics. Occipital line one being the cerebro spinal reflex line. Line two being the viscus reflex line, and line three being the structural reflex line. You will readily understand that this B type fiber has many complexities.

In all B type fibers in which the fiber is true vertical, and passes through the three lines at equal areas, we usually find that the answer to the patient's problem is some type distortion correction. The true vertical B type occipital fiber is a stabilized reflex system, in which the patient's pain is being produced by some type osseous distortion. Figure #1 shows a stable area 4 fiber.

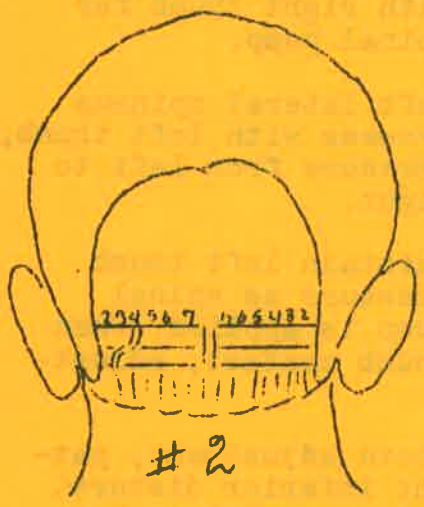


FIGURE #2. Non stabilized B type fiber. This fiber originates on a line one area, but ends as a continuous fiber on a line three area different than line one. This is a true mixed reflex fiber, and is usually non distortional. In this figure, origin is area 4 line one, left and termination line three area 2.

FIGURE #3. B type non stabilized. Origin line one, area 3 right, and termination line three area 6.

#4

OCCIPITAL	1	2	3	4	5	6	7
DORSAL	½	3	4-5	6	7	8	9
DORSAL	9/10	11-12					
LUMBAR			1	2	3	4	5

FIGURE #4. Chart used in all line one and two fiber majors.

#5

OCCIPITAL	1	2	3	4	5	6	7
DORSAL	1-12	2-11	3-10	4-9		5-8	6-7
LUMBAR	5	4	3	2	1		

FIGURE #5. Chart used in all line three fibers.

In all non stabilized B type fibers, test spinouses as indicated from line one, and lateral spinous areas as indicated from termination on line three. Use spinal pump first treatment, then as fiber straightens, adjust as per distortion, or as indicated from lateral spinous.

NON STABILIZED B TYPE FIBER

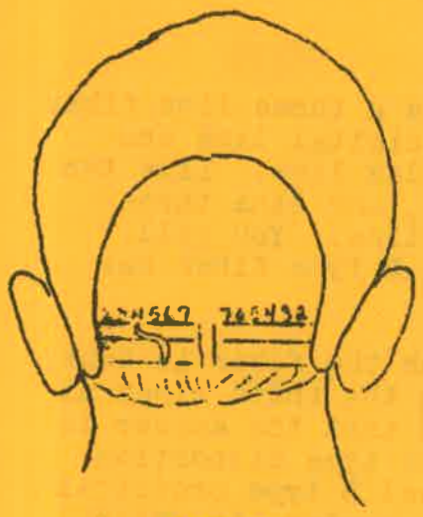


FIGURE #1. Fiber originate area four left on line one and terminate area 6 line [redacted]. 3

Test spinous tips dorsal 6 and lumbar 2.

Test lateral spinous processes dorsal 5 & 8.

Mark spinous tip producing sensation and lateral spinous area giving pain reaction. Mark direction of pressure on spinous process. If dorsal six gives spinous tip reaction, mark it. If dorsal eight gives lateral spinous pain reflex with pressure from right, mark left side.

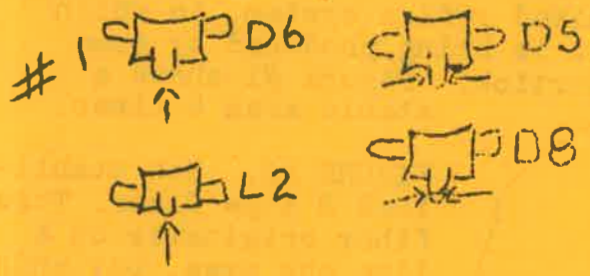


FIGURE #2. Adjustment made as follows:

Spinous tip contact with right thumb for spinal pump.

Left lateral spinous process with left thumb, pressure from left to right.

Maintain left thumb pressure as spinal pump is applied. When moisture appears under left thumb contact, adjustment is made.

FIGURE #3. Before applying above adjustment, patient shows a tenth dorsal right inferior distortion. If your occipital-spinal count and technic has been correct, this tenth dorsal distortion will now show improvement.

FIGURE #4. If your technic has been correct, the occipital B type lesion will straighten within twenty-four hours and now becomes a stabilized fourth area fiber. You may now adjust dorsal ten to the superior on the right and the distortion will correct permanently. Technic as used in Figure #2 has stabilized the reflex system, which is essential before a distortion can be corrected.

#4

STABILIZED AND NON STABILIZED B TYPE OCCIPITAL FIBER

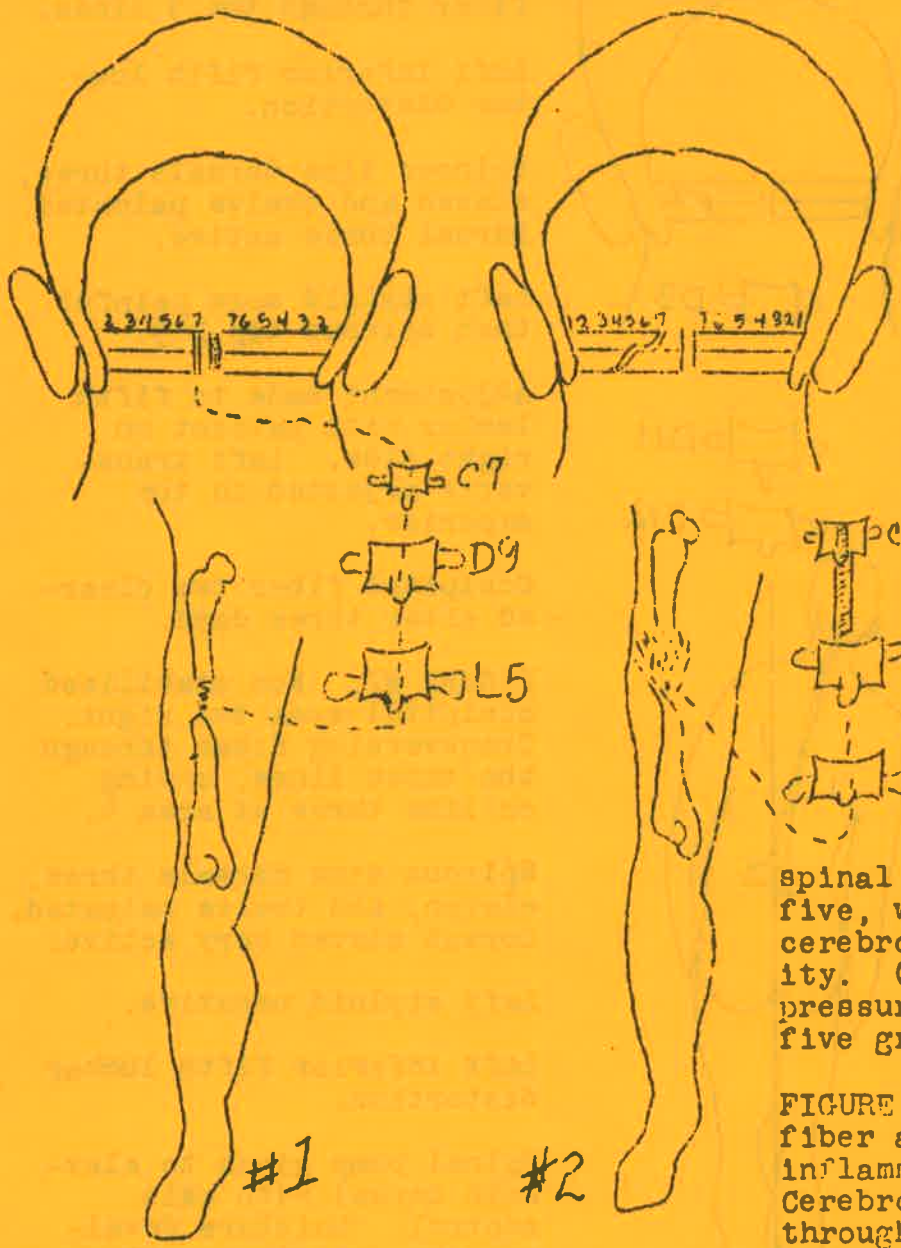


FIGURE #1. Fracture of the femoral shaft without resultant osseous or soft tissue pathology. Straight line B type fiber on occipital area # 7. In this instance recovery will be normal with proper stabilization and rehabiliation therapy.

FIGURE #2. Fracture of femoral shaft with resultant osseous fragment displacement and pathology. Occipital 7 fiber on line one, transversing occiput to left lateral through line two at area 5 and into line three at area four. This can be remedied by suitable surgery, plus the spinal pump technic to lumbar five, which is the level of cerebro spinal fluid abnormality. Cerebro spinal fluid pressure superior of lumbar five greatly increased.

FIGURE #3. Straight B type fiber associated with a benign inflammation of the prostate. Cerebro spinal fluid reflex through lumbar five disturbed. Spinal pump is the correction.

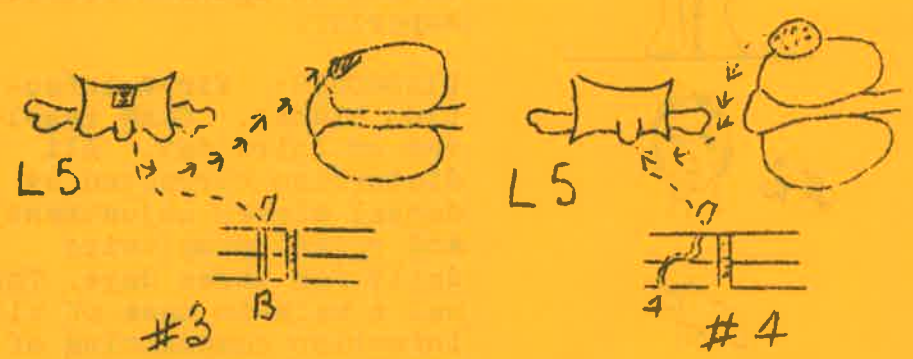


FIGURE #4. Transversing B type fiber in association with a malignancy of the prostate and a right rotation of lumbar five. The line two and three factor has produced the fifth lumbar rotation. The fifth lumbar rotation did not produce the malignancy.

STABILIZED AND NON-STABILIZED B TYPE OCCIPITAL FIBER

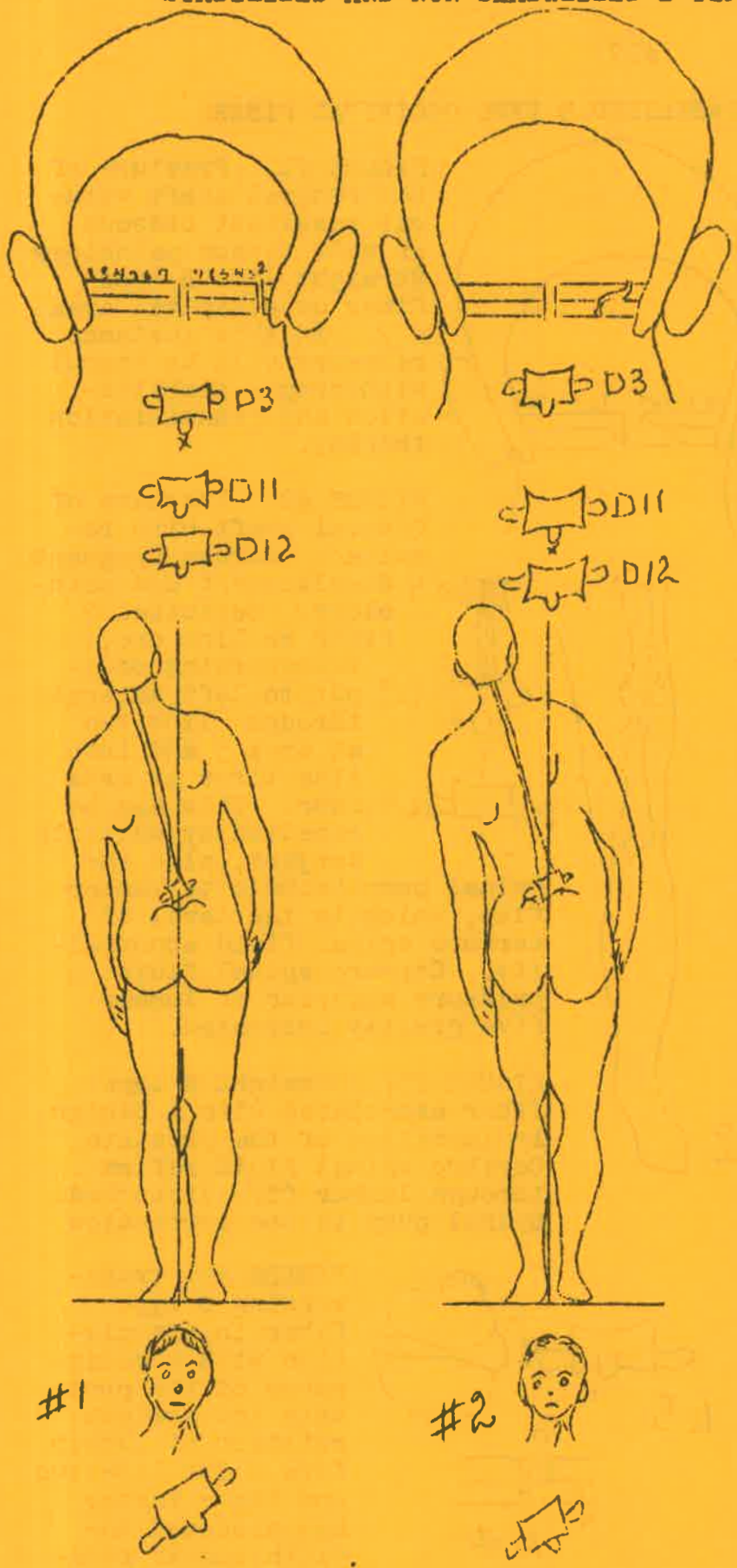


FIGURE #1. Stabilized B type occipital fiber, area two right. Straight line fiber through the 3 lines.

Left inferior fifth lumbar distortion.

Spinous tips dorsals three, eleven and twelve palpated. Dorsal three active.

Left styloid more painful than spinous tip D 3.

Adjustment made to fifth lumbar with patient on right side. Left transverse adjusted to the superior.

Occipital fiber two cleared after three days.

FIGURE #2. Non stabilized occipital area two right. Transversing fiber through the three lines, ending on line three at area 4.

Spinous tips dorsals three, eleven, and twelve palpated. Dorsal eleven very active.

Left styloid negative.

Left inferior fifth lumbar distortion.

Spinal pump given to eleventh dorsal with axis control. Moisture developed in one minute. Eleventh dorsal spinous recoiled superior.

DIAGNOSIS: Virus infection kidney. Case resolved on third day. All distortion corrected by dorsal eleven adjustment and spinal pump twice daily for three days. This was a walk-in case of virus infection complaining of a severe low back pain.

C TYPE LINE ONE OCCIPITAL FIBER REFLEX

FIGURE #1. Occipital area two, line one, left, C type fiber.

REFLEX ARC: Occipital two...C type fiber... Dorsals 3, 11, and 12. Control, C 2

Chart previously listed indicates that you are to palpate spinous tips of dorsals 3,11, & 12.

Start spinous tip palpation at dorsal 1. Count dorsal two, mark tip of three. Count 4-5-6-7-8-9-10...Mark tips of 11 and 12.

Using thumb of right hand, contact spinous tip dorsal 3 and use headward pressure. Hold for ten seconds, then ask patient if he feels a stinging or burning sensation. Proceed to dorsal 11 and 12 and repeat test.

Vertebra giving most acute sensation will be the spinal major. This proves to be D 12.

FIGURE #2. Dorsal 12 is the site of cerebro spinal fluid meningeal block.

Chart indicates C 2 as the vasomotor control area. Vasomotors presumably end at the first dorsal, but their dilating fibers are found in the cervicals, so C 2 becomes our indicator of vasomotor flushing.

Use thumb and index fingers of left hand to contact C 2 at its transverse processes. Make a light squeeze type contact.

Make thumb point contact to spinous tip of dorsal 12 with right thumb. Balance of hand flat on back and to the right of spine center.

Give light headward impulses with right thumb. When you feel moisture develop of C 2 contact, cerebro spinal block has been removed. This will usually occur within one minute. If it does not respond at C 2 within that period of time, break contacts. Rest one minute and reapply.

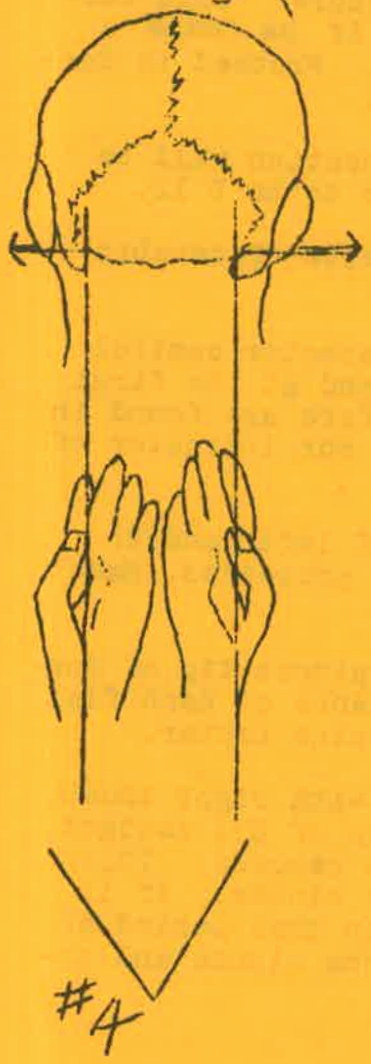
C TYPE LINE ONE OCCIPITAL FIBER REFLEX

#3

FIGURE #3. Following the SPINAL PUMP as applied in Figure #2 and its C 2 moisture reaction, you proceed to use a recoil to the spinous tip of dorsal 12.

Left hand pisiform contact to tip of dorsal 12. Flat hand contact. Support left hand with flat right hand contact. Give thrust straight headward. The thrust must be sharp and fast. If lordosis is present, support abdomen with cushion or pillow.

