

Integrating Manual Medicine and Nutritional Therapy with Acupuncture



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Dear Friends and Colleagues... It is always a distinct honor and pleasure to present workshops. As many of you know, I have been treating patients for over 45 years using a variety of modalities, including both complementary/alternative therapies and conventional “standard of care” medicine. Buzz words like “evidence-based” and “standard of care” have undergone their own evolution in the past three decades. As a medical student, I was chastised for asking questions about the use of folic acid for the prevention of neural tube defects, magnesium for certain arrhythmias and migraine, fish oil for autoimmune disease and cardiovascular health, and the existence of *Helicobacter Pylori*(which my course instructor dismissed as “junk science” proposed by a misguided quack Australian). We laugh now as these examples have been integrated into mainstream medicine, but we must not forget that for better or worse, medical science is a very conservative, skeptical, critical entity that often dismisses

truth with unfortunate consequences only to embrace these same facts later on down the road. Students of medical history are often appalled by what was the “standard of care” in those past times. Ridiculing and punishing hand-washing with soap, femur amputations for the treatment of pernicious anemia, and dismissing “stocking-glove” paresthesias and carpal tunnel syndrome as psychiatric illnesses or malingering were all part of a long-established history of blaming the patient whenever possible and punishing those that threatened the reigning paradigm. As acupuncturists, we have seen a growing acceptance and demand from the public at large to provide our services. “Evidence-based” studies have slowly infiltrated the mainstream medical establishment to the point where acupuncture is often included as a viable intervention for numerous conditions. Similar patterns of change have occurred in the fields of manual medicine and nutritional therapy. The burden of “evidence-based” studies helps prevent dubious therapies from being accepted but also limits many legitimate treatments because of the onerous time/money constraints placed on the investigators. This is particularly true in the field of nutritional therapy where money is not readily available unless the payoff is a drug patent for the pharmaceutical companies. Ironically, many drug companies are, indeed, trying to capitalize on the works of nutritional pioneers by patenting a slight variant of a readily available nutritional product. Prescription fish oil, time-released niacin, vitamin B-12/Folate and a recently approved strontium-hybrid are but a few examples. Fortunately, several of the top nutraceutical companies are sponsoring clinical trials with their products at major research centers around the world.

My knowledge of nutritionally based therapies represents a conflation of influences from many great teachers and innovators. A list of resources is included at the end of this introductory essay. My early teachers were Drs. George Goodheart Jr. and Walter Schmitt, who, along

with Harry Eidenier Jr. PhD, introduced me to the late and great genius, Royal Lee, DDS (the founder of Standard Process Laboratories. To this day, Dr. Lee's work offers endless clinical pearls for effective patient care. Another huge leap of knowledge occurred studying the works of Jeffrey Bland, PhD. His seminars and publications are masterpieces that weave physiology, nutritional biochemistry, and clinical medicine into a vibrant working model. Many physicians have been transformed by courses offered by the Institute for Functional Medicine that teaches much of Dr. Bland's life work. At the same time, Jonathan Wright, M.D. and Alan Gaby, M.D. were writing books and offering week-long courses to physicians. Their courses included applied nutritional therapies for almost every medical sub-specialty.

After attending their course at the Omega Institute in 1988, I became convinced that medical nutrition was destined to become an integral part of mainstream medicine. Melvyn Werbach, M.D from UCLA came along with his wonderful Third Line Press publications that documented the use of dietary, nutritional, and herbal interventions for nearly every medical condition. Finally, Kirk Hamilton P.A. offered comprehensive reporting on research in the field of medical nutrition with his Clinical Pearls services. My apologies to all the many other great contributors, leaders, and pioneers whose names have not been included in this brief presentation. This workshop pertains to the integration of nutritional medicine and manual medicine with acupuncture. As medical acupuncturists we appreciate those interventions that enhance a healthy physiology and homeostasis. Current theories about acupuncture propose mechanisms that involve cellular molecular biology in its varied forms including: neurotransmitters, cellular messengers, immune cells and modulators, endogenous opioids and cannabinoids, and numerous other components of immunology, neurology, and metabolism. Nutritional medicine shares many similar characteristics. It seems reasonable to postulate that acupuncture interventions and nutritional interventions are capable of achieving similar effects under certain circumstances and an enhanced synergistic result in yet others.

Often a pattern diagnosis in Chinese Medicine such as: Damp Heat in the Lower Jiao may represent in Western physiologic terms: intestinal dysbiosis involving an imbalanced microbial population in the bowel with overgrowth of candida albicans, the presence of parasites, and a deficiency of normal probiotic flora resulting in non-specific colitis or irritable bowel syndrome. An acupuncturist may choose to treat specific points that influence Damp Heat in the meridians: Spleen/Stomach, Large Intestine, Liver and Gall Bladder. Herbal formulas might be employed as well to resolve this issue. A functional medicine practitioner may order sophisticated stool studies, blood tests, and other tests before implementing a focused nutraceutical/pharmaceutical plan to resolve the abnormalities that appear in these investigations. Probiotics, prebiotics, antifungals, antimicrobials and nutrients that help heal and restore normal mucosal integrity may be utilized. Following treatment there will be a noticeable change in pulse and tongue findings from a Chinese Medicine standpoint in addition to the obvious clinical improvements. The question frequently arises as to whether or not acupuncture is necessary or sufficient to resolve these types of clinical disorders. During my internship year in medical school, I was completely cured by one acupuncture treatment for a refractory case of ulcerative proctitis that was confirmed by tissue biopsy and unresponsive to steroids. My physician friend, just back from China, diagnosed a severe Damp Heat invasion of my Lower Jiao by history, tongue and pulse diagnosis. This "acupuncture healing" profoundly affected my life and viewpoint about illness and treatment. Nutritional modalities were not involved nor were manual treatments.