FIGURE #4. Following delivery of the twelfth dorsal recoil, have the patient turn to the supine position. In this position palpate the left and right pulse at the same time. If the pulse is firm, proceed as here illustrated.



#4

Sit at head of table. Place little fingers together to form a wedge of the open hand. Place thumbs over index fingers. Place hands under occiput and thumbs just medial of the lambdoidal sutures. In this position hold the hand so a lateral wedge is formed. The object is to slightly relieve the temporal-occipital suture pressure and thus remove excessive stimulation to the choroid plexuses in the ventricles. You do not move the hands but simply hold the wedge and permit the weight of the patient's head to relieve this suture pressure.

This contact should be held for two minutes, and at the end of that time, the pulse should be softer. It is not necessary to repeat even if pulse remains firm. This particular adjustment can be used daily, but it would be unwise to repeat the same day. The reaction is sometimes severe if over treated.

This same type adjustment is indicated in all conditions of spasticity. We have even found it of help in relieving the pain of sciaticas and neuritis. Migraine headaches are a primary lesson in excessive choroid activity and this V type temporal-occipital spread helps control migraine attacks.

use on old apoplexy + cerebral Palsy cases

C TYPE LINE ONE OCCIPITAL FIBER REFLEX

#5

FIGURE #5. Following the delivery of the twelfth dorsal recoil as illustrated on a previous page, and following palpation of the right and left pulse, should the pulse be soft, proceed as follows:

Place the four finger tips together. The thumb rides atop the index finger. The hand forms a bowl and this bowl is now fitted to the patient's occipital bone with the thumbs along the lambdoidal suture between temporal and occipital.

Holding the thumbs stiff, you now roll the thenars medial into contact with the occipital bone. This roll is repeated every five seconds. The roll serves to stimulate the choroid plexuses into more productive excretion of cerebro spinal fluid. Treatment may last up to three minutes.

Normal cerebro spinal fluid pressure in a healthy adult varies greatly, but the average is 100-200 MM water or 7 to 15 MM mercury.

6

FIGURE #6. We illustrate the occipital bone being grasped by a pair of forcepts. When the handles are closed, the jaws increase their pressure. This is the object of the thenars and their inward rolling technic. This gentle squeezing motion does stimulate the ventricles.

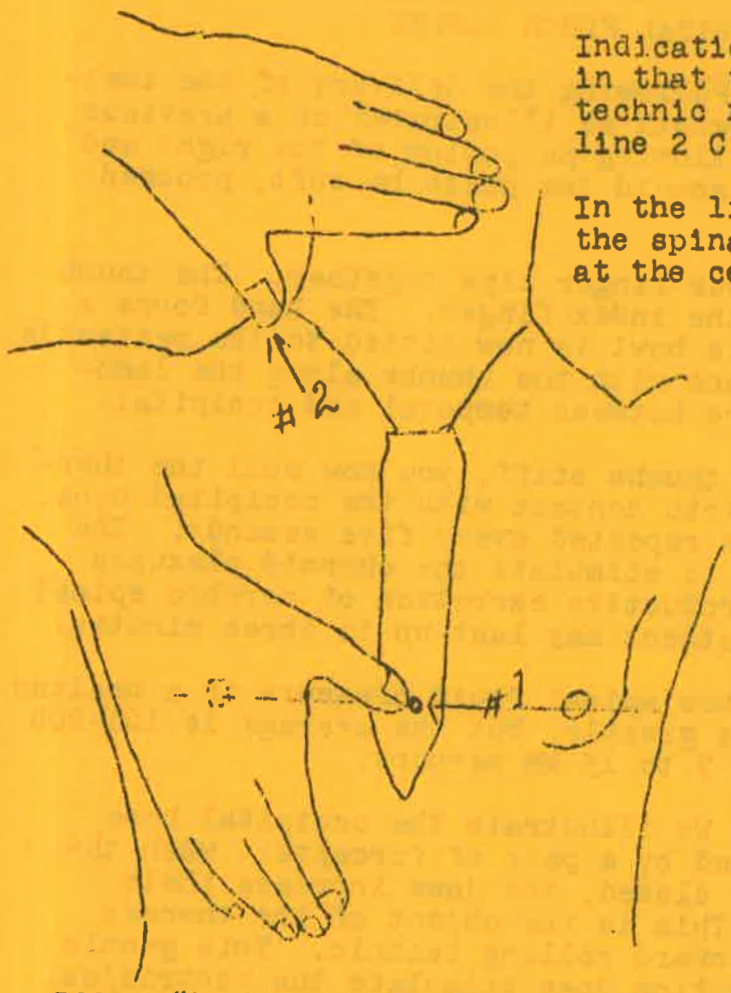
We have found that the cerebro spinal fluid pressure varies even in healthy people, but in such instances it never varies to the point whereby it cannot return to normal with a few minutes rest.

This variable pressure as associated with disease is different than in health, for it looses its ability to return to normal pressure unaided.

Bedside tec

#22

PRE AND POST GANGLIONIC TECHNIC



Indications for this technic are specific in that the technic is to be used when the technic for A type, B type, line 1, or line 2 C type lesion does not respond.

In the line one C type this would be when the spinal pump fails to produce moisture at the cervical control.

In the A type, it would be when occipital fiber stimulation fails to produce warmth at the contacted spinal major transverse area. This would also apply to the line 2C type lesion.

Pre or post ganglionic technic enables the body to respond to the indicated therapy. This technic of its own accord cannot be a truly productive technic.

Test point number one: This is located in the central sternal area on a horizontal line with the nipple.

Test point number two is located in the neck-shoulder triangle.

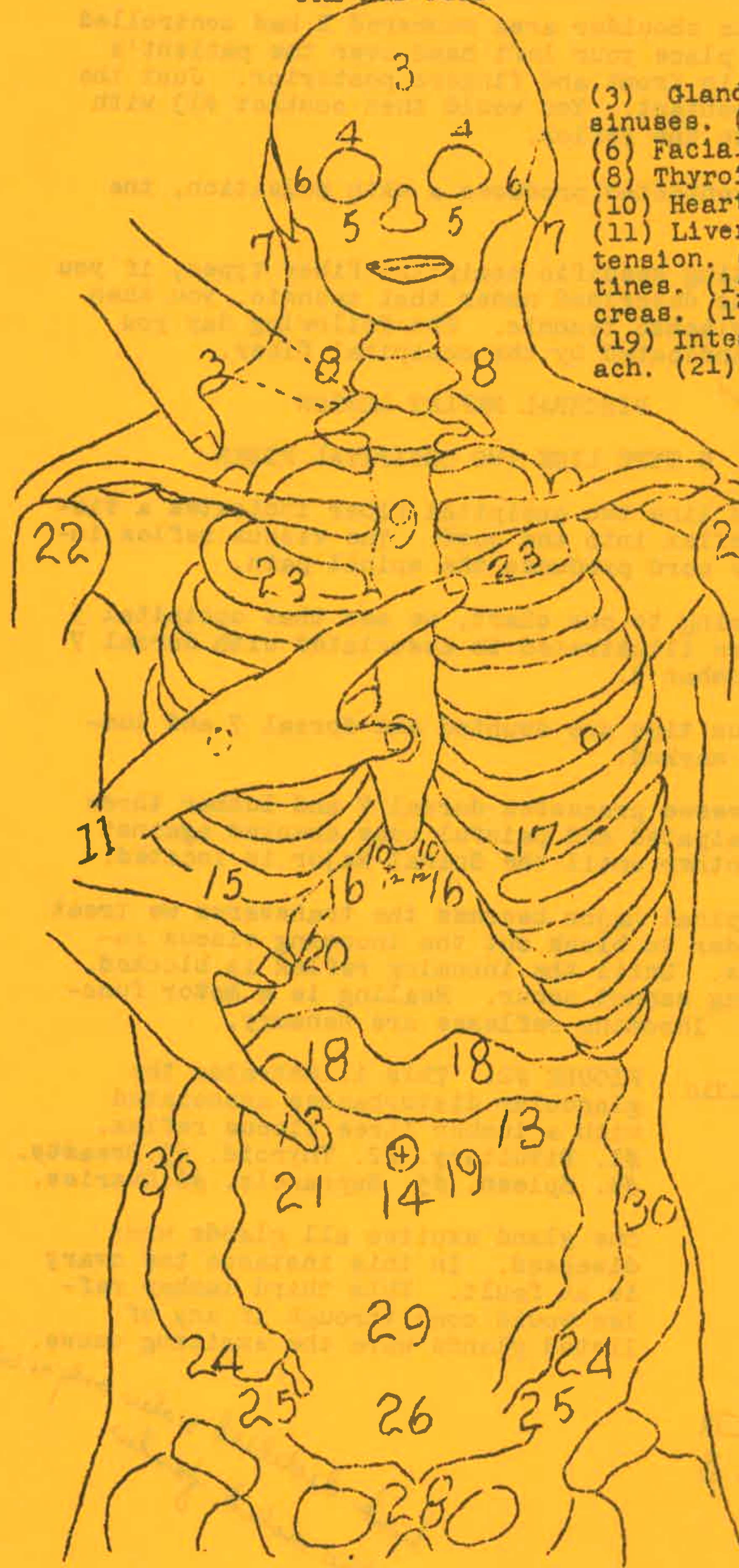
POINT #1 when painful to pressure indicates a pre-ganglionic disturbance. This disturbance is in the horns of the cord and is a failure type reflex in which the nerve impulse fails to leave the cord.

POINT #2 when painful to pressure indicates a post ganglionic reflex. in this type reflex, the incoming impulse fails to gain cord entrance.

Point one is associated with tonic contractures. Point two with non responding stimuli.

When both points one and two are tender to pressure, they are to be held equally until the patient can determine which one looses its sensation.

PRE AND POST GANGLIONIC TECHNIC



VISCUS AREAS

(3) Glandular control. (4) Frontal sinuses. (5) Maxillary sinuses. (6) Facial ganglion. (7) Mastoids. (8) Thyroid. (9) Bronchials. (10) Heart, Blood pressure control. (11) Liver. (12) Controls pulse *point 10* tension. (13) Kidneys. (14) Intestines. (15) Gall Bladder. (16) Pancreas. (17) Spleen. (18) Adrenals. (19) Intestinal circle. (20) Stomach. (21) Gall ducts. (22) Ileo cecal. (23) Coronaries. (24) Rectum. (25) Ovaries-testicles. (26) Uterus-prostate. (27) Cardiac muscle. (28) Emotional. (29) Bladder. (30) Colon.

We have just illustrated the technic for correction of the line one C type lesion. In this lesion we had an Occipital 2, line one with a dorsal 12 spinal major. Spinal pump applied to D 12 with cervical 2 control. In the event that the spinal pump to D 12 had not produced moisture at C 2 within two minutes, we would stop the technic at that point and refer to the pre and post ganglionic technic for that visit.

You would palpate area one on the sternum and area two at the neck shoulder union. If both were tender you would test against each other, and use the one that controlled the other for your MASTER TREATING CONTROL.

If it were sternal area one you would place your left thumb over that area and the index finger of your right hand over area 13 as shown on the chart because dorsal 12 is kidneys.

In making your test, if the shoulder area numbered 2 had controlled sternal area 1, you would place your left hand over the patient's right shoulder with thumb in front and fingers posterior. Just the weight of the hand for a contact. You would then contact #13 with your right hand to complete the reflex.

When the numbered reflex contacted produces a skin pulsation, the reflex is broken.

In all instances in adjusting specific occipital fiber types, if you fail to produce the effects described under that technic, you then resort to pre or post ganglionic technic. The following day you would use the technic as indicated by the occipital fiber.

Acute cases

VISCERAL REFLEX LESION

C TYPE LINE TWO OCCIPITAL FIBER

C type line two occipital fiber indicates a viscus reflex into the cord. The viscus reflex into the cord produces the spinal pain.

Referring to our chart, we see that occipital 5 as here illustrated is associated with dorsal 7 and lumbar 3.

Spinous tips are counted and dorsal 7 and lumbar 3 marked.

Transverse processes dorsal 7 and lumbar three are palpated and painful ones checked against each other until the Spinal Major is located.

The Spinal Major becomes the transverse we treat in order to block out the incoming viscus reflexes. Until the incoming reflex is blocked, healing cannot occur. Healing is a motor function. Incoming reflexes are sensory.

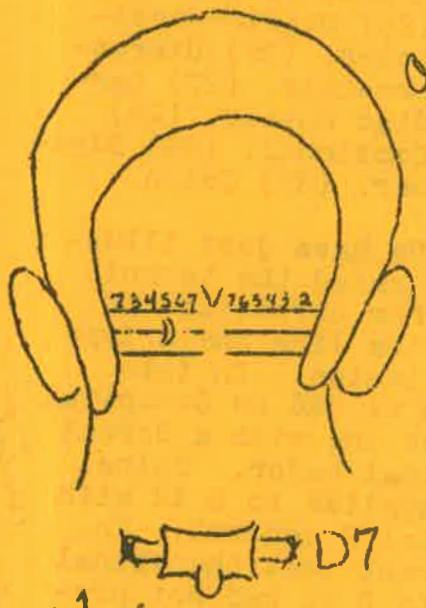
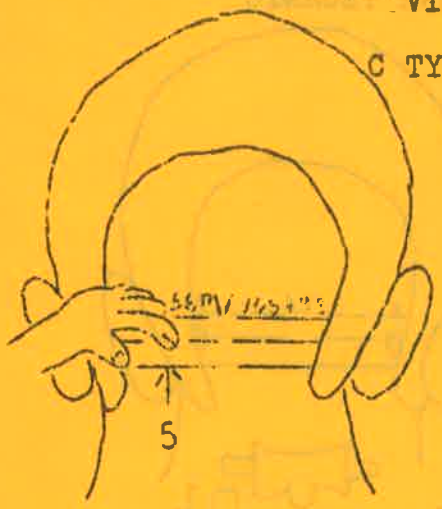


FIGURE #2. This illustrates the glandular disturbances associated with a lumbar three viscus reflex. #1. Pituitary. #2. Thyroid. #3. Breasts. #4. Spleen. #5. Supranels. #6. Ovaries.

One gland excites all glands when diseased. In this instance the ovary is at fault. This third lumbar reflex would come through if any of listed glands were the exciting cause.

Drink distilled water only as wanted
no solid foods

VISCERAL REFLEX TECHNIC



C TYPE LINE TWO OCCIPITAL FIBER

Treating technic: Place a finger of the left hand on the major occipital fiber on line 2. In this instance it is number five on the left. Index finger of right hand contacts to extreme lateral of third lumbar right transverse and makes a light skin contact.

Occipital fiber 5, line two left is manipulated as vigorously as possible. The right index finger merely waits for a sensation of warmth to develop under its contact. When this sensation occurs, the incoming reflex arc has been broken.

You now proceed to specific viscus manipulations and skeletal reflex technic.

SPECIFIC VISCERAL REFLEXES

In all line two occipital reflexes, the spinal major indicates the viscus producing the incoming reflex arc.

Visceral manipulations are indicated when ever a skeletal reflex is present, but specifically indicated in all line two fibers.

Line two occipital fibers give you a specific technic for specific viscus identification. This identification is made by locating the spinal major.

The occipital fiber on line two disappears when the viscus reflex is broken and the viscus is returned to normal function.

Dorsal 1.....Coronaries

Dorsal 2.....Heart valves

Dorsal 3.....Pulmonary

Dorsal 4.....Gall bladder

Dorsal 5.....Stomach

Dorsal 6.....Pancreas

Dorsal 7.....Spleen

Dorsal 8.....Liver

Dorsal 9.....Intestines

Dorsal 10.....Adrenals

Dorsals 11-12.Kidneys

Lumbar 1.....Ileo cecal

Lumbar 2.....Cecal

Lumbar 3.....Glandular

Lumbar 4.....Colon

Lumbar 5.....Uterus-prostate.

CHIROPRACTIC BLOODLESS SURGERY MANIPULATIVE TECHNIC

CORONARY TECHNIC

FIGURE #1. Occipital area 1 right or left, line two. Dorsal one transverse major. Specifically indicates a coronary or coronary tendency.

FIGURE #2. Left thenar pad. Divided into upper and lower parts. Two finger squeeze to thenar pad, eliciting pain, indicates coronary involvement. The thumb part of the thenar when painful, indicates anterior coronary. The wrist part, indicates posterior coronary.

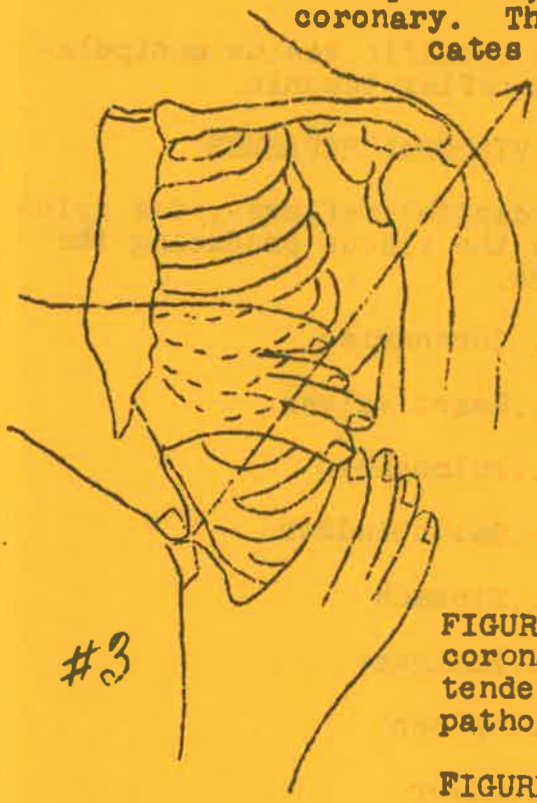


FIGURE #3. Double thumb contact to left costal arch, with pressure into soft tissue structure under ribs, and directed toward left shoulder. When painful indicates coronary constriction due to emotional disturbances.

FIGURE #4. Thumb contact left anterior shoulder point at humeral center with palm of hand facing inferior. When painful, to pressure in conjunction with right thumb pressure into left costal arch and under ribs, indicates coronary due to physical over exertion.

FIGURE #2 does indicate coronary tendency and tendency to coronary pathology.

FIGURE #3. Being an emotional constriction does not eliminate its seriousness for emotion does kill.

FIGURE #4. Physical over exertion is more difficult to control than any other disease.