In my experience, acupuncture enhances the therapeutic effects of other modalities such as manual medicine or nutritional/pharmaceutical interventions. As physicians we appreciate the seriousness of pneumonia and will often prescribe an appropriate antibiotic. As medical acupuncturists, we would want to treat the Lung meridian and any additional corresponding meridian disturbances that were present during the illness and after the pneumonia had resolved. Furthermore, as healers we would seek out the inherent weaknesses or vulnerabilities that allowed our patient to acquire pneumonia in the first place. Acupuncture, nutritional medicine, and manual medicine can be pro-active and preventive in addition to being treatment responses for medical conditions. They are interventions that promote healing and homeostasis in addition to attacking pathology and dysfunction.

As an integrative medicine physician, I am frequently treating patients with multiple interventions simultaneously. It is not unusual for these patients to receive nutritional/herbal therapies, dietary manipulations, manual therapies, and acupuncture in their total treatment plans. Identifying the specific curative factor or factors is therefore rather difficult. Each therapeutic input is intended to address or resolve specific aspects of the troubling condition. Some refer to the “combination- lock theory “ of healing wherein all the numbers (factors) must be known and the specific sequence is needed to unlock the lock (heal the condition). A brief example might be useful here. Suppose the patient has chronic asthma as their chief complaint and is currently not facing an acute life-threatening crisis. In addition to, or as an alternative to the typically prescribed medications such as Albuterol, Flovent, Singulair, Zyrtec , etc. one could prescribe a food elimination diet, nutritional supplements such as: vitamin B-12, vitamin C, magnesium, n-acetylcysteine, and quercetin to name just a few. Acupuncture needles could be administered based on the specific etiology imbalances discovered during pulse, tongue, and history diagnostics. Herbal formulas could be added to support and enhance the acupuncture effect. Manual medicine techniques could be utilized to remove mechanical restrictions in the diaphragm, cranium and axial skeleton. Lymphatic drainage and respiratory-circulatory techniques could be used as well. Mind-body therapies could be taught to reduce “stress” and control triggers from a mental-emotional origin.

We can take advantage of the many readily available diagnostic tests for evaluating : nutritional deficiencies, toxicities, hormonal and metabolic disorders, food/chemical allergies and sensitivities, and bowel flora disturbances. Numerous studies have pointed out that nutritional deficiencies are common and often go unrecognized in our elderly population. As our “life energies” or “Jing” wanes with age there are often corresponding deficiencies seen with nutrients and hormones that if treated can markedly improve quality of life parameters.

I hope you will find useful, information in this presentation that can benefit your patients, your families and yourselves. Applied nutritional therapy is wonderfully synergistic with medical acupuncture. While you treat a Liver problem from an acupuncture perspective with needles, you can simultaneously identify specific dietary and nutraceutical interventions by history, examination, and diagnostic testing. One can also treat the liver organ itself with viscreal manipulation. Many useful charts, tables and clinical pearls are included for your review. A section is included in the slides that focuses on each principal meridian and how one can integrate specific nutraceutical interventions for that channel. Another section focuses on the treatment of Inflammation (Fire) which is very relevant for the treatment of inflammatory conditions involving the neuro-musculoskeletal system, cardiovascular system, respiratory system, gastrointestinal system, and the integument.

TRAUMA : AN INTEGRATIVE MODEL FOR DIAGNOSIS AND TREATMENT

Caillet defines trauma as a: “wound or injury with implication of a force applied externally or internally causing a tissue reaction. Pain is the resultant which has varying degrees of intensity and effective interpretation with numerous avenues of transmission.” This lecture introduces a variety of treatment principles and modalities for patients who have suffered trauma in their past and are unable to move forward in their recovery. This presentation will not address the management of serious acute trauma that requires emergency interventions or acute hospital care. Rather, we will discuss approaches that can be utilized after the patient is medically stable but is “stuck” and unhappy with their current state of recovery. We often encounter these patients who have been told: “You’ll have to learn to live with it” (for the remainder of their lives). Be it chronic pain, loss of function, loss of motion, depression, or other sequelae to trauma: these patients could benefit from a variety of interventions that are not typically offered by traditional mainstream medicine. As acupuncturists we are quite familiar with these truths and most of us have already helped numerous patients with needles, moxa, and/or herbs. This session is meant to add to that growing list of possible complementary and alternative approaches for healing past trauma.