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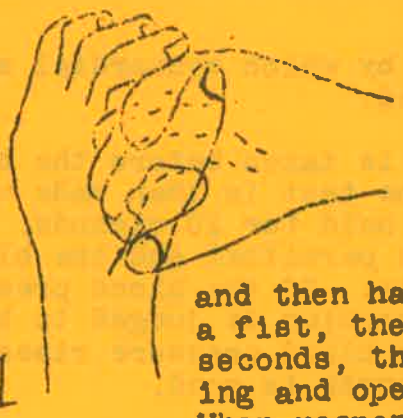
CORONARY TECHNIC

FIGURE #1. Illustrates technic of treating left thenar pad. This pad is best grasped between your right thumb and index and middle fingers. The thumb is posterior and the index and middle fingers anterior. The contact should be on either the upper or lower one half, which ever is the more painful. If both are painful, cover both with index and middle fingers. The thumb is posterior to support the patient's left hand. Close the contact until it is very firm and the patient conscious of the pain it produces. Hold contact, and then have patient forcefully close fingers into a fist, then thumb into the fist. Hold for ten seconds, then have patient open fist. Repeat closing and opening until thenar pressure pain disappears. When response is normal this requires about 1 to 2 minutes.



THENAR RESPONSE TEST

Before applying thenar pad technic, palpate both of patient's radial pulse at same time. When coronary is active, left pulse will be lower in volume than the right. Apply thenar squeeze for required 1 to 2 minutes, then re-palpate pulse. Pulse will be equal in volume if technic has dilated coronary arteries.

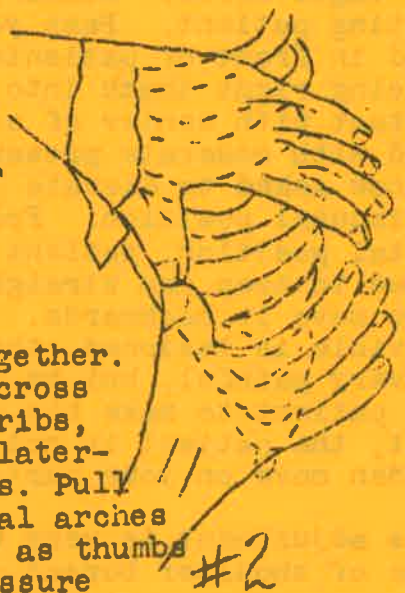
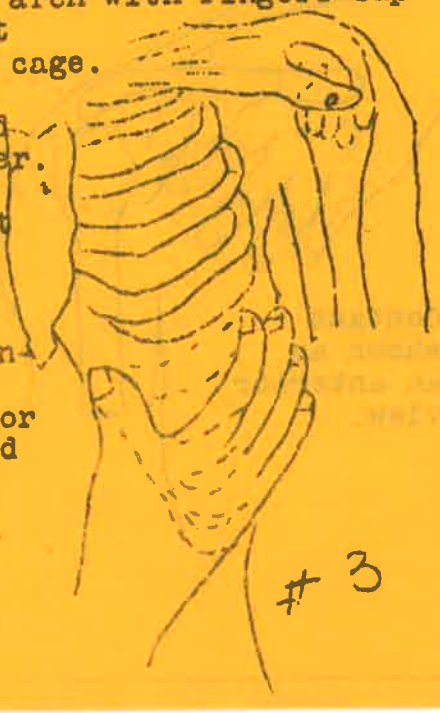


FIGURE #2.

Emotional coronary technic.

Thumbs together. Fingers across anterior ribs, grasping lateral borders. Pull left costal arches to medial as thumbs exert pressure under the medial costal arch to the left superior. Work the thumbs into position slowly as this process is often very painful.

FIGURE #3. Useful when left arm pain is complained of in coronary disorders. Place left thumb over anterior humeral head tubercle. Balance of fingers posterior to support contact. Right thumb into left costal arch with fingers supporting left lateral rib cage. Point right thumb toward left shoulder. Hold right hand contact while left thumb manipulates its contact. Continue until left anterior humeral head pain eases.



CORONARY TECHNIC

FIGURE #5. Bilateral sternal zyphoid contact with thumb pressure superior-lateral oblique.

This is a test by which myocardial strength can be estimated.

Blood pressure is taken before the bilateral thumb test. The test is then made with the contacts being held for 20 seconds. A one minute lapse is permitted and the blood pressure taken again. If the blood pressure falls, the myocardium is judged to be weakened. When the blood pressure rises, the myocardial strength is good.

This is one of our most important tests for heart function. In event the blood pressure falls following this test, you may suspect severe cardiac trouble in the future.

When this contact raises a low blood pressure, the contacts may be used as part of your coronary technic. Never use this technic as a therapy when the blood pressure is judged to be high for any individual.

Contact shown as an anterior view.

FIGURE #6. This is a clavicular adjustment. The object is to free the vagus nerve. Stand back of sitting patient. Pass your right hand in front of patients neck, placing right thumb into posterior contact with center of clavicle. Hold with moderate pressure. Patient is now asked to elevate left arm into horizontal position. From this horizontal position, patient is then asked to keep arm straight horizontal, then move it backwards. When the clavicle is lesioned, this adjustment is very painful, but by permitting the patient to make his own arm movement, the patient is not afraid of a sudden move on your part.

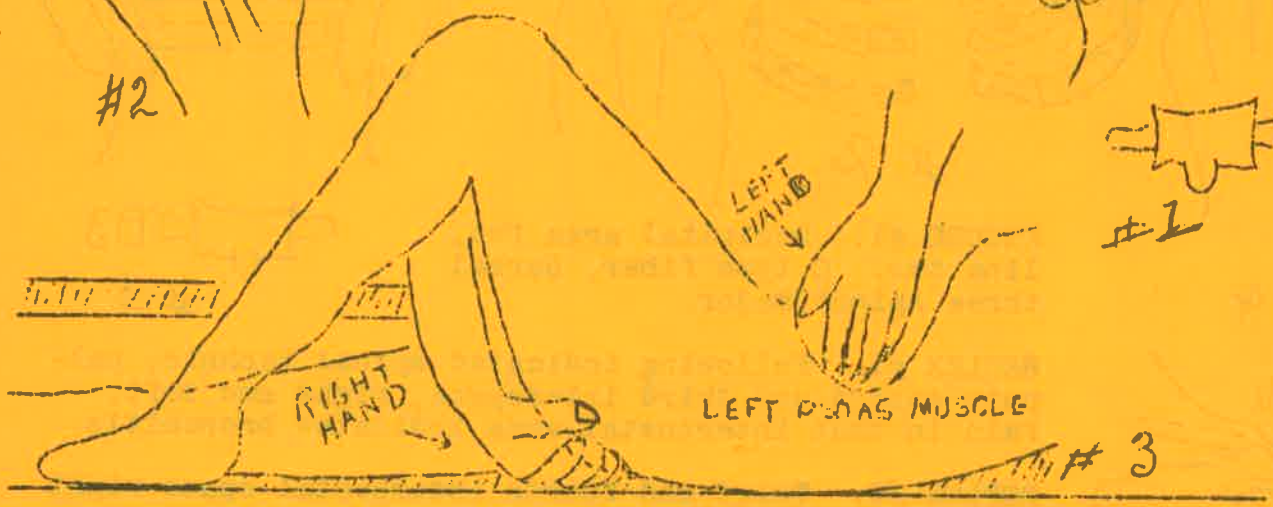
This adjustment is very useful in all type of shoulder bursas. + Asthmatic Patients

CARDIAC VALVULAR TECHNIC

FIGURE #1. Occipital area one, line two. Dorsal two spinal major.

Following your application of the transverse process-occipital fiber technic, have patient take supine position.

Take your position at head of table



Grasps patient's wrists and extend arms over his head. Place palms together. When one arm is short, fingers of long arm will extend beyond fingers of short arm as shown in figure #2.

FIGURE #3. Left arm was short. Left psoas contracted. To make adjustment, stand to patients right. Place straight fingers of left hand just lateral of the medial abdominal line. The left psoas will be subluxated to the medial.

Right hand now passes between patient's legs. Patients left leg is flexed and right leg straight on table. Right hand grasps patients left gluteal. This contact should be as close to the superior iliac crest as possible.

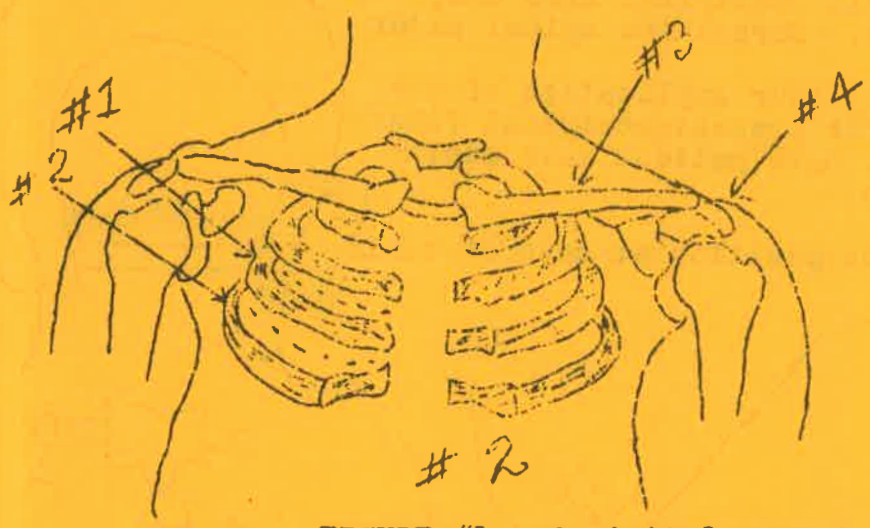
Adjustment is now made by working left hand into abdominal tissues until medial border of psoas can be felt. You will have to work through the intestinal coils, so take it easy.

When psoas is contacted, direct left hand toward left acetabulum and exert force in that direction. Right hand tightly draws left gluteal toward table.

Make certain that flexed left leg is not disturbed. You must not carry left knee to either medial or lateral.

This psoas adjustment is very important in all disc lesions involving lumbar spine as the psoas is the only muscle taking insertions from the inter-vertebral cartilages.

PULMONARY DISORDERS



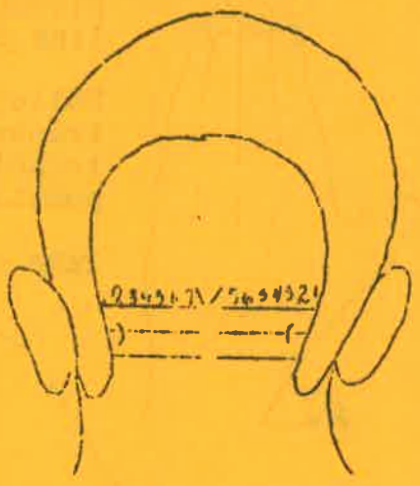


FIGURE #1. Occipital area two, line two. C type fiber, Dorsal three spinal major.

REFLEX #1. Following indicated spinal technic, palpate second and third interspace, right and left. Pain in that intercostal area indicates bronchitis.

REFLEX #2. Third and fourth intercostal space right or left, pain on palpation, indicates pneumonia. Usually the pain is greatest at lateral limits of interspace.

REFLEX #3. Superior clavicular palpatory pain, right or left, indicates chronic lung pathologies.

REFLEX #4. Coracoid-clavicular union. Superior-anterior shoulder area. Palpatory pain indicates asthmatic disorders.

FIGURE #4. Corrective technic. Sternal area for pre-ganglionic control will be master contact. Reflexes #1, 2, 3, or 4, to be manipulated with finger tip movement along intercostal space.

REFLEX #4. manipulated over coracoid-clavicular union. Manipulate until all tenderness is removed. Sternal contact is merely firm pressure without finger movement. The above four reflexes are all pre-ganglionic types.

#31

GALL BLADDER REFLEXES

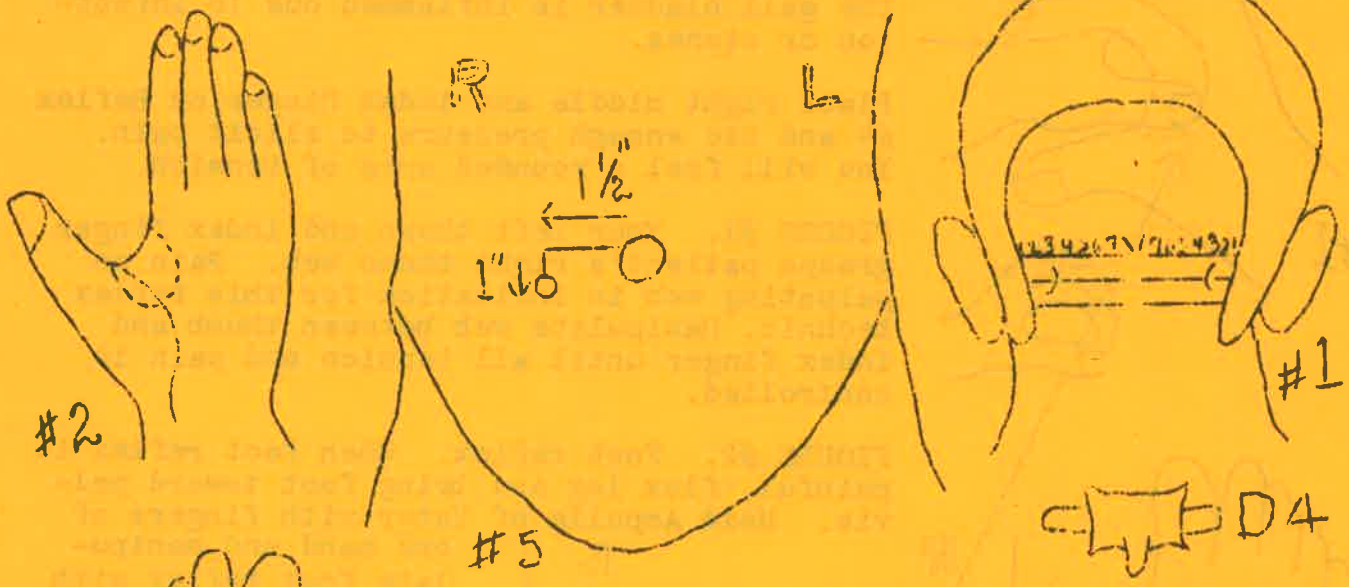


FIGURE #1. Occipital area 3, left or right, line two. Dorsal 4 spinal major.

FIGURE #2. Thumb-index finger web right hand, three fourths inch into web. Thumb and finger squeeze eliciting palpatory tenderness is diagnostic af an acutely inflammed gall bladder.

FIGURE #3. Sole right foot. Locate malleoli line. Locate center of line on sole of foot. Move toeward 1½ inches. Thumb pressure over area eliciting pain indicates gall stones, plus gall bladder inflammation.

FIGURE #4. Medial right costal arch eighth and ninth ribs at sternal border line. When painful to palpation indicates inflammation of the gall ducts.

FIGURE #5. Ampulla of vater reflex point. One and one half inches right lateral of umbilicus, and one inch inferior of lateral point. When painful to palpation indicates spasticity of ampulla. This is the most specific of all causes for gall bladder and duct failure. When the common duct cannot convey bile to the duodenum due to spasticity of the Ampulla of Vater, intestinal digestion is retarded and bolus ferments, setting up an inflammation of the complete gastro intestinal tract.

GALL BLADDER TECHNIC

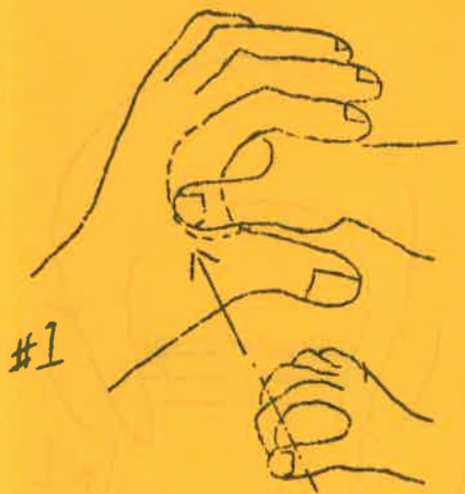


FIGURE #4. Ampulla of Vater as master control. This area will always be painful when the gall bladder is inflammed due to infection or stones.

Place right middle and index finger on Reflex #4 and use enough pressure to elicit pain. You will feel a rounded area of tension.

FIGURE #1. Your left thumb and index finger grasps patient's right thumb web. Pain on palpating web is indication for this reflex technic. Manipulate web between thumb and index finger until all tension and pain is controlled.

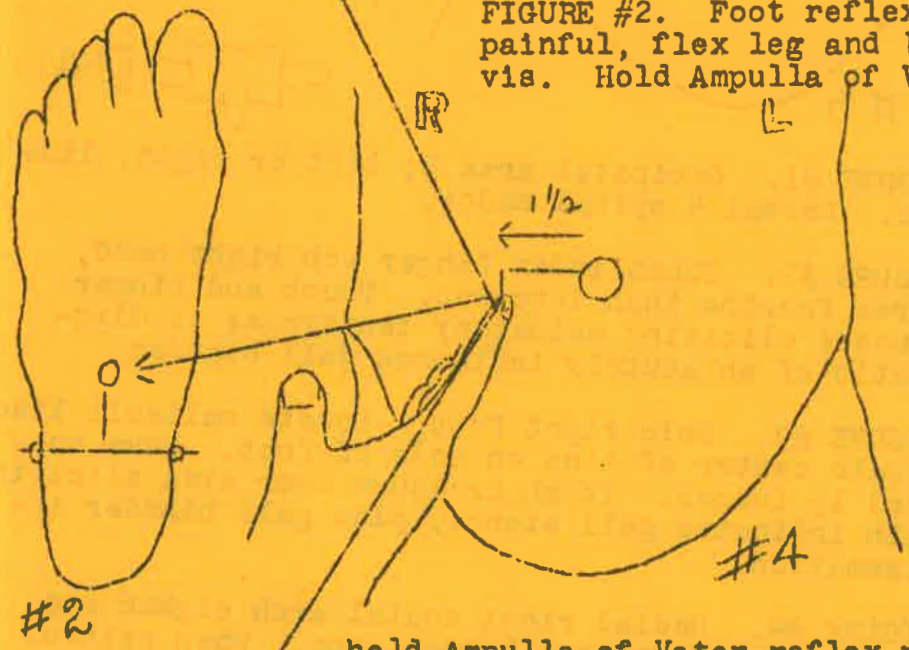


FIGURE #2. Foot reflex. When foot reflex is painful, flex leg and bring foot toward pelvis. Hold Ampulla of Vater with fingers of one hand and manipulate foot reflex with thumb of free hand. Continue until foot reflex is controlled.

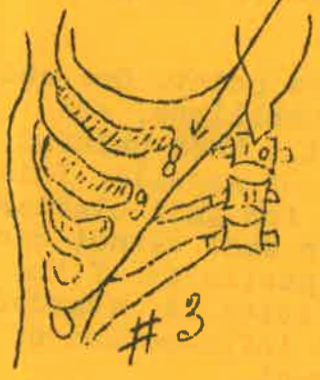


FIGURE #3. Eighth and ninth medial costal areas. Always involved when right thumb web or right foot reflex active. This is the finishing technic. Hold contact to 8-9 medial costal ridge with left hand while fingers of right hand hold Ampulla of Vater reflex point. Manipulate eighth and ninth costal area until all pain is controlled.

In all gall bladder disorders, patient should be on a fat free diet for four days. Distilled water to capacity. Vitamins A & F help relieve the inflammation. Rest is essential. The bronchial inflammation accompanying the gall bladder disorder is secondary. It will respond when the gall bladder responds.

Above reflexes should be treated until neutralized. Accomplish this the first visit if possible.

GASTRIC TECHNIC

FIGURE #1. Occipital area 3 line two, right or left.

Dorsal five spinal major.

Treat with occipital fiber-dorsal 5 transverse technic.

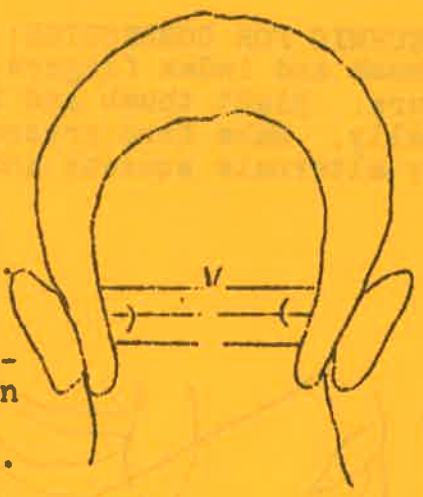


FIGURE #2. Left thumb-index finger web pain on pressure. Grasp left web between your left thumb and index finger and produce pressure.

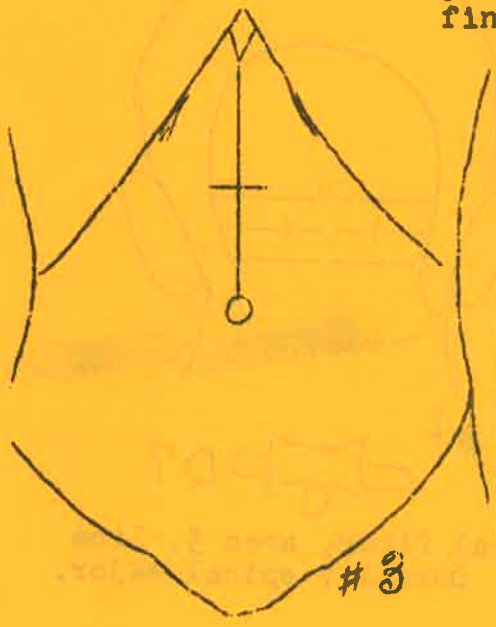


FIGURE #3. Linae alba line tenderness. Midway between sternal ziphoid and umbilicus. Pressure at this point, eliciting tenderness indicates gastritis or gastric ulcer.

CORRECTIVE TECHNIC: Contact patients left thumb-index finger web between your left index finger and thumb. Produce enough pressure to bring pain reflex to its highest point. Hold at that pressure, while fingers of right hand are placed over the abdominal reflex area. Manipulate left thumb-index finger web until abdominal area completely relaxes.

PANCREATIC TECHNIC

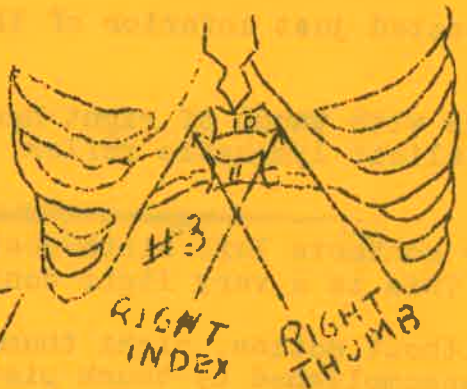


FIGURE #1. Occipital area 4, line two, right or left. Dorsal six spinal major.

FIGURE #2. Right thenar pad painful to pressure in pancreatitis.

FIGURE #3. Medial costal arches at tenth rib area anterior painful to pressure in diabetes.

PANCREATIC TECHNIC

TECHNIC FOR CORRECTION: Hold squeeze contact right thenar with left thumb and index fingers. Bring in maximum degree of pain with pressure. Right thumb and index fingers contact tenth costal area medially. Make firm pressure and hold until right thenar pain is removed by alternate squeeze and relaxation.

SPLENIC TECHNIC

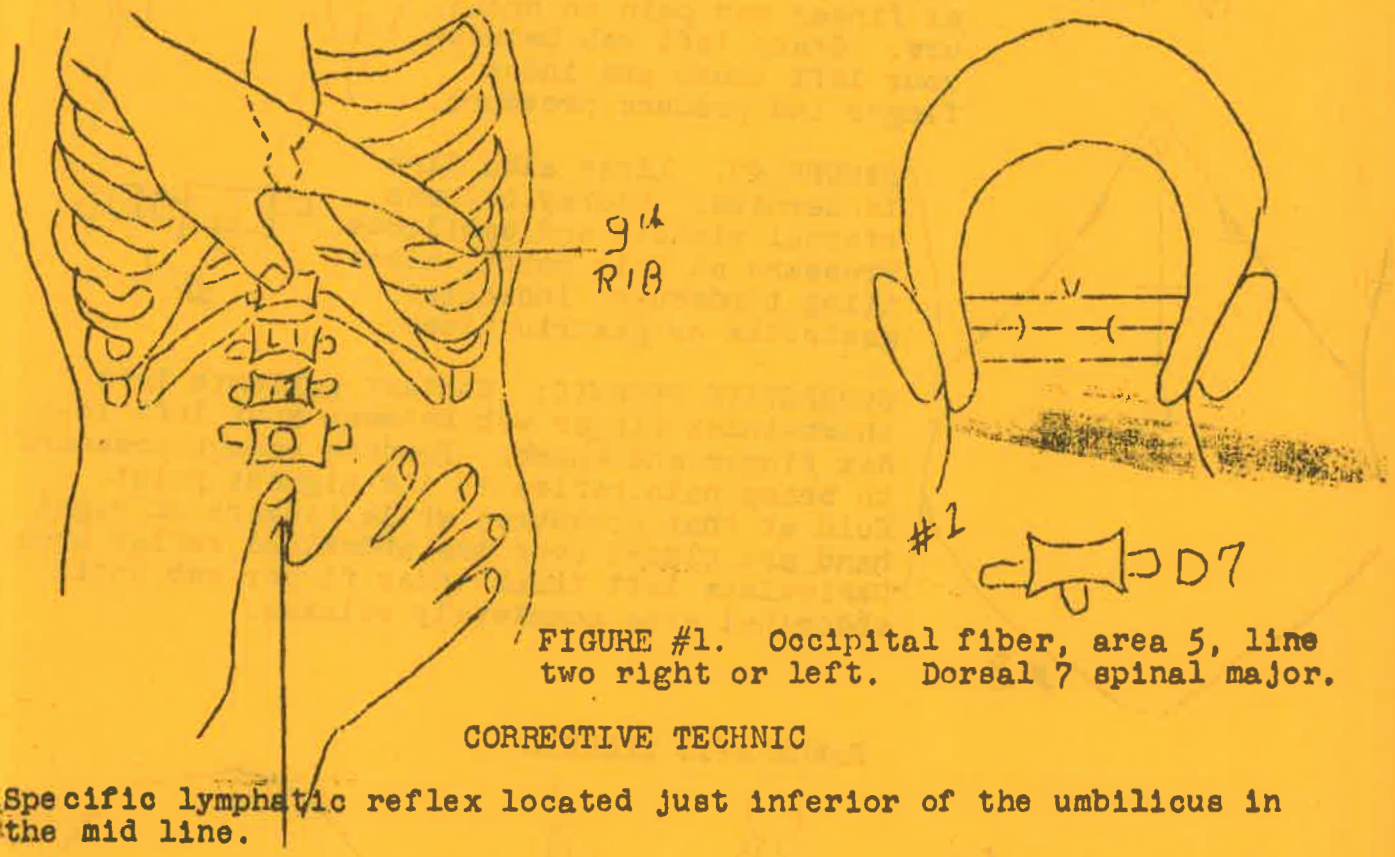


FIGURE #1. Occipital fiber, area 5, line two right or left. Dorsal 7 spinal major.

CORRECTIVE TECHNIC

Specific lymphatic reflex located just inferior of the umbilicus in the mid line.

Contact inferior of umbilicus with thumb of right hand. Make sufficient posterior pressure to elicit lymphatic reflex. Hold this contact firmly.

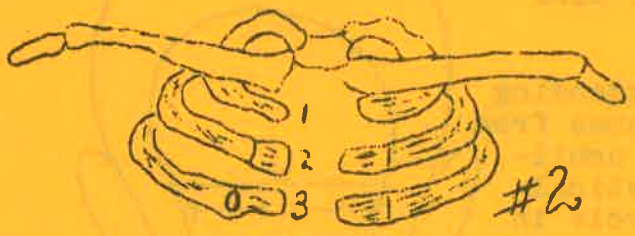
Left index and middle finger contacts left ninth costal cartilage at its central anterior area. This is a very light contact.

Holding left hand contact without motion, right thumb now pumps its contact superior. This is accomplished by thumb piston strokes without lessening posterior pressure.

Right thumb continues its superior piston strokes until all inferior umbilical tension is broken.

#35

LIVER TECHNIC



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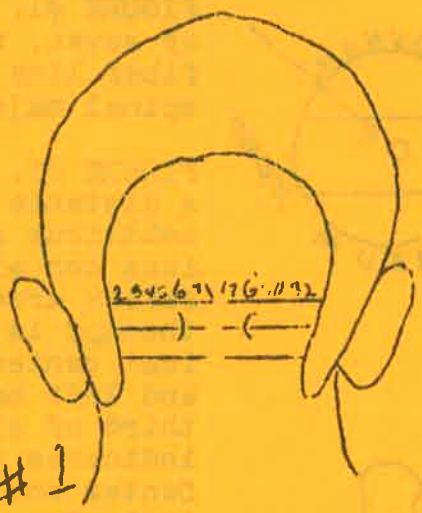

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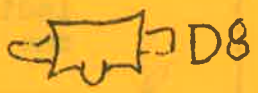


FIGURE #1. Occipital area 6 line two right or left. Dorsal eight spinal major.

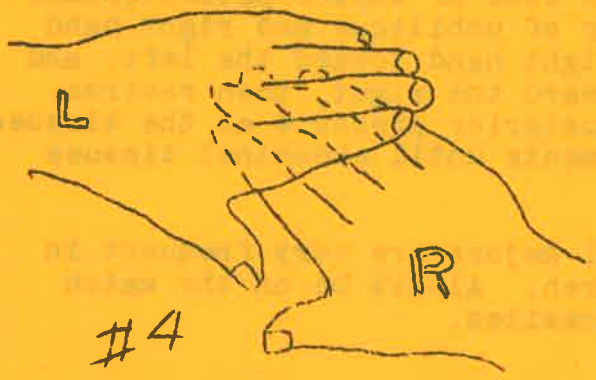
FIGURE #2. Third right rib, one and one half inches lateral of sternal border. Palpatory pain, indicates inflammation of the ~~posterior~~ anterior lobes of the liver.

FIGURE #3. Third right dorsal transverse at rib junction. Palpatory pressure, producing pain, indicates inflammation of the posterior lobes of the liver.

CORRECTIVE TECHNIC: When both anterior and posterior reflexes are painful, have patient lie prone. Place a finger contact over third right rib anterior at reflex point. Patients weight will make contact. Free hand makes a two finger contact over right transverse of dorsal three. Manipulate this contact until all tension and pain is removed.

THE LIVER PUMP

FIGURE #4. Following the technic to third right rib and third dorsal right transverse, have patient lie supine. Doctor sits to patients right. Left hand placed over sixth to eleventh right ribs, covering from lateral to as far as hand will reach medially. Right hand placed into right medial costal arch area with index finger lying against medial costal arch.



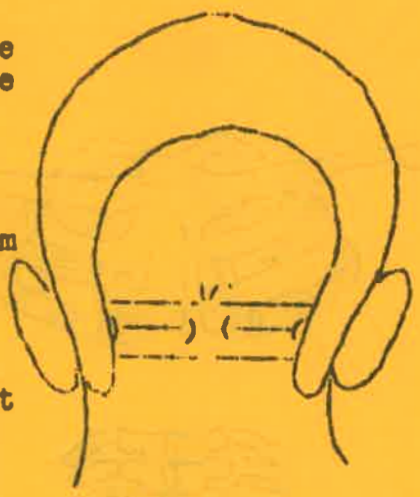
#4

Left hand forces ribs to the left and then posterior, while this is being accomplished, right hand forces tissues posterior and as finger tips pass under costal arches. This combined double hand movement is repeated slowly for six complete movements. All, except acute ferbile, conditions benefit from this type liver pumping.

INTESTINAL TECHNIC

#2

FIGURE #1. Occipital areas one or seven, right or left, C type fiber line two. Dorsal nine spinal major.



#1

FIGURE #2. A circle extending a distance of three inches from umbilicus and circling umbilicus contains the intestinal reflex areas. This circle in therapy is broken at the vertical centers, and becomes right and left halves. Superior one third of circle, when painful, indicates duodenal disorders. Center one third, when painful, indicates jejunum, and lower one third, the ilieum.


#3

FIGURE #3. CORRECTIVE TECHNIC: Sternal pre-ganglionic area is always controlled in intestinal disorders, as the pre-ganglionic reflex is the exciting cause. Contact sternal area with index and middle fingers of left hand. Right middle and index fingers contact painful part of circle, and with light pressure, draw fingers along the rim of the circle. This is repeated until all circle tension is broken.

FIGURE #4. The intestines are coils, just like coils of rope atop each other. These coils do become spastic and when such occurs intestinal digestion is nihl. Nervousness is the symptom complex, plus a host of other vague depressive symptoms. When you have a dorsal nine spinal major, you have a patient with an intestinal complex.


#4

The corrective technic is a see-saw movement across the intestinal coils made with your two hands as illustrated.

Working from right side of supine patient, place left hand superior of umbilicus and right hand inferior. Move right hand toward the left, and pull left hand toward the right, then reverse. Keep increasing posterior pressure as the tissues relax. Work movements until abdominal tissues relax.

Dorsal nine spinal majors are very frequent in diseases of children. Always be on the watch for intestinal parasites.

asthmatics

#37

SUPRARENAL TECHNIC

FIGURE #1. Occipital area one, line two right or left. Dorsal ten spinal major.

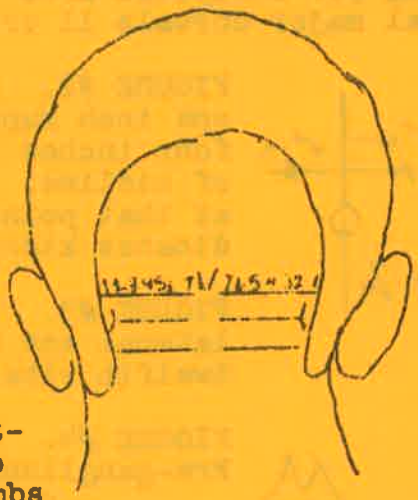
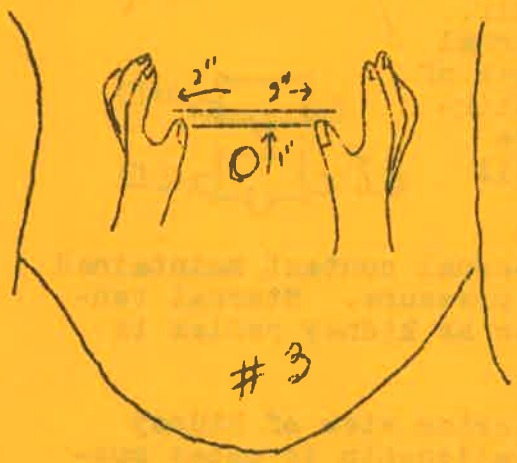


FIGURE #2. Patient prone. Locate spinous of dorsal ten. Move lateral along tenth ribs, right and left for three inches. Palpatory pain at this point, right or left, or both indicates adrenal inefficiency.

TO CORRECT: Use anterior pressure onto ribs area with thumbs directed toward spine. Use a gouging type pressure for one minute.



This reflex is usually seen in cardiac asthmatics and low blood pressure cases due to low myocardial power. Useful in arthritis.

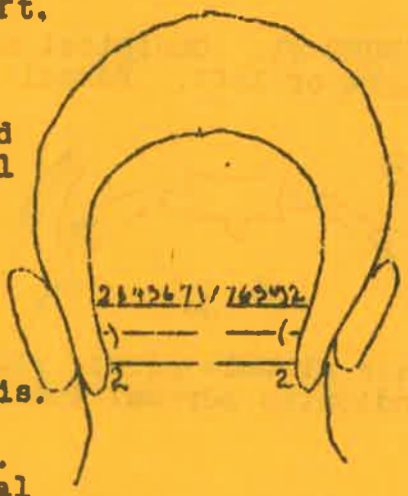
FIGURE #3. Patient supine. Locate reflex points on a line one inch superior of umbilicus and two inches lateral of midline. Palpatory pain indicates adrenal over activity. Correct with posterior pressure until tissues relax. Seen mostly in menustral disorders, and male impotency.

The adrenals are playing a greater role in human physiology today than are many of the glands thought to be of great importance in by gone years. The pituitary gland along with the adrenals are the trigger glands that control cell formation and also collagens. Experience has shown that the adrenals have much to do with metabolism. They are over active in the thin individual and under active in the obese. Under activity produces asthenia and low blood pressure because of poor protein metabolism. Our records prove that a great percentage of symptomatic coronaries are primarily poor adrenal function and control of their important roles in cell formation and protein metabolism. Every cancer patient that we have examined in the past two years has shown an occipital area one, line two, dorsal ten disturbance. The control of that reflex has helped to control pain in such individuals.

Protein collagens

KIDNEY TECHNIC

FIGURE #1. Occipital area 2, line 2 right or left, Spinal major dorsals 11 or 12.



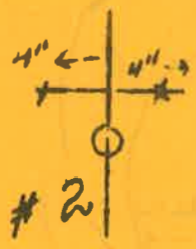


FIGURE #2. Kidney reflex. Area one inch superior of umbilicus and four inches right and left lateral of midline. Posterior palpation at that point producing pain, indicates kidney inflammation.

FIGURE #3. Palpatory pain at lateral end of eleventh or twelfth ribs indicate kidney ptosis.