THE “LIST”

Osteopathic Manipulative Medicine: Cranial Osteopathy, Visceral Manipulation, Strain-Counterstrain, Myofascial Release, Functional Release, Muscle Energy Technique, High Velocity Thrust, Facilitated Position Release, Balanced Ligamentous Tension, Percussion Hammer

Special Attention to: Breathing(3 Diaphragms), Visceral Mobility and Motility disorders, Sacrum-Coccyx(Holds fear/insecurity), Dural strains, Cranial/TMJ dysfunctions (often unexamined), Greenman’s “Dirty Half-dozen” (non-neutral facet joint restrictions, symphysis pubis shears, sacral posterior torsion or nutation, hip bone shear, short-leg/pelvic tilt syndrome, and muscle imbalance of the trunk and extremities), Nerve Restrictions, “Energy Sinks” (Robert Fulford’s Concept that is treated with the Percussion Vibrator)

Chiropractic: Applied Kinesiology (Injury Recall Technique, Emotional Neurovascular Holding Points), Sacro-Occipital Technique (Suture Releases), Neuro-Emotional Technique

Homeopathy: Arnica, Hypericum, Symphytum, Natrum Sulphuricum, Ruta Graveolens
Bach Flower/ Other Flower Essences: Star of Bethlehem, Rescue Remedy, Revive All (FlorAlive Remedies)

Aroma Therapy: Spruce, Rose, Lavender

EMDR (Eye Movement Desensitization and Reprocessing): Psychotherapy Tool

Redcord: A Revolutionary Rehab Device

Gyrotonic and Pilates

Prolotherapy: For hypermobility unresponsive to other modalities or strengthening

Nutritional/Metabolic: Evaluation of: Nutritional status (intracellular vs. other), Endocrine balance (blood, urine, saliva), Toxicity (hair, blood, urine, feces), Food and chemical sensitivities (ALCAT et al), Mitochondrial function (Cellular Energy Profile et al), Dysbiosis/“Leaky gut syndrome” (Comprehensive Stool Analysis), Immune panels with other traditional laboratory and diagnostic studies.

Hypnotherapy, Biofeedback, Neurofeedback et al: Brain, behavior, and psyche

Bioenergetics and other Mind-Body oriented therapies: Somato-emotional therapies

Rolfing, Hellerwork, Soma Bodywork, Anatomy Trains: Core patterns

Magnets, Crystals, Lasers, and other energy transfer devices: Energy fields

Shamanic Healing and other forms of “Soul Retrieval”

Chinese Medicine: Seven Dragons, Chakra Acupuncture, Yintang, Shao Yin- Jue Yin
groundingreleasing points: H-7, PC-6, LR-3, K-3, K-25, 26, 27, CV-17
Treat the “scattered” or “suspended” Qi, treat the loss of Heart Qi,
Heart pulse is Fine and Tight, Complexion is bright-white or bluish tinged forehead.
Pulse is rapid, short, shaped like a bean, vibrating
Eyes may be dull without glitter** (from Giovanni Maciocia)

As an osteopathic physician I have been greatly influenced by my teachers, mentors, and the past masters of my profession. To better understand the osteopathic philosophy and treatment approaches to trauma, I can highly recommend the writings and methods of: Andrew Taylor Still M.D./D.O., Rollin Becker D.O., Robert Fulford D.O., William Johnston D.O., Viola Frymann D.O., Myron Beal D.O., William Sutherland D.O., Fred Mitchell Jr. D.O., Lawrence Jones D.O., Anne Wales D.O., Irwin Korr Ph.D., Philip Greenman D.O., Robert Ward D.O., Anthony Chila D.O., Edward Stiles D.O., John Upledger D.O. and Jean-Pierre Barral D.O. This is a partial list but certainly representative of the rich and prolific tradition of osteopathic healers and educators.

My first mentor, George Goodheart Jr., D.C., developed a unique system of diagnosis and treatment using manual muscle testing. His system, Applied Kinesiology, has been in a state of continual evolution for over 60 years. A central theme runs through his work known as the “Triad of Health”. This concept proposes that there is a continuous interaction between structure, chemistry, and emotional/energetic facets. When a patient presents with post-traumatic pain, there will undoubtedly be multiple somatic dysfunctions present. A careful history and thorough examination usually reveals biochemical and emotional- energetic problems as well. Food allergies, chemical sensitivities, toxicities, nutritional deficiencies, endocrine disturbances and subtle disorders of metabolism such as mitochondrial dysfunction are more common than one might imagine. “Post-Traumatic Stress Disorder” with its myriad of manifestations: Depression, Anxiety, OCD, ADHD, Paranoia, Phobias, Insomnia, Somatic Disorders, and Sexual Dysfunction, (just to name a few) is also quite common.

Perhaps a case example might illustrate the application of this “Triad of Health” paradigm. A 45 year old white female has had three years of pain in the cervical, mid-thoracic and lower back regions following a whiplash injury. Additionally, she complains of retro-orbital and temporal headaches, jaw tension with “clicking and popping,” insomnia, fatigue, depression, anxiety, irritable bowel syndrome, irregular periods, right carpal tunnel syndrome, left patella pain, and “foggy, dull thinking.” All of these complaints began after the accident. She was stopped at a red light and was rear-ended at approximately 35 mph. She hit her head on the driver’s window, hit her knee cap into the dashboard, and felt extreme strain to her wrist during the accident. A month after the accident she developed a thyroid nodule with goiter and became hyperthyroid requiring Tapazole medication. Patients with these scenarios are often treated as if their entire whiplash injury is strictly limited to their musculoskeletal system. Medications, injections, physical therapy, chiropractic, massage and other musculoskeletal modalities are often employed. The lucky patients recover with those interventions alone. Some are not so lucky.