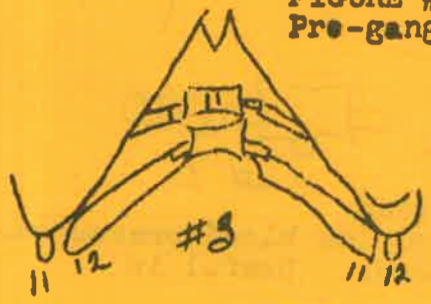


FIGURE #4. Kidney reflex technic. Pre-ganglionic technic with sternal control contact. Finger of free hand produces continuous posterior pressure over kidney reflex until that softens. Kidney reflex point held with posterior pressure. Sternal contact maintained with slight vibratory pressure. Sternal tenderness does not lessen as kidney reflex is broken.

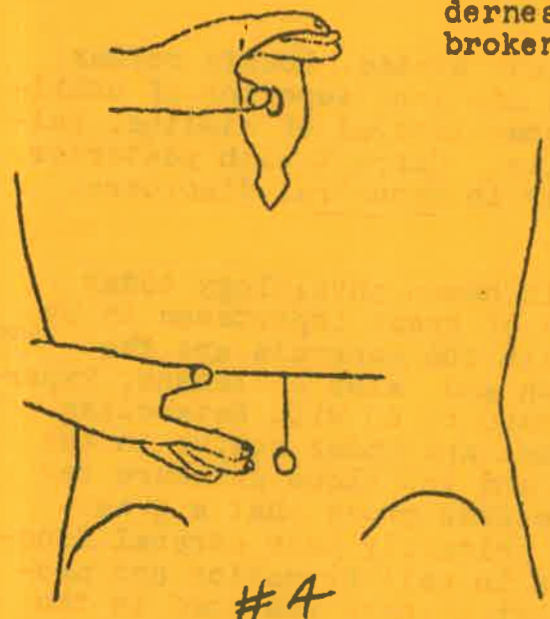
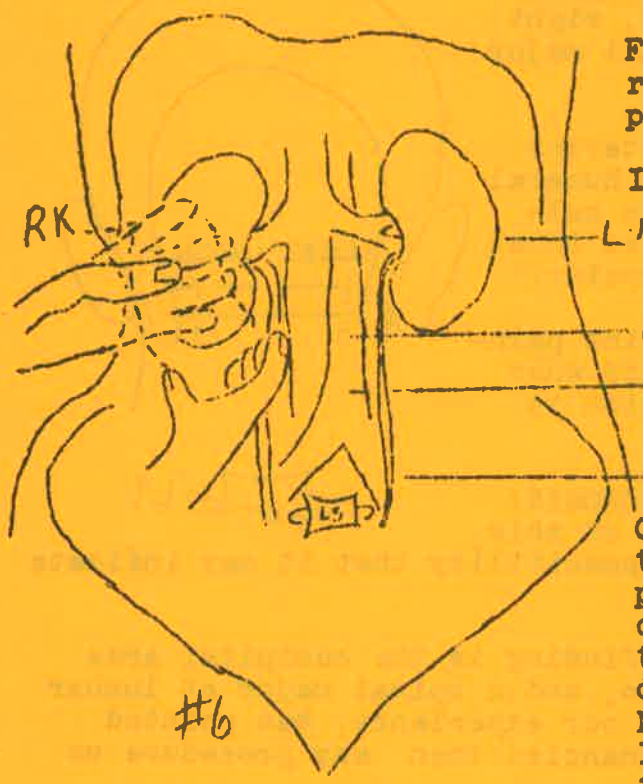


FIGURE #5. Anterior view of kidney position in relationship to psoas muscle position. In all kidney lesions, psoas must be corrected. Indication for correction is short arm in over head arm test. This technic for psoas correction illustrated under CARDIAC VALVULAR TECHNIC. It often happens that the left kidney produces an abnormal reflex but the right arm is short, indicating a contraction of the right psoas. A great percentage of actual kidney ptosis is caused by psoas discortions.

KIDNEY TECHNIC



#6

FIGURE #6. Illustrates ptosis of the right kidney and position of hands in palpating for kidney ptosis.

In palpating a right kidney, have patient turn to the left oblique position. In this position the ~~right~~ left shoulder will be on the table, but the right hip will be off. The right leg will be passed over the left, and will be flexed. The right arm is above the patient's head and the left at his side.

Operators left hand will be contacting the right kidney through the lateral-posterior abdominal wall. The fingers of the left hand are posterior and the thumb anterior. This hand must make deep pressure tn order to contact the kidney capsule. The right hand acts like a scoop and makes its contact through the abdominal wall.

#7

FIGURE #7. Illustrates patient in left oblique position, and operators hands in position for repositioning right kidney.

Have patient inhale deeply and during inhalation increase right nnd left hand pressure. Patient will have to repeat inhalation several times before hands can penetrate deep enough to contact kidney.

When kidney has been contacted, patient may feel a slight nausea. To move kidney into position, left hand stabilizes kidney as right hand elevates it into position by headward force.

Following replacement, patient should lie in oblique position for fifteen minutes.

It may be necessary to use a corset type support for several weeks in some cases to maintain position until capsule heals.

#40

ILEO CECAL TECHNIC

FIGURE #1. Occipital area 3, line 2, right or left. Spinal major is lumbar one.

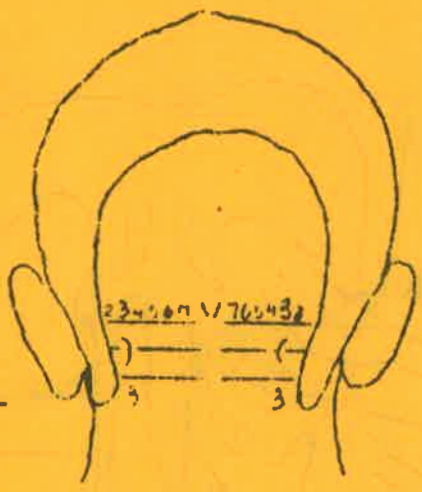


FIGURE #2. Anterior tubercle right humeral head painful to palpation when ileo cecal valve is incompetent.

Mc Burney's Point painful to palpation when ileo cecal region is inflammed.

ILEO CECAL DIAGNOSIS: The importance of this reflex is the possibility that it may indicate malignancy.

The important finding is the occipital area three, line two, and a spinal major at lumbar one. This, in our experience, has pointed out more malignancies than any procedure we have used.

Inflammation and incompetency of the ileo cecal valve is associated with more disorders than any single complication, yet this association is not serious until we develop a specific Occipital area 3, line two, and a lumbar one spinal major.

CORRECTIVE TECHNIC: Right index and middle fingers explore Mc Burney's point until a round nodulated area is discovered. This is a well localized area. A contact is made on this area with the right index and middle fingers, and sufficient posterior pressure maintained to bring in the maximum pain reflex at that point. While this reflex is held, the thumb of the left hand explores the anterior humeral head center. If a very painful fiber develops at that humeral head area, we then assume our patient has a tendency to a malignancy. This does not mean that a malignancy now exists.

Mc Burney's point reflex is held for its pain production, while the left thumb manipulates the right anterior humeral head fiber. If this left thumb manipulation controls the pain at McBurney's point within a minute, the occipital fiber on re-palpation will be much less painful, and we assume that we have corrected an ileo cecal reflex.

If within one minute the humeral head fiber increases in pain and Mc Burney's point likewise becomes more painful, we can re-palpate occipital area three and it will be much more painful. This finding causes us to suspicion cancer.

#41

CECAL TECHNIC

FIGURE #1. Occipital area 4, line 2, right or left. Lumbar two spinal major.

Right transverse of lumbar two most painful, so will become our treating contact. If left transverse had been most painful it would have been our tre treating contact.

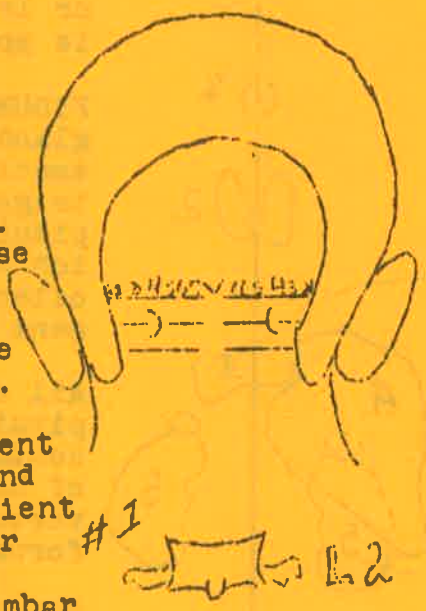


FIGURE #2. Patient supine. Left hand passed under patient and middle finger contacting right transverse of lumbar two.

Right index and middle fingers contact Mc Burney's point at its most sensitive area. You will palpate to elicit that area.

Left hand holds transverse contact with alternate pressure and relaxation. Right hand increases posterior pressure as tissues relax. Continue until contact under right index and middle fingers become moist.

Strange as it may seem, this cecal technic is indicated in more instances where appendectomies have been performed than in non appendectomy cases.

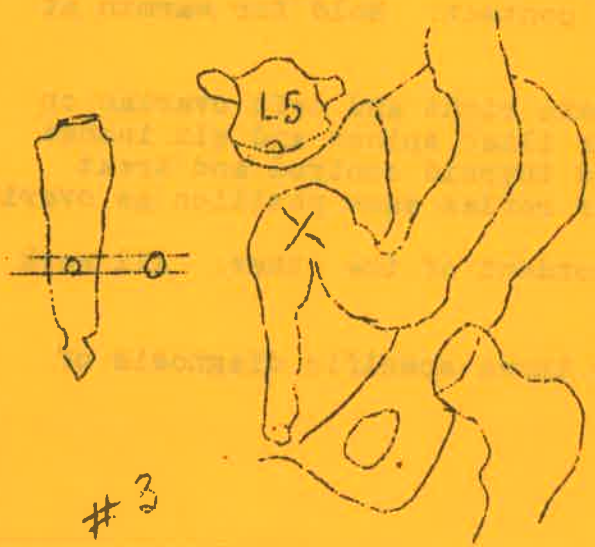


FIGURE #3. Sigmoid reflex. This is a very important reflex in all cecal disorders. This reflex is also present in all hemorrhoidal cases. varicose veins

CORRECTIVE TECHNIC: Following technic used in Figure #2, palpate area indicated by X on sigmoid. If painful, palpate sternal area marked, and if sternal area painful, use it as the control, while fingers of free hand gently contact sigmoid and hold for relaxation. You will be amazed how this works on many hemorrhoidal cases.

#42

GLANDULAR TECHNIC

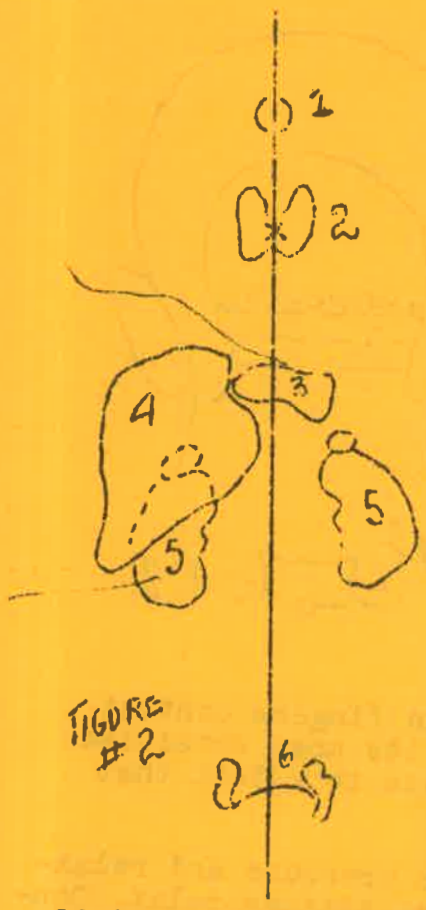


FIGURE #2

FIGURE #1. Occipital area 5, line 2, right or left. Lumbar three is spinal major.

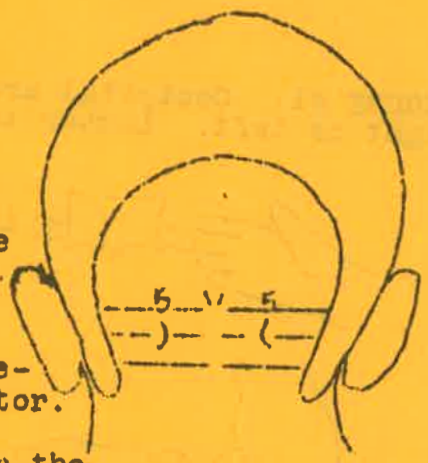


FIGURE #2. Represents glands in order of excitement. The thyroid is the trigger gland, but the pituitary is the explosion when the thyroid excitement or lack of excitement is the causative factor.

All correction starts with the pituitary contact at #1. Thumb contact in mouth at junction of hard and soft palate, with vertex pressure and slight forward pull.

Free hand then contacts #2 which is the thyroid and hold lightly until warmth is felt. This neutralizes the trigger gland and its explosion agent the pituitary. Thyroid contact over center of gland as shown by X marking.

You now palpate right and left lobes of thyroid, and if either are sensitive or produce coughing, that lobe is used as a control contact. Make a light contact with two fingers. Free hand now moves to #3 which is pancreas. Contact three inch inferior of ziphoid in central line and hold for warmth at that area. Neutralize #4 next (Liver) from thyroid contact. Contact for #4 in 8-9 intercostal space, four inches right lateral of medial costal area.

Neutralize kidney and adrenals wirh free hand contact by contacting right and left, one inch superior of umbilicus and three inches lateral. Thumb and little finger spread contact. Hold for warmth at adrenal reflex.

Neutralize ovarian reflex last. Palpate right and left ovarian on horizontal line with anterior superior iliac spines and six inches medial. Palpate for tenderness. Hold thyroid control and treat ovarian reflex for warmth. Testicular reflex same position as ovarian.

You cannot neutralize one gland independent of the other. All work as a chain reaction.

Occipital area 5, line two and lumbar three specific diagnosis of glandular incompatibility.

#43

GLANDULAR TECHNIC

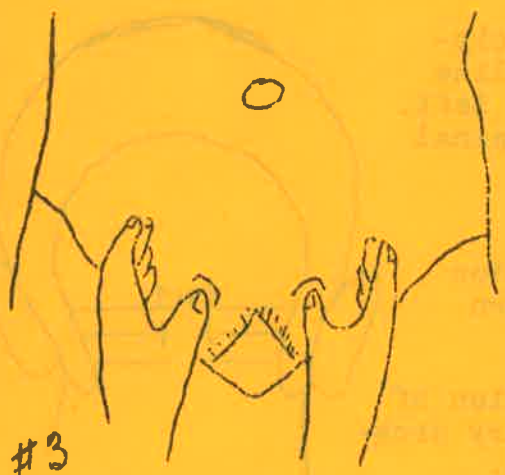


FIGURE #3. HARMONE CONTROL TECHNIC.

STIMULATION: Right and left thumb contacts on a horizontal line across superior acetabular line, six inches medial of lateral Poupart structure. This would place the contacts just lateral of the superior pubic hair line. Stimulation produced by a one minute posterior pressure contact.

INHIBITION: Same contact area, posterior pressure for three minutes.

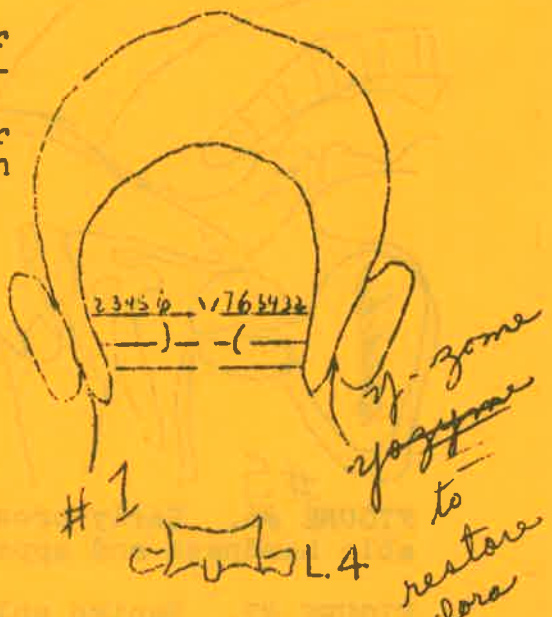
INDICATIONS FOR STIMULATION: Excessive lip, arm and leg hair in the female. Lack of normal lip, arm and leg hair in the male. Obesity both male and female, Frigidity both sexes, Female characteristics in male's voice and manner. Male characteristics in female.

INDICATIONS FOR INHIBITION: Extreme tension states, depression states, nervousness, tremors, insomnia, menopause both sexes.

COLON TECHNIC

FIGURE #1. Occipital area 6, line two, right or left. Lumbar 4 spinal major.

In all lumbar four distortions whether mechanical or reflex, colon technic is indicated.



CORRECTIVE TECHNIC: Stand to right of supine patient. Your right hand contacts right colon just inferior of the hepatic flexure and points its fingers superior. Your left hand contacts left colon just inferior of splenic flexure, and points its fingers inferior. Make posterior pressure to tolerance, then move right contact superior and left contact inferior. Repeat movements until abdominal tissues relax.

#44

PROSTATIC TECHNIC

FIGURE #2. Position for prostatic examination is with patient on right side with knees drawn toward abdomen.

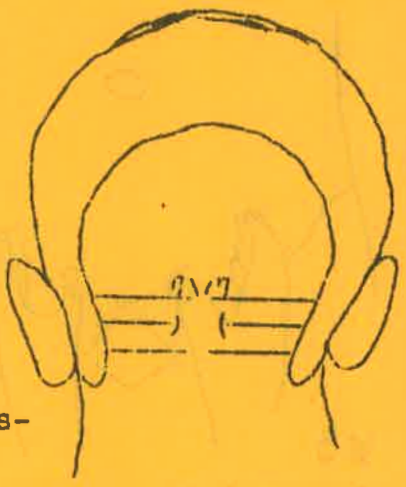


FIGURE #1. Occipital area 7, line two, right or left. Lumbar five spinal major.

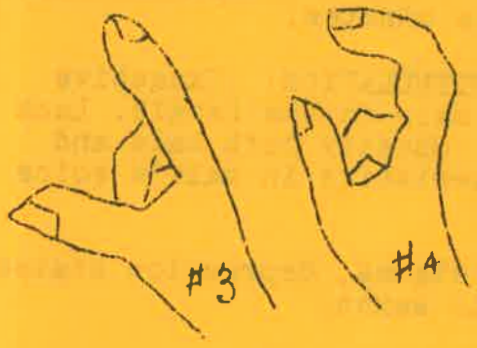


FIGURE #3. Position of hand in preliminary prostatic examination.

FIGURE #4. Position of hand in prostatic correction.

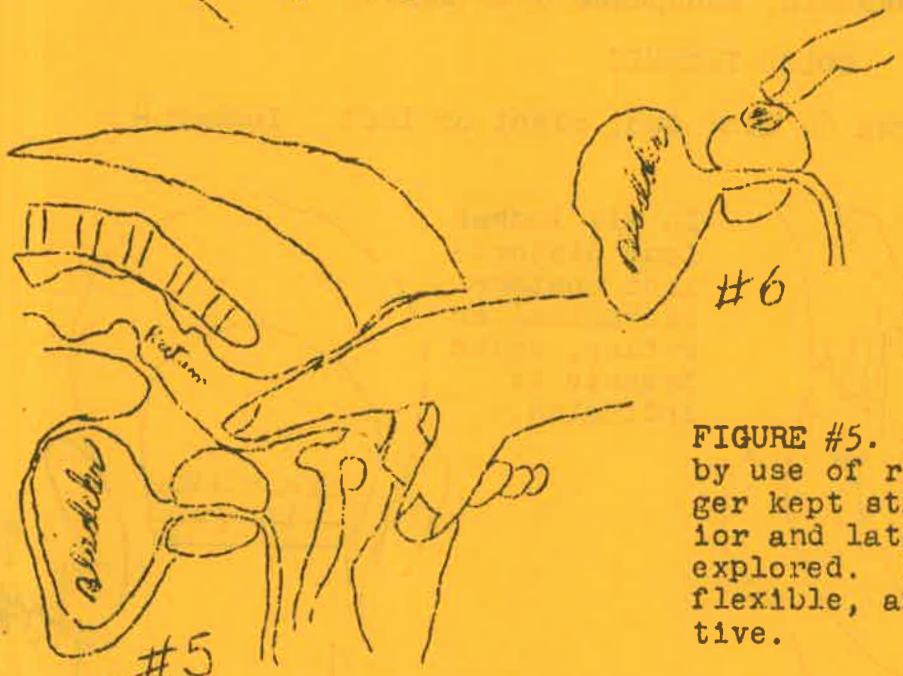


FIGURE #5. Examination of prostate by use of right index finger. Finger kept straight. Complete posterior and lateral parts of lobes explored. Normal prostate is smooth flexible, and only normally sensitive.

FIGURE #6. Early prostatic cancer. Note isolated nodule of noticeable hardness and appears encapsulated.

FIGURE #7. Benign enlargment of the prostate. Produces early symptoms due to urethra closure and inability to micturate. First symptoms are urethral burning. Maybe a simple inflammation, or a total fibrosis. Total fibrosis demands surgery.

#45

PROSTATIC TECHNIC

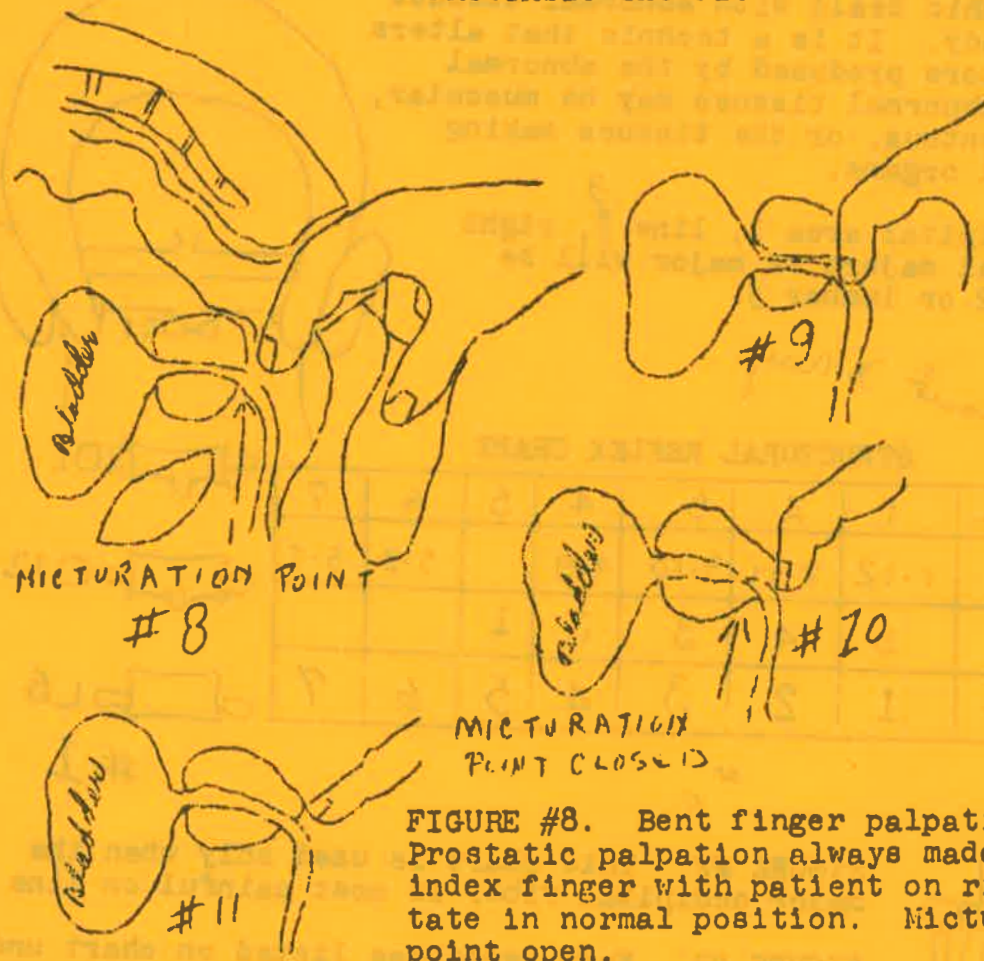


FIGURE #8. Bent finger palpation of urethra. Prostatic palpation always made with right index finger with patient on right side. Prostate in normal position. Micturition reflex point open.

FIGURE #9. Finger pressure continued from figure #8. Finger compresses urethra. Micturition reflex now very urgent. This indicates normal prostatic position.

FIGURE #10. Ptosis of prostate. Urethral reflex covered by prostate and micturition reflex impossible to elicit. This is the starting position for all prostatic correction. Prostate is now slowly elevated by index finger nail point. Pain is severe so go slow. As prostate raises, micturition reflex appears.

FIGURE #11. Note that finger has straightened as prostate is forced headward. Prostate now normally positioned and mounded. Micturition reflex over urethra cleared.

Preceeding prostatic examination sponge rectal orfice with witch hazel. Dry with cotton ball. Place surgical cot on right index finger, lubricate with KY or any type lubricant. May use an anesethizing ointment such as Nupercaine if desired. Spread buttocks with left hand to expose anus. Slowly insert right index finger to first joint. Now bend index finger and insert as a hook with point toward pubes. This will direct you to prostatic floor and inferior prostatic urethra. If micturition reflex is absent, raise prostate. That is the adjustment.

#46

STRUCTURAL TECHNIC

Structural technic deals with abnormal tissues in the human body. It is a technic that alters the stress factors produced by the abnormal tissues. The abnormal tissues may be muscular, osseous, ligamentous, or the tissues making up the internal organs.

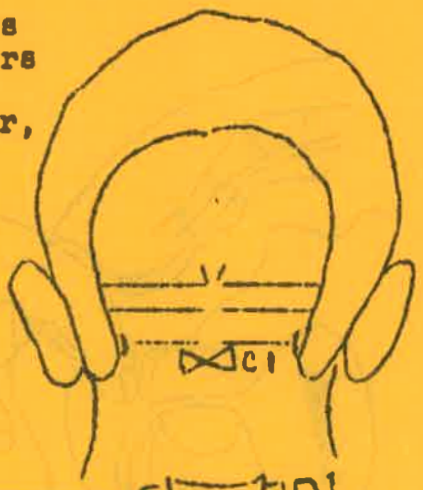
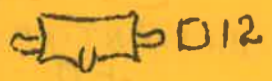


FIGURE #1. Occipital area 1, line 3 2, right or left. Spinal majors or major will be dorsals 1 or 12 or lumbar 5.

Never use without X-Ray

STRUCTURAL REFLEX CHART

OCCIPITAL	1	2	3	4	5	6	7
DORSAL	1-12	2-11	3-10	4-9		5-8	6-7
LUMBAR	5	4	3	2	1		
CERVICAL	1	2	3	4	5	6	7

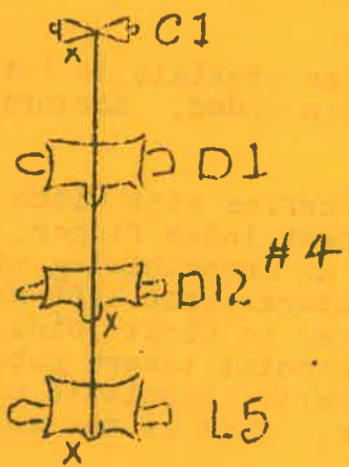


#1

#3

FIGURE #2. This chart is used only when the major occipital fiber is most painful on line 3.

FIGURE #3. Each vertebrae listed on chart under figure #2 is tested with a double thumb contact on its spinous process. Working from the left of a prone patient, the right thumb contacts right side of spinous and left thumb the left side of the spinous. Right thumb presses to the left and left thumb to the right. When this vertebra is a link in the stress factor, directional pressure will produce pain. The side of pain is marked.



#4

FIGURE #4. Atlas pain is produced by left to right pressure. Mark atlas on left.

Dorsal 1 is negative.

Dorsal 12 pain is produced by right to left pressure.

Lumbar 5 pain is produced by left to right pressure.

STRUCTURAL TECHNIC

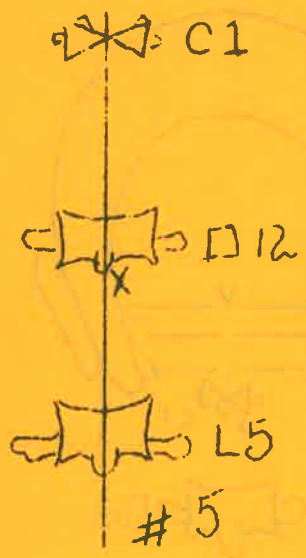
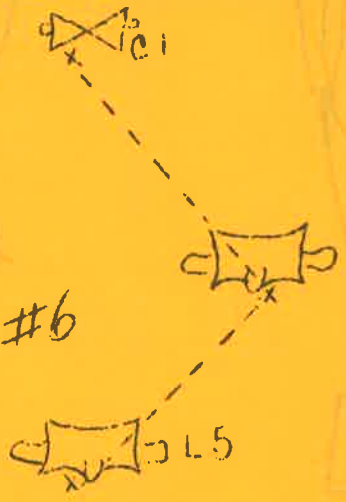


FIGURE #5. Re-palpate the spinouses of the marked vertebrae. Determine which is the most painful.

Dorsal 12 right spinous is the most painful. This now becomes our reflex control.

FIGURE #6. Contact right side spinous D 12 with one finger and light pressure from right to left. Use free finger to contact left side posterior tubercle of atlas. Hold at atlas for warmth.



Holding dorsal 12 contact, move free finger to left side spinous lumbar 5 and use pressure to left. Hold for warmth at lumbar 5 contact.

FIGURE #7. Adjust atlas with right thumb contact to left of posterior tubercle. Thumb pointing to right. Left hand grasps skull and hold firmly. Right thumb pressure constant until tissue movement is felt. DO NOT ROLL SKULL.

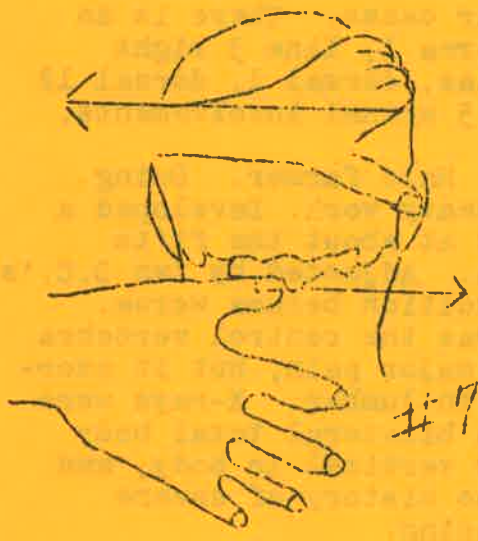
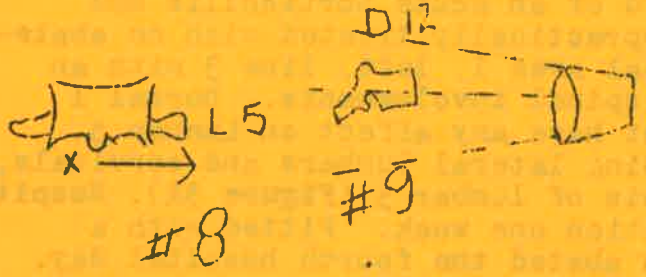


FIGURE #8. Adjust lumbar 5 with a left pisiform contact to left o. spinous. Support contact with right hand. Thrust from left to right with a light recoil. Abdomen should be supported with a cushion or by elevating the pelvis pad on the table.

FIGURE #9. X-ray Dorsal 12 region of spine. This is the major control vertebra and is the major stress point. You always x-ray the major stress point. If non-pathological, adjust specifically according to x-ray interpretation. This is avvery specific stress lesion. To violate the major stress vertebra by adjusting without x-ray studies may invite trouble.



STRUCTURAL TECHNIC

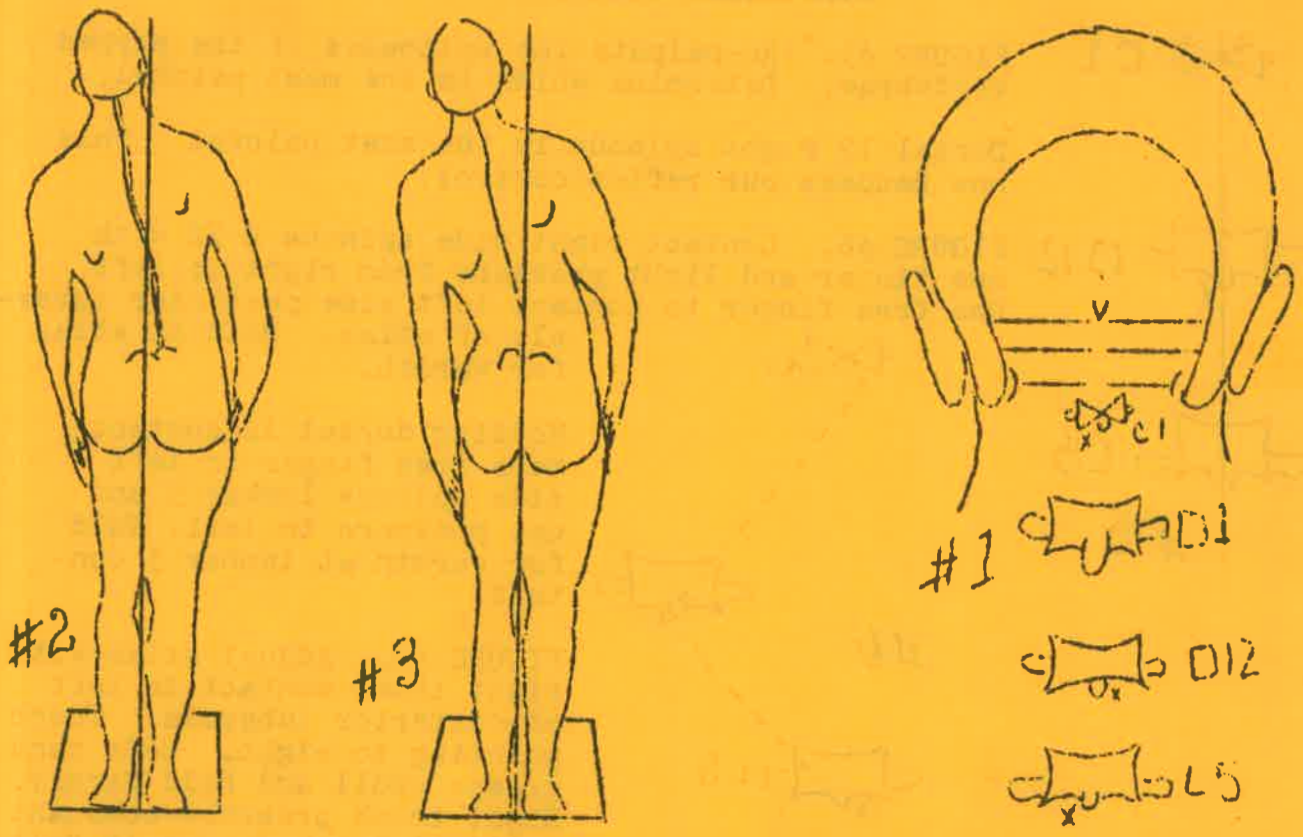


FIGURE #1. This illustrates two very similar cases. There is an occipital area 1, line 3 right with an atlas, dorsal 1, dorsal 12 and lumbar 5 spinal involvements.

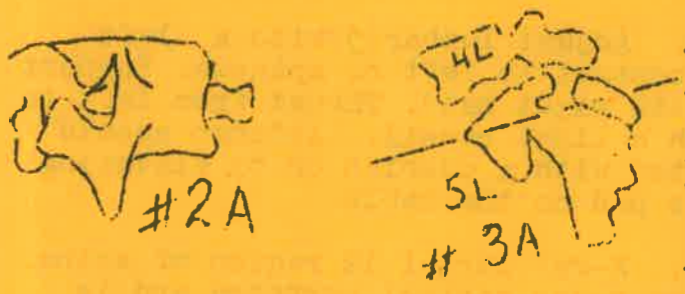


FIGURE #2. Male farmer. Doing extremely heavy work. Developed a sudden pain at about the fifth lumbar area. Adjusted by two D.C.'s but the condition became worse. Dorsal 12 was the control vertebra due to its major pain, but it exerted very little control over the atlas, or fifth lumbar. X-rays were made of the entire spine. Dorsal eleven had a bilateral total body fracture, involving left transverse, which lay vertical to body, and both pedicle and lamina. Patient could give no history of severe trauma. FIGURE # 2A illustrates the x-ray tracing.

FIGURE #3. Male, age 64. Complained of an acute torticollis and severe vertigo. Medically and chiropractically treated with no abatement of symptoms. We had an occipital area 1, left, line 3 with an atlas, dorsal 1 and 12 and lumbar 5 spinal involvements. Dorsal 1 was the control vertebra, but did not have any affect on Lumbar 5. X-rays of the complete spine, including lateral lumbars and cervicals, show a fourth degree spondylolisthesis of lumbar 5,(Figure 3A). Hospitalized.Kept in prone jack-knife position one week. Fitted with a rocking chair support. All symptoms abated the fourth hospital day. Does same manual labor as before. Exostosis formed to stabilize fifth lumbar.