This patient requires deeper attention to the specific disruptions of her structure, chemistry, and energetic psychology. Osteopathic examination reveals: cranial somatic dysfunctions involving a petro-jugular dislocation, fronto-sphenoid compression, lateral sphenoid strain,

lowered cranial rhythmic impulse and impairment of venous sinus drainage. Physical examination reveals TMJ dysfunction which is supported by an MRI, documenting a dislocated/torn disc and capsule allowing for complete dislocation of the TMJ disc during opening and closing. Cervical MRI demonstrates atrophy of the rectus capitis superior minor muscle with resultant instability of the occipito-atlantal joint. Neural and myofascial tension is noted from the anterior cervical regions down the right arm into the wrist and hand. The diaphragmatic breathing pattern is markedly dysfunctional with dyskinesia of the thoracic, pelvic, and cranial diaphragms. Hypermobility of the cervical and thoracic ligaments is noted at multiple levels. The sacrum and coccyx are abnormally tight and intra-osseously compressed with a backward sacral torsion. A right pelvic shear is evidenced by the asymmetrical positions of the ischial tuberosities. "Listening" reveals a restricted and mildly ptosed left kidney. The liver's mobility and motility are also restricted.

The treatment of the above structural somatic dysfunctions would require skilled interventions with cranial manipulation, visceral manipulation, prolotherapy, neuro-fascial release, myofascial release, and temporomandibular joint treatment from a dentist familiar with cranial-mandibular mechanics (severe TMJ pathology may require surgery). Many of these patients benefit from the intelligent use of nutraceutical products including: vitamins, minerals, trace minerals, enzymes, amino acids, anti-oxidants, and herbs. Magnesium, zinc, vitamin C, proline, and a host of other nutrients are necessary for connective tissue integrity. Chronic inflammation can be treated with an anti-inflammatory diet (Mediterranean diet minus their food sensitivities) along with therapeutic levels of Omega-3 fatty acids, boswellia serrata, turmeric, bromelain, ginger, garlic, devil's claw, MSM, CoQ10, and alpha lipoic acid. Several companies offer intra-cellular nutrient testing to specifically identify deficiencies.

The hypothalamic-pituitary-adrenal axis is universally stressed and often dysfunctional post-traumatically. Patients need a thorough examination of their endocrine system to determine the extent of abnormal hormonal involvement. The most common finding is adrenal dysfunction: either hyperactivity or exhaustion. Continuous stress on the adrenal system leads to fatigue, depression, idiopathic rashes, paradoxical wakefulness at night, sugar and stimulant cravings, gastrointestinal irritation, weakened ligaments, dilated pupils, orthostatic hypotension, susceptibility to infections, and marked susceptibility to joint injuries. B-complex vitamins, vitamin C, minerals, ginseng, gotu kola, sarsaparilla, rehmannia, adrenal glandular products, and selective Chinese herbal formulas can help restore energetic and metabolic balance to the gland. Occasionally, the patient will require physiologic doses of Cortisone (Cortef). Thyroid dysfunctions are very common and often present after severe stress or trauma particularly to the head and neck. In general, any gland may exhibit post-traumatic dysfunction. The pancreas may become hypo-functioning on an endocrine or exocrine basis. Menstrual irregularity may follow head or back injury. Each case is unique and needs to be evaluated for possible deleterious sequelae. Ideally, successful manipulation of "key lesions", dietary adjustments, individualized nutritional and herbal therapies and acupuncture can provide considerable relief and improvement to their former condition. One can not underestimate the importance of also treating the mental-emotional, psychic, etheric, and spiritual dimensions of trauma. As triune beings we resonate in accordance to the health and balance of our mind-body-spirit. Treating the subtler energy fields can at times produce the greatest changes in our patients. Many patients are stuck in their fixed attitude, posture, and energy resonance. EMDR, Bach Flower Remedies, Homeopathy, Hypnosis, Reiki, Hands of Light, Chinese Medicine, and other modalities on "The List" work with those

dimensions that are rarely acknowledged by conventional medical treatments. Dr. Fulford said that the goal of the healer is to help the patient find their destiny. To put the patient in touch with what their ultimate purpose was for being on this earth in this lifetime. Once a patient is doing what they were meant to do, everything else begins to fall in place. Sometimes trauma is a gift that leads to an awareness of what is important and what needs to be done.

Trauma can occur in “one fell swoop” or as the “straw that breaks the camel’s back.” Repetition stress is commonplace and what I see in my practice is a body finally running out of adaptations. We see this often in children today playing sports or having a series of injuries where each one leads to an adaptive response that eventually can’t compensate. Too often, parents are told that their child athlete is fine and will “get over it” because he’s just a kid. Soccer trauma, gymnastics injuries, and all the other trauma prone sports are creating a nation of “walking wounded child-athletes” who are only given ice and ibuprofen for their aches and pains. Very little attention is paid to the specific, discrete nature of their injuries that can be treated by competent manual medicine practitioners and/or acupuncturists. A child might present with headaches or neck pain that is the result of untreated ankle or lower back strains from past injuries. The athlete will keep compensating for their previous injury with altered posture and motion mechanics which will ultimately take them down a path of new injuries. Gaining the skills to diagnose and treat somatic dysfunctions as they occur in the child or adult proves rewarding to the patient and doctor alike. “An ounce of prevention is worth a pound of cure” and treating and resolving trauma in a timely fashion can restore function and prevent a lot of unnecessary pain and suffering down the road.