LINE I REFLEX CHART

OCCIPITAL	1	2	3	4	5	6	7
CERVICALS	1	2	3	4	5	6	7
DORSALS	1-2 10	3 11-12	4-5	6	7	8	9
LUMBARS			1	2	3	4	5

LINE II REFLEX CHART

OCCIPITAL	1	2	3	4	5	6	7
DORSALS	1-2 9-10	3 11-12	4-5	6	7	8	
LUMBARS			1	2	3	4	5
SACRAL			1	2		4	
TRAPEZIUS	1(4#)	2(3½#)	3(3#)	4(2½#)	5(2#)	6(1½#)	7(1#)

LINE III REFLEX CHART

OCCIPITAL	1	2	3	4	5	6	7
DORSALS	1/12	2/11	3/10	4/9		5/8	6/7
LUMBARS	5	4	3	2	1		
CERVICALS	1-2	1-2	1-2	1-2	1-2	1-2	1-2

AREA 1 - T1 CORONARY SYNDROME

REFLEX POINT - left thenar (3-10 # pressure)

constriction/emotional
(no instrumentation findings)

occlusion/physical
(aggravated by exertion)

Pulse is lower in volume on left than right (indicating coronary tendency) & when arms are extended overhead the left will increase in volume while right will decrease - confirming a constriction

CONSTRICTION : 1) manipulate thenar until left pulse gains in volume
2) double thumb manipulation under left costal arch to relaxation

OCCLUSION : manipulate under left costal arch and simultaneously the left anterior humeral tubercle until pain at tubercle eases.

POSTGANGLIONIC CONTROL: hold Rt shoulder contact with left hand & gently manipulate between costal arches with right hand (2 minutes)

CORONARY EFFICIENCY TEST:
1) take systolic B.P.
2) apply double thumb contact under costal arches -- 15 seconds
3) retake B.P. - if B.P. increases then no coronary constriction
if B.P. decreases then constriction

HEART STRENGTH TEST:
1) take systolic B.P.
2) apply pressure (2 #) over right T.P. T5, both T.P.'s of T10 & L2 (10 seconds)
3) retake B.P. - if B.P. decreases then heart is strong

VAGUS STIMULATION TECHNIC for tachycardia: thumb to superior center of left clavicle, patient elevates arm to horizontal, hold thumb contact 20 seconds to slow heart & ease chest & arm pain.
Note: entire thenar pad may be involved in tachycardia

PATIENT MANAGEMENT:

- don't make these statements - "you have a coronary", "you have a bad heart", "did your parents die from heart attacks".
- typical coronary patient is very emotional
- obesity should be carefully explained but remember the ectomorph is coronary material if eat wrong foods. e.g. "a big steak, started by two cocktails, cream for coffee, 3 lumps sugar, fluffy mashed potatoes & rich gravy, lots of bread with butter, pie & 3 cigarettes while he relaxes & belches".
- recommend: beef heart, liver, fish
  vitamin E from whole grains, wheat germ oil, sunflower seeds, soy beans, lettuce, spinach, alfalfa
  safflower oil
- don't go way out on the stairs deal or an upstairs bedroom.

AREA 1 - T2 MYO & ENDOCARDIAL SYNDROME

NO REFLEX

1) check psoas & correct if necessary
2) lift intercostal arches superior as patient flexes left leg slightly & raises it from table - repeat with right leg (aim is to free diaphragm & give heart space to pump)

POSTGANGLIONIC CONTROL:

1) right or left shoulder contact
2) gently manipulate left costal arch centrally (2 minutes)

PATIENT MANAGEMENT:

- this syndrome is associated with rheumatic fever (vitamins C,P,A)
- short, stubby fingers with short nails indicate cardiac trouble.
- the swollen ankle & hand that pits on pressure is due to cardiac insuffiency
- bluish lips, swollen eyelids & dyspnea are indicators
- extreme fatigue: vitamin F & B complex foods
- skipped heartbeat: thiamine HCl
- recommend beef heart, wheat germ, oranges.

AREA 2 - T3 RESPIRATORY SYNDROMES

REFLEX - styloid (uni or bilateral)

1) manipulate styloid area from superior to inferior (above area or manipulate)
2) SINUS: a) thumbs to axis, fingers anterior of first 3 cervicals force thumbs anterior while pulling fingers posterior (repeat) 3 4X
   b) frontal sinus: flat hand to occiput, fingers to frontal sinus; press together extending the C spine (bilateral & repeat)
   c) maxillary sinus: thumb to central occipital base, index & middle fingers of other hand to maxillary sinuses - this hand makes superior & posterior pressure while thumb presses into occiput extending C spine. When a), b), c) completed, place head down to drain
3) BRONCHIAL: gently manipulate 1st & 2nd rib spaces until cleared
4) PULMONARY: a) gently manipulate 3rd & 4th rib spaces until cleared
   b) double thumb manipulation of intercostal arch (acute pneumonia) contraindication

Neg Trapez

5) THROAT: (stylohyoid fixation) grasp pharyngeal & laryngeal tissues with right hand & pull right as left hand on frontal bone forces face to left - repeat procedure from opposite side
6) POSTGANGLIONIC CONTROL: a) Rt shoulder contact
   b) right & left abdominal areas at level of umbilicus - 2 minutes each

PATIENT MANAGEMENT:

- decrease carbohydrate & dairy products in diet
- recommend foods containing vitamins C,P,A,D
- the typical sinus picture is pain over eyebrows or at cheekbones; these sinuses are natural sewers & collection points for used mucous; sinusitis means the patient is retaining toxins instead of eliminating them.
- home care: never use moist heat on a sinus unless head is in a position for nasal drainage.
- throat technic (above) applied over thyroid gland is useful in goiter

Stan Process pneumotrophin (very powerful)

Styloid fix: turn head opp dir pull (medially) on laryngeal/pharyngeal ms. ⇒ easier breathing

Rt T.U.P.

AREA 3 - T4 GALL BLADDER SYNDROME

REFLEX POINTS: a) thumb web right hand, (nodule)
b) sole of right foot - 1½" distal to malleoli centrally (indicates gall-stones)
c) inferior margin of 8th rib on right hand side next to sternum
d) ampulla of Vater (1½" lateral of umbilicus to right & 3" inferior)

1) manipulate reflexes a), b), & c) until pain decrease
2) hold reflexes a) & d) with 2 lbs. pressure for 3 minutes or until gurgling sensation at ampulla
3) hold b) at 4 lbs. pressure & d) at 2 lbs. for 3 minutes
4) POST-GANGLIONIC CONTROL: hold shoulder contact & manipulate gently ampulla & then 8th rib area

N.B. on subsequent visits perform 2), 3), & 4) only

PATIENT MANAGEMENT:
- nutritional regimen:
  1) eat slowly & methodically
  2) lie down & relax completely for 20 minutes following lunch & dinner

3) 6 glasses water per day, 1 cup sauerkraut juice before breakfast twice per week
4) no pork, lard, shortening, coffee, alcohol
5) use lean beef, bread, vegetables, salads, safflower oil (A, B, E)

- for flatulence &/or rheumatic pains: ½ lemon & 2 tsp. bicarbonate soda in glass of water, drink 20 min. before breakfast

Gall-stones:
1) 8 oz. apple juice every hour (no food) - first 3 days
2) 4th day: 8 oz. apple juice first thing in morning, then 1 hr. later 6 oz. pure olive oil
3) within 20 min. to 6 hours rush evacuation of stones

- many so called anginal & pectoral pains are due to this syndrome, also right shoulder pain & chronic torticollis - is a syndrome of upper right body
- may have grave emotional problems
- if gall bladder is removed, patient still requires CMRT

- advanced gall bladder disease produces yellow pigmentation of whites of eyes, palms & soles

Gall Stones

AREA 3 - T5 GASTRIC SYNDROME

REFLEX POINT: left thumb web (3-5 lb. pressure) nodule & pain
1) manipulate left thumb web as
2) hold most painful area between xiphoid & umbilicus until relaxation
3) POST-GANGLIONIC CONTROL: hold shoulder contact & gently manipulate abdominal area found in 2)

PATIENT MANAGEMENT:
- the following can be involved in abnormal gastric function:
  a) right occipital compression (prone)
  b) right occipital side-slip (supine)
  c) C3, 4, 5
  d) anterior dorsals 4 & 5
- no alcohol, tobacco, coffee, lard saturated fats
- pain relieved by eating is usually an ulcer - pain after eating is usually gastritis or malignancy
- gastric ulcer care: Lenhartz diet
  1st day: 100 cc milk, 100 cc cream, 2 raw eggs, whip together & use as 12 equal feedings - night time rest
  2nd day: ↑ 200 cc milk, 3 eggs, same schedule

3rd - 6th days: increase by 100 cc milk & 1 egg each day.
7th day: 800 cc milk, 4 raw eggs, (4 soft boiled eggs)
- this syndrome can have left shoulder & arm pain

heal along w/ appropriate Chiropractic care

AREA 5 = T7 SPLENIC SYNDROME - INFECTIONS, LYMPHATICS, BLOOD DISEASES

REFLEX POINT: just inferior of umbilicus - thumb contact in headward direction eliciting pain indicates involvement of lymphatic system as a whole.

1) bilateral thumb drainage from medial to lateral following superior margin of clavicle - gently but deeper with each stroke
2) axilla drainage - place towel wrapped left hand in axilla then carry patients arm across his/her body, repeat as pumping action
3) inguinal drainage - flat hand into inguinal region with pressure, rotate leg medial with other hand
4) pumping action over lower sternum as thumb manipulates reflex area until it softens
5) POST-GANGLIONIC CONTROL: hold shoulder contact & gently manipulate reflex area

PATIENT MANAGEMENT:

- never manipulate a painful lymph node or a painless node that causes a sensation of chilliness
- persistent nodulation along lymphatic channels & increasing density may point to Hodgkin's.

- patients may complain of fatigue, irritability, memory problems, balance problems, pain in groin & axilla
- vitamin C in all infections accompanied by increased secretions. (effectiveness of vit. C depends on acid pH) (vit. C decreased by fever & aspirin)
- throat infection: dissolve vit. D tablets in mouth.
- post-ganglionic contacts are of value in rheumatic fever & rheumatoid arthritis

AREA 6 - T8 LIVER SYNDROME

REFLEX POINTS:

a) nodulation 3rd right rib - 2" lateral of sternum
b) T3 right transverse process
c) center of forehead
d) top of head (a pressure as if something were trying to escape)

1) right hand manipulates 3rd right rib nodule as left hand holds right transverse process of T3 to relaxation
2) left hand holds 3rd right rib as right hand manipulates cecal area (McBurney's point) to relaxation
3) liver pump: left hand over right liver area (ribs 7-11), right hand over cecal area with fingers headward. Left hand moves up, over & down as right hand presses posterior & superior; slowly 5 times

   CONTRAINDICATIONS for liver pump
   a) gastric or abdominal pain associated with acute gastric ulcer
   b) abdominal pain associated with temperature.
4) POST-GANGLIONIC CONTROL - use only if above procedures don't produce tissue relaxation. Hold right shoulder contact & gently manipulate liver area

PATIENT MANAGEMENT:

- patient may complain of upper dorsal pain that worsens under stress or multiple & shifting pains, or stiff muscles upon resting.
- liver disease seldom manifests severe symptoms until pathology is grave
- all liver diseases produce that severe afternoon fatigue; a tablespoon of white karo syrup quickly releases sugar & restores energy.
- liver inactivity always coats the tongue
- monitor patients progress with bilirubin test on urine taken before breadfast (3 times per week)
- detoxifiers: a) 1 cup sauerkraut juice 20 minutes before breakfast
  b) buttermilk
  c) sodium phosphate in water 20 minutes before breakfast
- cases of hepatitis, cirrhosis, etc. require: choline, inositol, methionine, betaine HCl & B complex
- most people are B complex deficient especially alcoholics.

AREA 7 - T9 ADRENAL SYNDROME (no fiber nodulation)

REFLEX POINTS: a) 1" superior & 2" lateral of umbilicus - adrenal contact
b) nodulation mid-sternum

1) take blood pressure (A) 95-140 (B) 140-250
2) fingers to anterior margin of temporal plates & thumbs to vertex of skull:
if (A) press (3 lb.) & release every second for 30 seconds
if (B) hold (3 lb.) for 1 minute
3) thumbs 3" inferior of xiphoid & fingers on costal arches:
if (A) thumbs depress (2 lb.) & relax, then fingers depress ribs slightly - very rapidly & lightly
if (B) as above except very slowly & firmly
4) gently stimulate sternal contact as hold adrenal contact(s)
(A) lightly (B) firmly - 2 minute limit
5) POST-GANGLIONIC CONTROL: hold shoulder contact & gently manipulate adrenal contact on same side as transverse nodulation (continue until blood pressure remains normal for 1 month)

PATIENT MANAGEMENT:

- must understand stress inorder to understand many arthritic, hypo & hyper tension states, abnormal fatigue, skin conditions.
- many conditions diagnosed as disc lesions are primarily the result of poor calcium metabolism due to steriod deficiencies.
- this patient can't tolerate hard adjustments
- for controlled production of steroids use oranges & calcium lactate.
- vitamin C is depleted rapidly during stress; recommend 1000 mg/day
- hypertension: rutin, vitamin E & rice diet

AREA 1 - T10 INTESTINAL SYNDROME

REFLEX POINTS: a) umbilical box (4" square about umbilicus) - tension & pain
b) proximo-lateral forearm (acute)
c) weak & painful metatarsal arches (chronic)

1) hold shoulder contact (same side as painful umbilical area) & manipulate (3 lb.) umbilical contact until relaxation
2) gall-bladder reflex: hold right thumb web & ampulla of Vater (1½" right & 3" inferior of umbilicus) until gurgling sensation is felt at ampulla
3) thumb & index finger contact unbilical box bilaterally & force tissues superior as the left hand does liver pump - 6 times
4) POST-GANGLIONIC: hold shoulder contact & gently manipulate umbilical contact (2 minutes) - very effective, use often

PATIENT MANAGEMENT:

- parasites may be involved in intestinal disorders.
- patients with stubborn intestinal ills must not handle pets.
- weight problems always concern themselves with intestines.
- think wrongly & the intestines join right in with that thinking.

- a great percentage of supposedly gastric ulcer patients are intestinal problems, therefore frequent eating is better than 3 meals per day.
- potatoes are specific for intestinal problems, better raw than cooked
- B complex & apple concentrate are indicated
- no fried foods, tobacco, alcohol.

AREA 2 - T11 & 12 KIDNEY SYNDROME

REFLEX POINTS: a) 1" superior & 4" lateral of umbilicus (kidney reflex)
b) nodulation lower sternum

OVERACTIVE - increased urine output - cystitis: hold major trapezius contact & painful kidney reflex until tension dissipates

UNDERACTIVE - decreased urine output - chronic kidney disease: manipulate sternal contact & kidney reflex area for 2 min. (2 lb)

KIDNEY [redacted]: a) check psoas & correct if necessary
b) if psoas positive suspect a ptosis on short arm side & confirm by palpation
c) correction:
1) leg flexed - place fingers lateral of linea alba & slightly inferior of umbilicus & push superior as draw knee medial
OR 2) support kidney from posterior while other hand contacts pelvis & forces kidney superior as patient lowers leg
3) have patient gain 5-10 lb.

PATIENT MANGEMENT:
- when this triad occurs a CBC & urinalysis are indicated.
- physical signs: swollen malar skin folds, swollen ankles, chubby hands with short brittle nails, cracked lips, eye-glasses.
- blood in urine: 500 mg. vitamin C perhour until controlled (check for hyperacidity); vitamins K & A also indicated.
- kidney stones: 1) a solution made from mashed potato skins OR
2) 1000 mg. vitamin C per hour (helps dissolve matrix)
- no salt, tobacco, alcohol, coffee, meat.
- fresh vegetables & melons (all kinds) are indicated (vit. A)
- lactic acid yeast useful as it controls intestinal flora eliminating bacteria that would invade kidneys.

allergies involving eruptions at body surfaces are due to wheat products.

AREA 3 - L1(S1) ILEOCECAL SYNDROME

REFLEX POINT: 2" inferior of McBurney's point (ileocecal reflex area)

1) hold ileocecal reflex area with 2 finger contact & excite pain reflex to maximum as thumb rotates the anterior center of humeral head clockwise & counterclockwise (patient palm up). Start with 2 lb. pressure & increase until humeral head no longer is sensitive.
2) POST-GANGLIONIC: hold shoulder contact & gently manipulate superior to McBurney's opposite the umbilicus. (very important for proper ileocecal function - use each visit)

PATIENT MANAGEMENT:

- all ileocecal problems result from excessive gas accumulations in the colon due to putrefaction.
- an incompetent or overcompetent ileocecal is the beginning of a toxicity problem that may simulate appendicitis.
- patient who can't elevate right arm & keep C column straight usually has an incompetent ileocecal.

- nutrition regimen:
  1) no large meals, eat frequently, chew food well, moderate liquids with meals.
  2) avoid all foods producing flatulence
  3) avoid all fats except moderate use of unsaturates
  4) no fried foods, raw foods, raw juices, bulky foods until acute reaction have passed
  5) all meats lean & well cooked - minimal protein until flora normal i.e. when stools no longer foul smelling
  6) ripe bananas, bread, milk staple diet until acute stage gone
  7) 8 glasses water per day
  8) chocolate is a poison to ileocecal
  9) buttermilk & B complex are indicated
- 3 daily rest periods (5-10 minutes), patient must lie supine, relax then tighten abdominal muscles (suck in abdomen) for 10 seconds while breathing normally.

AREA 4 - L2(S2) CECAL SYNDROME

REFLEX POINT: McBurney's point
ACUTE (appendicitis) - hold S2 foramen (or trapezius 4) & A-P at McBurney's point for 1 minute; then manipulate S2 foramen until positive relaxation at McBurney's point.
CHRONIC - gently manipulate mid to lower sternum as contact at McBurney's & force tissues superior until feel internal tissue movement
POSTGANLIONIC: hold shoulder contact & gently manipulate McBurney's

PATIENT MANAGEMENT:
- invariably the arthritic exhibits this syndrome.
- skimmed or buttermilk, fresh vegetables, no pork.
- if excessive weight loss & dehydration then following regimen:
  1) high protein liquid foods until stools lose foul odor & are less frequent
  2) solid food starts with high protein - one week
  3) then add ripe bananas well mashed
  4) when above tolerated add cream or cottage cheese
  5) when stool is controlled & near normal color add orange juice, soft boiled eggs, bean puree
- appendectomy patient requires CMRT

AREA 4 - T6 PANCREATIC SYNDROME

REFLEX POINT: right thenar (3-5 lb. pressure)

1) manipulate right thenar with left hand 3 minutes as you
2) hold superior aspect left costal arch - 1 minute then
3) hold inferior aspect right costal arch - 1 minute then
4) hold central gastric area - 1 minute.
5) POST-GANGLIONIC CONTROL: hold shoulder contact & gently manipulate central gastric area (relieves much of patient's tension)

(check kidney

PATIENT MANAGEMENT:

- use combi-stix or tes-tape routinely for sugar, protein & pH
- urine specimen should be the second voided in morning, or 2 hrs. after eating
- diabetic care:
  1) de-sugarize by use of raw cabbage, high protein & low CHO foods
  2) sugar in any form (including honey & syrups) must never be used
  3) not soft drinks, refined foods, milk & dairy products
  4) drink 8 full glasses water per day
  5) if patient is obese, then must control calories to bring to normal weight
- a cardinal sign of acute pancreatitis is the patient sits with the legs drawn up

AREA 6 - L4(S4) COLON SYNDROME

REFLEX POINT: inferior border of lateral ¼th of clavicle - lateral part of this area indicates constipation; medial part of this area indicates diarrhea/overactivity

1) palpate colon bilaterally & select most painful area
2) UNDERACTIVE/constipation: manipulate clavicular reflex as apply pressure starting behind most painful area & move to rectum.
3) OVERACTIVE/diarrhea: manipulate clavicular reflex as apply pressure starting in front of most painful area & move in a reverse peristalsis direction.
4) POST-GANGLIONIC: hold shoulder contact as gently manipulate abdomen just medial to A.S.I.S. - perform bilaterally

PATIENT MANAGEMENT:

- patient must eat a balanced breakfast daily.
- constipation: a) 8 glasses water/day - no coffee or tea
  b) always use vegetable laxatives
  c) never use mineral oils.
- diarrhea: tea, toast & banana powder.
- ulcerative colitis: no uncooked foods or juices, no leafy vegetables, liver extract, boiled beef, poached eggs, malted milk
- non-ulcerative colitis: cooked cereals, toast, boiled fowl
- roughage only when colon not inflamed.

AREA 5 - L3 GLANDULAR SYNDROME

REFLEX POINT: pubic arch

N.B. when neutralizing this fiber use increasing pressure (up to 8 lb.) on transverse of L3 until moisture develops

1) hold shoulder contact as squeeze pubic arch between thumb & index finger until patient relaxes
2) POST-GANGLIONIC: hold shoulder contact as place hand over pubic area

PATIENT MANAGEMENT:

- nervousness expresses this syndrome exactly.
- the emotionally disturbed, the metabolic (either too thin or too fat) & the patient who can never reach a total decision fit this syndrome.
- home care: have patient perform the postganglionic procedure on self for few minutes prior to bedtime.
- vit. E for production of estrogens during menopause (600 units/day)
- iodine in form of kelp.
- niacin for depression.
- eat liver once/day.
- if overweight, oily skin, fatigued, insomnia, pulse greater than 65 - try thyroid extract.

AREA 7 - L5 PROSTATIC OR UTERINE SYNDROME

REFLEX POINT: prostate - central perineal line between rectum & scrotum
uterus - inguinal ligament

PROSTATE:
1) hold prostatic reflex until tissues relax & pain eases - patient in knee chest position.
2) prostate manipulation: patient on side, enter anal canal & point towards pubic arch, lift prostate to elevate transverse bar, move contact lateral & force lobe medial - same for opposite lobe

N.B. don't manipulate a hob-nailed or small nodular prostate

3) POST-GANGLIONIC: hold shoulder contact & gently manipulate lower abdominal area slanting from umbilicus to mid-inguinal

UTERINE:
1) select major point of pain & nodulation along either inguinal ligament. Hold major trapezius area on side of nodulation as manipulate nodules until pain gone.
2) manipulate mid-sternum as hold most painful area on inguinal ligament until warmth at ligament contact
3) POST-GANGLIONIC: as for prostate

PATIENT MANAGEMENT:
- nodulation on area 7 fiber indicates malignancy
- if you don't care to assume responsibility for prostate or uterine examinations then refer; malignancies arecontrollable if control is begun in time.

Condyle Syndrome

High Ear shoulder / Long Leg > Same Side < Low Ear shoulder / Short Leg

Shoulder Pain,
Mid-Clav Pain
Outer Thigh Pain

Cat. II Long Leg Syndrome

Long Leg → Tender Rib Head

Coronary Syndrome
Myocardial "
Lung "
Gall Bladder "

Sindale → Toes up & Chin down

Lt $ – acute stage/Health
Rt $ – chronic " " (problem of the day → relates to sympathetic blocking)

Dorsal – press straight down – pain – Ant.
T – S – pain – inf.

SACRO ILIAC

Listing	Patient	Operator	Contact	Line of Drive
I.* Ilium: post-inf-~~lat~~				
A. Pube: ant-sup on post-inf PSS side	Supine	Face feetward, same side	Pube, just lat to symphysis	Post-inf
B. Sacrum: post-rot, inf tilt on post-inf PSS side	Prone	Face headward, either side	Sacrum, just off PSS on post-inf side	Ant-sup
C. Sacrum: lat to ant rot side	Prone	On side of laterality	Sacral spinouses between the PSS's	Straight medial (shallow thrust)
D. Ilium: post-inf-~~lat~~	Prone	Face headward, same side	Post-inf aspect of PSS	Ant-sup
II.* Ilium: ant-sup-~~med~~				
A. Sacrum: ant rot, sup tilt on ant-sup PSS side	Prone	Face headward on post-inf rot side	Sacrum, just med to PSS on post-inf side	Ant-sup
B. Sacrum: lat to ant rot side	Prone	On side of laterality	Sacral spinouses between the PSS's	Straight medial (shallow thrust)
C. Ilium: ant-sup-~~med~~	Prone	Face feetward, same side	Post-lat aspect of ischium	Ant-inf-med

FEMUR HEADS

I.* Ant-sup-med	Supine	Face feetward on opposite side	Ant aspect of greater trochanter	Post-inf-lat
II.* Post-inf-lat	Prone	Face headward on same side	Post-lat aspect of greater trochanter	Ant-sup-med

PUBES

I.* Medial	Supine	Straight lat on opposite side	Medial aspect of medial pube	Lateral
II.* Lateral	Supine	Straight lat on same side	Lat aspect of lat pube	Medial

* All starred items are multiple listings.

2nd THROUGH 10th DORSALS

Listing	Patient	Operator	Contact	Line of Drive
I. Dorsals (thrust on both the ant and post rot sides)				
A. Ant rot, sup or inf tilt, lat to ant rot side	Prone	On side of ant rot	Lamina on ant rot side	
		1.* Sup tilt: face feetward 45°		1.* Sup tilt: inf-med
		2.* Inf tilt: face headward 45°		2.* Inf tilt: sup-med
B. Post rot, inf or sup tilt	Prone	On side of post rot	Post rot TP	
		1.* Inf tilt: face headward 45°		1.* Inf tilt: sup-floorward
		2.* Sup tilt: face feetward 45°		2.* Sup tilt: inf-floorward
C. Spinouses				
1.* Inferior	Prone	Face headward	Inf aspect of SP	Superior
2.* Superior	Prone	Face feetward	Sup aspect of SP	Inferior
II. Ribs (Usually subluxate unilaterally on ant rot TP side, but may subluxate on post rot TP side)				
A.* Post-inf on inf TP side (pulled out)	Prone	Face headward 45° on same side	1" lat to rib head	Sup-med-floorward
B.* Post-sup on sup TP side (jammed in)	Prone	Face feetward 45° on opposite side	1" lat to rib head	Inf-lat-floorward
C.* Ant-sup-lat on sup TP side	Supine	Face feetward 45° on same side	Midway bet nipple and sternum lines	Post-inf-med
D.* Ant-inf-med on inf TP side	Supine	Face headward 45° on opposite side	Midway bet nipple and sternum lines	Post-sup-lat

LUMBO-SACRAL

Listing	Patient	Operator	Contact	Line of Drive
I. Muscular Involvement				
A. Psoas (one goes each way)				
1. Inferior (contracted)	Supine	Face headward 45° on inf side	Bet navel and ASS	Sup-med
2. Superior (stretched)	Supine	Face feetward 45° on inf side	Bet navel and ASS	Inf-lat
B. Tensor fascia lata: post-sup (both same way)	Prone	Face feetward, either side	Slide off greater trochanter	Ant-inf
C. Quadratus (one goes each way--the same as psoas)				
1. Inferior (contracted)	Prone	Face headward on inf side	Just lat to TP of L4 above ilium	Sup
2. Superior (stretched)	Prone	Face feetward on inf side	Just lat to TP of L4 above ilium	Inf
D. Notch involvement (one goes each way)				
1. Counterclockwise	Prone	Face headward, either side	5/8" plexor into notch until meet resistance. Torque clockwise	Directly into notch--headward
2. Clockwise	Prone	Face headward, either side	5/8" plexor into notch, torque counterclockwise	Directly into notch--headward
II. Osseous Involvement				
A. L5 ant rot, sup tilt, lat to reactive leg side	Prone	Face feetward 45° on reactive leg side	Root of L5 SP on ant rot side	Inf-med
B. L4 ant rot, sup tilt, lat to non-reactive leg side	Prone	Face feetward 45° on non-reactive leg side	Root of L4 SP on ant rot side	Inf-med
C. L3 ant rot, sup tilt, lat to reactive leg side	Prone	Face feetward 45° on reactive leg side	Root of L3 SP on ant rot side	Inf-med

Dr L2

LUMBO-SACRAL cont.

Listing	Patient	Operator	Contact	Line of Drive
D. Laterality of L5,4,3,2	Prone	On side of laterality	Lat aspect of SP of L5,4,3 in turn	Straight medial
E. Post-inf rot TP	Prone	Face headward	Inf aspect of post-inf TP of L5,4,3 in turn	Sup-floorward
F. Spinouses				
1.* Inferior (all three)	Prone	Face headward, either side	Inf aspect of SP of L5,4,3 in turn	Superior
2.* Superior (all three)	Prone	Face feetward, either side	Sup aspect of SP of L5,4,3 in turn	Inferior
G. Sacral base				
1.* Ant-sup	Prone	Face feetward, either side	4th or 5th tuberosity of sacrum	Inf-floorward
2.* Post-inf	Prone	Face headward, either side	1st tuberosity of sacrum	Sup-floorward

H. If pain continues after complete lumbo-sacral or low back correction, suspect a disc involvement. Mostly, the disc is involved on the open wedge side, but can, in rare cases be involved on the closed wedge side. Mostly, only one disc is involved, but all 4 disc's may be involved--between the sacral base and L5, between L 5 and L4, between L4 and L3, and between L3 and L2. Use 3/8" plexor between two transverse processes. Line of drive is right at the disc medially and floorward, at an oblique angle.

11th and 12th DORSALS

I. Dorsals 11 or 12: usually only one is involved. May occur with sacro iliac, lumbo-sacral or by itself. They rotate, tilt, lateral, posterior, spinouses up or down. Adjust like lumbars or dorsals.

II. Ribs: usually bilateral--one goes each way

1. Post-sup on ant-sup TP side (jammed in)	Prone	Face feetward 45° on opposite side	1" lat to TP	Inf-lat-floorward
2. Post-inf on post-inf TP side (pulled out)	Prone	Face headward 45° on same side	1" lat to TP	Sup-med-floorward

UPPER CERVICALS

Listing	Patient	Operator	Contact	Line of Drive
I. Condyles (always subluxate opposite atlas listing)				
A. Post or ant rot	Prone, head turned so post condyle is up	Back of head	Bet mastoid and post arch foramen magnum	Faceward
B. En masse				
1.* Post en masse	Prone, nose in hole, chin pulled out	Top of head, face feetward	Just above post arch of foramen magnum	Ant-inf
2.* Ant en masse	Prone, nose in hole, chin pulled in	Back of head, face headward	Post arch foramen magnum	Superior
C. Laterality	Prone, head turned so lat condyle is up	Top of head, face feetward	Mastoid or in ear	Floorward
II. Axis (usually subluxates post or ant en masse the same as atlas)				
A.* Post				
1. Post en masse, post rot, inf or sup tilt	Prone, nose in hole, chin pulled in	Post rot side 1.* Inf tilt: face headward 45° 2.* Sup tilt: face feetward 45°	Just lat to SP on post rot side	1.* Inf tilt: sup and floorward 2.* Sup tilt: inf and floorward
2. Laterality	Prone, nose in hole	Straight lat on side of lat	Tip of lat TP	Straight medial
B.* Ant en masse, ant rot, inf or sup tilt, lat	Supine, chin lifted	Ant rot side 1.* Inf tilt: face headward 45° 2.* Sup tilt: face feetward 45°	As close to center of body of C2 as possible, on ant rot side	1.* Inf tilt: sup-med-floorward 2.* Sup tilt: inf-med-floorward

UPPER CERVICALS cont.

Listing	Patient	Operator	Contact	Line of Drive
III. Atlas				
A. En masse and rot				
1.* Post en masse, post rot	Side posture, post rot side up, bottom shoulder back, nose down	Back of head, face feetward 45°	Post aspect of post rot TP	Ant-inf-floorward 45°
2.* Ant en masse, ant rot	Side posture, ant rot side up, bottom shoulder forward, nose up	Front of face, face feetward 45°	Ant aspect of ant rot TP	Post-inf-floorward 45°
B. Laterality (usually goes lat opposite reactive leg)	Side posture, lat side up, shoulders straight, knees bent, nose parallel to floor	Back of head, in close	Tip of lat TP	Straight floorward

LOWER CERVICALS

I. Usually C5 is involved. Adjust like C2. Avoid adjusting C3 and spinouses.

II. D1 should be adjusted like the other dorsals.

III. 1st Ribs (always subluxate bilaterally, with one going each way.)

A. Ant-sup on ant rot TP side	Supine	Face Feetward	1" lat to D1 TP	Post-inf
B. Post-inf on post rot TP side	Prone	Face headward	1" lat to D1 TP	Ant-sup

CRANIAL

Listing	Patient	Operator	Contact	Line of Drive
I. Frontal				
A. Sup on reactive leg side	Supine	Face feetward at top of head	Frontal bone just off suture	Inf
B. Lat on reactive leg side	Supine	Face midline	Lat aspect of frontal bone	Med
II. Temporal and Sphenoid				
A. Sup and ant or med on reactive leg side	Supine, head to side	Face feetward 45° to face	Temporal: above ear just off temporal suture	Post-inf
			Sphenoid: just off lat angle of eye	Post-inf
B. Post-inf on non-reactive leg side	Supine, head to side	Face headward 45° to back of head	Temporal: above ear just off temporal suture	Ant-sup
			Sphenoid: just off lat angle of eye	Ant-sup
III. Parietals				
A. Ant-med on reactive leg side	Supine, head to side	45° to face	Just off parietal suture	Post-lat
B. Post-med on non-reactive leg side	Supine, head to side	45° to back of head	Just off parietal suture	Ant-lat
IV. Occiput: sup-lat on reactive leg side	Prone	Face feetward at top of head	Occiput just off suture	Inf-med

FACE

Listing	Patient	Operator	Contact	Line of Drive
I. Nose: sup-lat on reactive leg side	Supine	Face feetward on lat side, 45° to head	Sup-lat aspect of nasal bone	Inf-med
II. Zygomatics: both go sup-med	Supine, head to side	Face feetward on face side	Frontal process of zygomatic	Inf-lat (adjust both)
III. Maxilla				
A. Inf on reactive leg side	Supine	Face headward	Angle of nose on maxilla above teeth	Sup
B. Sup on nonreactive leg side	Supine	Face feetward	Angle of nose on maxilla above teeth	Inf

JAW

I. One side goes ant-sup	Supine, head to side	Face feetward 45° to face	1. Temporomandibular joint	Post-inf
			2. Angle of jaw	Post-inf
			3. Coronoid	Post-inf
II. Other side goes post-inf	Supine, head to side	Face headward 45° to back of head	1. Temporomandibular joint	Ant-sup
			2. Angle of jaw	Ant-sup
			3. Coronoid	Ant-sup

The jaw may or may not be part of the cranial pattern. If it is, adjust it first.

SHOULDER

I. Muscular Involvement
   A. Pectoral: sup
   B. Latissimus: sup
   C. Biceps: sup-lat
   D. Deltoid: sup-lat, but can also go ant or post too
   E. Triceps: sup-lat
   F. Supra and infra spinatus: sup-lat
   G. Trapezius: (rare) always bilateral--one goes sup, other goes inf

II. Osseous Involvement
   A. Coracoid and acromion: usually go ant-inf-med
   B. Clavicle: usually goes ant-inf at sternal notch end and post-sup at at acromial end
   C. Sternum: manubrium rot post on clavicle subluxated side (adjust ant rot side)
      gladiolus rot ant opposite manubrium
   D. Arm and forearm bones
      1.* Anterior type
         a. Humeral head: ant-sup-lat
         b. Distal end of humerus: sup-lat_ant.
         c. Radius and ulna: ant-sup-med (towards each other) (adjust at elbow and wrist)
      2.* Posterior type
         a. Humerus: post-sup-lat (adjust both ends)
         b. Radius and ulna: post-sup-med (towards each other) (adjust at elbow and wrist)
   E. Elbow cartilage: find lump and make listing. Usually sup-lat (away from the center)
   F. Scapula: usually tips sup at acromial end. Adjust on the apex with patients forearm behind back
   G. In all shoulder cases: check 5th cervical, 1st dorsal and ribs, and 2nd dorsal with possible ant rib involvement

KNEE AND MENISCUS

I.* Anterior type

A. Distal end of femur: ant-sup-lat

B. Proximal and distal ends of tibia: ant-sup-lat (away from midline of the leg)

C. Proximal and distal ends of fibula: ant-sup-lat (away from midline of the leg)

D. Patella: ant-sup-lat

E. Talus: ant-sup-lat

F. Lateral and medial meniscus: ant-sup-lat (away from midline of the knee)

II.* Posterior type

A. Distal end of femur: post-inf-lat

B. Proximal and distal ends of tibia: post-inf-lat (away from midline of the leg

C. Proximal and distal ends of fibula: post-inf-lat (away from midline of the leg

D. Patella: inf-lat

E. Talus: inf-lat

F. Lateral and medial meniscus: post-inf-lat (away from midline of the knee)