Trauma: An Osteopathic Approach authored by Jean-Pierre Barral D.O. and Alain Croiber D.O. is an outstanding text for exploring the varied depths and multi-dimensional consequences of trauma. “Nothing is forgotten”, “Nothing is isolated”, “Everything accumulates”, “Everything is recorded”, summarizes several critical concepts that are at the foundation of traditional osteopathic thought. All structures and tissues do not respond identically to the same given traumatic forces. The pre-existing state of the person’s mind/body/spirit influences the outcome of any traumatic event. Barral and Croiber describe in great detail the biomechanics and physics of trauma. Each system of the body is included in their analysis. Novel diagnosis and treatment procedures are presented for treating: cranial, dural, visceral, neural, vascular, and osteoarticular injuries. (Several of these modalities are presented in the powerpoint presentation).

Foundations for Integrative Musculoskeletal Medicine: An East-West Approach authored by Alon Marcus D.O.M., L.Ac., D.A.A.P.M. is certainly one of the most comprehensive texts I’ve ever read regarding the musculoskeletal system. Dr. Marcus has done an amazing job of merging orthopaedic, neurological, and osteopathic principles of diagnosis and treatment with that of Chinese Medicine; both acupuncture and herbal medicine. A wonderful reference text for almost any clinical presentation in musculoskeletal medicine.

Enjoy! Jay Sandweiss D.O., F.A.A.M.A.

MANUAL MEDICINE TECHNIQUES THAT TREAT CHANNEL RESTRICTIONS

CONCEPTION VESSEL: **CV-17** COUNTERSTRAIN

GOVERNING VESSEL: **GV-1** COUNTERSTRAIN, **GV-20** CRANIAL

LUNG: **LU- 1&2** COUNTERSTRAIN, **LU-7-9** MYOFASCIAL RELEASE

LARGE INTESTINE: **LI-4** UNWIND THUMB, **LI-11** COUNTERSTRAIN/MFR

STOMACH: **ST-41** MUSCLE ENERGY TECHNIQUE OR THRUST TECHNIQUE

SPLEEN: **SP-2,3,4** MYOFASCIAL RELEASE OR MUSCLE ENERGY TECHNIQUE

HEART: **HT-1** ACTIVATED RELEASE, **HT-3** COUNTERSTRAIN OR THRUST

SMALL INTESTINE: **SI-11,13,14** COUNTERSTRAIN , **SI-19** TMJ RELEASES

BLADDER: **ANY SPINAL LEVEL**(e.g. **BL-23**) MET/ COUNTERSTRAIN

KIDNEY: **KI-10** COUNTERSTRAIN, **KI-27** MET

TRIPLE ENERGIZER: **TE-10, 11, 12** DEEP MYOFASCIAL RELEASE

GALL BLADDER: **GB-34,40** MET TO FIBULA, **GB-20** MET OR COUNTERSTRAIN, **GB-21** COUNTERSTRAIN OR MYOFASCIAL RELEASE

LIVER: **LR-2,3** MFR OF TOE, **LR-4** MFR OF ANKLE MORTISE, **LR-14** VISCERAL

CERVICAL REGION PEARLS

- **PROBLEMS** OF THE CERVICAL SPINE REGION CAN COME **FROM ANYWHERE!**
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- **COMMON NEUROMUSCULOSKELETAL CAUSES** OF THESE PROBLEMS INCLUDE:
- **CRANIAL FIELD SOMATIC DYSFUNCTIONS** (JUGULAR FORAMEN: CN9,10,11)
- **VISUAL DISORDERS**
- (OFTEN UNDIAGNOSED VERTICAL HETEROPHIA OR OTHER VISUAL PERCEPTUAL DEFECTS), **TMJ AND HYOID BONE** DYSFUNCTIONS.
- THESE MUST BE IDENTIFIED AND TREATED TO ACHIEVE LASTING CORRECTIONS
- **LOVETT BROTHER REACTIVITY :**
- SACRUM=OCCIPUT, L5=C1, L4=-C2, L3=-C3, L2=C5, L1=-C6
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- **SACROILIAC FIXATIONS**= INHIBIT POSTERIOR CERVICAL EXTENSOR MUSCLES
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- **UPPER THORACIC VERTEBRA, RIBS, AND UPPER EXTREMITIES** GREATLY INFLUENCE CERVICALS
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- **VISCERAL PTOSIS** (USUALLY KIDNEY OR LIVER) OR **VISCERAL RESTRICTIONS** FROM THE THORAX(PLEURA/LUNG) CAN CREATE OR PERPETUATE CERVICAL SYNDROMES
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- **AFTER WHIPLASH INJURY** NEED TO TREAT DIAPHRAGM, DURAL STRAINS, CRANIAL DYSFUNCTION (OFTEN PETROJUGULAR DISLOCATION), LOCAL SOFT TISSUES: MUSCLE SPINDLE CELLS, FASCIA, MUSCLES, GOLGI TENDONS
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- **POSTURAL ERGONOMICS: “THE HEAD IS A HEAVY BOWLING BALL”**
- *ALEXANDER TECHNIQUE, WORKSITE EVALUATION, POSTURAL TRAINING MAY ALL BE NECESSARY*
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- **GAIT AND LOWER EXTREMITY INVOLVEMENTS:** SHORT LEG, FOOT PRONATION, TIGHT TALOCRURAL MOTION, ASYMMETRICAL GAIT SWING, “WALKING GAIT” DISORDERS CAN ALL CAUSE OR PERPETUATE CERVICAL PROBLEMS
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- **OTHER IDEAS TO CONSIDER:**

- ALL **ACUPUNCTURE CHANNELS AND POINTS** IN THE HEAD AND NECK REGION ARE **YANG** EXCEPT FOR THE CONCEPTION VESSEL IN THE VENTRAL MIDLINE

- **4** OF THESE **YANG** CHANNELS ARE CONNECTED TO THE **EYES** (BL, ST, TH AND GB)

- **4** OF THESE **YANG** CHANNELS ARE CONNECTED TO THE **TMJ** REGION (SI,ST,TH, AND GB)

- DISTURBANCES IN ANY OF THESE CHANNELS CAN BE A CAUSE OF CHRONIC CERVICAL COMPLAINTS. DISTURBANCES CAN INVOLVE ORGANS AND GLANDS ASSOCIATED WITH THOSE CHANNELS. (EXAMPLE: **GERD** MAY BE CAUSED BY”**REBELLIOUS STOMACH QI**”. GERD MAY CAUSE SORE THROAT OR OTHER SYMPTOMS IN THE CERVICAL/TMJ AREA WHICH FOLLOW THE TRAJECTORY OF THE UPPER STOMACH MERIDIAN.) THIS IS ANOTHER WAY OF UNDERSTANDING VISCERO-SOMATIC PAIN PATTERNS. **GALL BLADDER MERIDIAN PROBLEMS** MAY PRESENT AS NECK OR SHOULDER PAIN

- **THE NECK IS A VULNERABLE, SENSITIVE AREA:**

- CAROTID ARTERIES, THYROID, PARATHYROIDS, TRACHEA, SPINAL CORD VAGUS AND PHRENIC NERVES

- **“BOTTLE NECK”** : CONNECTOR BETWEEN THE HEAD (MIND) AND BODY (HEART) BECOMES SYMPTOMATIC WHEN THERE IS CONFLICT BETWEEN MIND AND EMOTION

- **SADNESS AND GRIEF** STORED THERE

- REPRESENTS THE **INHERENT FLEXIBILITY** TO SEE BOTH SIDES OF AN ISSUE

TMJ PROTOCOL

1. Find strong muscle (e.g. TFL)
2. Have patient therapy localize the TMJ with thumb and 5th finger opposing each other, while 2nd, 3rd, and 4th fingers touch jaw joints.
3. Ask patient to:
 - * Bite hard
 - * Open a little
 - * Open wide
 - * Lateralize left
 - * Lateralize right
 - * Extrude jaw
 - * Retrude jaw
 - * Chew slowly (aerobic)
 - * Chew fast (anaerobic)
 - * Swallow
 - * Talk
4. If any procedures described above weaken the patient, have them repeat the action while holding only the left side of jaw alone and then only the right side of jaw. Whichever side they were touching when their muscle weakened, is the involved side.
(You may need to change their head position up/down or left/right for this problem to display itself.)
5. There is a specific treatment procedure for each specific pattern of weakness.
6. You may place paper or tongue depressors between their teeth and see if a specific change in vertical dimension changes their bite weakness. For example, if a person weakens when they clench their teeth forcefully, but they no longer weaken when two tongue depressors are placed between their teeth, then they probably need a bite splint that will approximate this correction. In other words, send them to a dentist who does TMJ work.

Final note: The above screening procedure helps confirm that there is a problem with the jaw that needs attention. The patient may have already shown signs and symptoms of TMJ problems in the initial history and physical.

Upper Extremity Pearls

Upper extremity problems may be locally and/or distally induced and perpetuated

Always evaluate the whole patient/whole body for somatic dysfunctions of the spine, ribs, cranium, pelvis, sternum and lower extremities

Muscle testing helps identify the source of many problems. It helps to gauge the success of treatment by testing pre and post muscle response

Many upper extremity **issues come from cervical and upper thoracic/rib** somatic dysfunctions

Think brachial plexus trouble makers (cervical spine, T1, scalenes, upper ribs)

Multiple reflex systems affect the upper extremity **from the opposite side of the body:**

Muscle Interlink

Ligament Interlink

Gait Reflexes/Brain Cortex

Acupuncture Meridians: Inverse /Contrary pairings

Shoulder = Opposite Hip

Elbow = Opposite Knee

Wrist = Opposite ankle

Fingers = Opposite toes

Upper Extremity = Opposite Cortex (80%)

Yang Meridians run from fingers to face (Large Intestine - Small Intestine - Triple Warmer)

Yin Meridians run from trunk to fingers (Heart – Lung – Pericardium)

Organ and meridian disturbances create upper extremity problems by referral through reflexes and channels

Poor posture/poor ergonomics are a form of repetitive stress on the upper extremity in addition to typical repetitive stressors

Stretching and strengthening is essential for total recovery

Worksite evaluations are very appropriate and helpful Occupational Therapy is invaluable with many tough cases

Ask patient about **job, cell phones , keyboarding, mouse, one sided carrying habits**

Often Cranial/TMJ involvement:

Screen with Applied Kinesiology Protocols

Breathing patterns– use upper extremity muscle group

TMJ Protocol- use upper extremity muscle group

Specific Pearls:

Weak Adductor: Same side of **chronic elbow problem** (use neurolymphatic reflex) * **Goodheart**

Medial ulna subluxation: causes **chronic subscapularis weakness** and perpetuates **medial epicondylitis**

Radial head restriction: causes or perpetuates **wrist issues** and **lateral epicondyle** problems, biceps tendonitis

T12-L1 spinal fixation: causes **B/L lower trapezius weakness** which disturbs scapular function and contributes to **upper trapezius tension**/trigger points

Latissimus Dorsi: can come from cervical somatic dysfunctions (innervation) or thoracic, lumbar or sacral dysfunctions (origin of Latissimus)

Levator scapula: sensitive to calcium metabolism/parathyroid, **torticollis**. Use neurolymphatics aggressively consider nutrition

SCM/Upper Trapezius: Innervation **CNXI** (jugular foramen)/**Cranial**

Superior 1st rib dislocation: Pain/numbness down arm into hand

Persistent shoulder problems: Often undiagnosed visceral restriction of liver, lung, pleura, heart, pericardium or diaphragm. Consider when everything else has failed with traditional physical therapy

Carpal Tunnel Syndrome: Usually a continuum from C-spine/thoracic inlet
Boggy lymphatics, B6 deficiency or thyroid problem
Give patient the Dr. Sucher myofascial stretches for carpal tunnel
Interosseous forearm strain: do indirect release

Pectoralis Minor: Often short tight or weak: important for lymphatic drainage

Retrograde lymphatic test and techniques

Must free diaphragm for all chronic shoulder problems

Subclavius often involved when patient can not put humerus next to their ear. **Last part of frozen shoulder cases**

Motion loss in minor movements cause loss of major movements
(e.g. elbow flexion/extension affected by lateral glides and rotation of elbow)

***More will come spontaneously during the course get ready!**

LOWER EXTREMITY PEARLS

- ALWAYS EXAMINE THE WHOLE PERSON FROM TOP TO BOTTOM AND FROM BOTTOM TO TOP. BRAIN, SPINE, AND PELVIS MUST BE CHECKED AS WELL AS LOCAL STRUCTURES (KNEE, ANKLE, FOOT)
- GAIT DYSFUNCTION CAUSES REPETITION STRESS INJURY. THE AVERAGE PERSON REPEATS A GAIT CYCLE ONE MILLION TIMES A YEAR
- FASCIAS ARE IMPORTANT TO TREAT BECAUSE THEY STORE AND RELEASE ENERGY DYNAMICALLY. FASCIAL DYSFUNCTIONS IN THE LOWER EXTREMITIES WILL GENERATE MULTIPLE PROBLEMS INTO THE TRUNK AND PELVIS
- THE KNEE IS A PLACE OF MANY MINOR MOVEMENTS (SLIPPING, EXTERNAL AND INTERNAL ROTATION OF THE TIBIA). VERY FREQUENTLY, A DECREASE IN A MAJOR MOVEMENT COMES FROM RESTRICTIONS OF MINOR MOVEMENTS.
- KNEE PAIN IS USUALLY CAUSED BY A PROBLEM ABOVE OR BELOW THE KNEE UNLESS THERE WAS DIRECT TRAUMA TO THE KNEE
- LONG BONES LIKE THE TIBIA AND FIBULA MUST BE EVALUATED AT BOTH ENDS AS THE TWO ENDS MOVE IN OPPOSITE DIRECTIONS. AN APPARENT ANTERIOR TIBIO-TALUS DISTALLY CAN ACTUALLY BE A POSTERIOR PROXIMAL TIBIA AT THE FEMUR
- AFTER TRAUMA, THE TISSUES WILL RETAIN THE INJURY PATTERN. INDIRECT SOFT TISSUE TECHNIQUES MUST BE USED TO RESTORE PROPER PROPRIOCEPTION AND FUNCTIONING. REST AND STRENGTHENING IS NEVER ADEQUATE TO RESTORE NORMAL FUNCTION.
- MOTION TEST ALL FOOT AND ANKLE BONES TO ASSURE THEY ARE DOING THEIR JOBS. PARTICULARLY CALCANEUS, NAVICULAR, CUBOID, TALUS, AND CUNEIFORMS
- CAREFULLY CHECK FOR “TRUE” SHORT LEGS VERSUS FUNCTIONAL SHORT LEGS
- MANY KNEE, CALF, ANKLE AND FOOT PROBLEMS ARE DUE TO ADRENAL GLAND STRESS OR OTHER VISCERAL-SOMATIC ISSUES

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General Considerations

Occasionally after strain/counterstrain technique a patient will complain of pain in the general area the following day. This appears to be related to the release of excessive amounts of lactic acid accumulated from prolonged muscle dysfunction. A cold pack applied to the area will usually provide relief. An ice pack is not recommended; rather, use cold tap water in a plastic bag laid over the area and allow it to come to room temperature.

Nutritional support for strain/counterstrain is that which usually applies to the muscle involved. For example, the gastrocnemius is related in applied kinesiology to the adrenal gland. Adrenal concentrate is usually the choice nutrition.

In small muscles, such as those in the hand, it may not be possible to spread the tender points with two fingers. In this case use one finger to stretch the tissue over the area. Similar shortened treatment time will result as if two fingers had been used.

Gait Testing

Walking and running are complex neurologic activities that have received much attention in applied kinesiology. It is important to test a patient in the way in which he lives. Often examination, including manual muscle testing, is done with the patient prone or supine; this fails to consider the aspects of weight bearing, walking, running, and other movements. There are many techniques that enable the physician to evaluate the effect of these daily activities on a patient's health. For example, an individual may have a negative category I or II therapy localization and challenge to the pelvis; however, when he therapy localizes to the sacroiliac while walking, a positive test is seen.

As a leg advances in gait activity, the contralateral arm swings forward. The trailing leg is organized with the contralateral arm as both the hip and shoulder move in extension.

Further organization in gait is present in simultaneous activity of the leg adductors with the contralateral arm adductors, and the leg abductors with the contralateral arm abductors. Additional organization is present in the gluteus medius with the contralateral abdominal muscles. The gluteus medius must contract to support the pelvis during stance at the same time the contralateral abdominals lift the pelvis on the opposite side.¹⁷

Organization of muscle groups in gait can be evaluated by applied kinesiology gait testing.^{3,26} Although all types of gait problems are not identified by this testing procedure, it is an effective clinical tool for finding the cause of many gait disturbances. The system is to simulta-

neously test groups of muscles that are organized in gait. A positive test is when one or both groups test weak when tested simultaneously, but are strong when tested individually. The most efficient method of gait testing is to simultaneously test both muscle groups first. If they are strong, proceed to the next pair. If one or both muscle groups test weak, then test each group individually. Again, for a positive gait test, both groups must test strong when tested individually, but one or both groups test weak when tested simultaneously. If one or both groups test weak individually, the muscles must be strengthened by treatment with the five factors of the IVF before a satisfactory gait test can be performed.

Contralateral Shoulder and Hip Flexors

The supine patient flexes his hip and shoulder, keeping the knee and elbow extended. The arm and leg are raised approximately the length of a normal step. The examiner directs force against the arm and leg in the direction of extension, testing the general muscles of flexion.



6—49. Contralateral shoulder and hip flexors.

Contralateral Shoulder and Hip Extensors

This test can be done with the patient supine or prone. If done prone, the patient extends his hip and contralateral shoulder, keeping the knee and elbow in extension. The examiner directs force on the distal thigh and humerus in a direction of flexion.

When the test is done supine, the patient attempts to hold the contralateral extremities against the table while the examiner lifts on the arm and leg in a direction of shoulder and hip flexion. The supine position is convenient because all the other tests are done supine, and the testing can be done with minimal patient movement.



6—50. Contralateral shoulder and hip extensors.



6—51. Contralateral shoulder and hip abductors.



6—52. Contralateral shoulder and hip adductors.



6—53. Contralateral psoas major and pectoralis major.

Contralateral Shoulder and Hip Abductors

The supine patient abducts his contralateral arm and leg, keeping the elbow and knee in extension. The extremities are abducted approximately 30°. The examiner applies pressure to the distal arm and leg in a direction of adduction.

Contralateral Shoulder and Hip Adductors

The supine patient holds his arm and contralateral leg in adduction, with the elbow and knee kept in extension. The examiner applies force to the distal arm and leg to abduct them.

Contralateral Psoas Major and Pectoralis Major

The psoas and pectoralis test is similar to the contralateral shoulder and hip flexor test, but it localizes testing more to the individual muscles of flexion. The supine patient raises his leg and contralateral arm into the positions for testing the psoas major and the general pectoralis major. Testing pressure is applied in the same manner as individual psoas and pectoralis major muscle testing.

Contralateral Gluteus Medius and Abdominals

There are two tests for the contralateral gluteus medius and abdominals. One, with the patient supine, tests the gluteus medius with abdominal contraction. The supine patient begins a curling sit-up in which the shoulders are raised from the table. The trunk



6—54. Gluteus medius with abdominal contraction.

is turned to lift one shoulder higher from the table. This contracts the abdominals more on the side of higher shoulder elevation. A positive test is weakening of the contralateral gluteus medius.

The abdominals are best tested with the patient seated. The physician stands beside the patient, whose trunk is rotated toward the physician. The patient presses his knee against the examiner's leg. Testing pressure is applied to the shoulder to test the contralateral abdominals, while the knee on that side is stabilized. This more effectively tests the abdominals. Some failure of gluteus medius activity can be observed by the experienced examiner.



6—55. Contralateral abdominals and gluteus medius.

Treatment

When a gait test is positive, there will be an active acupuncture point associated with it. After the acupuncture point is stimulated, the gait test will be negative. Stimulation can be done by any method, e.g., digital pressure, acupuncture needles, electrical stimulation, and acu-aids.

Three gait complexes have meridian points located across the dorsum of the foot. The hip and shoulder adductors have points located lateral to the 5th metatarsal, while the shoulder and hip extensor complex has its point located close to the metatarsophalangeal articulation of the great toe on the medial aspect. The point for the psoas major and pectoralis major muscles is on the plantar surface of the foot (figure 6—56).

Four of the complexes have primary and secondary acupuncture points, which are the three meridians on the dorsum of the foot and the bladder meridian on the lateral aspect of the foot. On the illustration, the primary point is the larger dot where the involvement is usually found; if not, the secondary point should be evaluated. The active acupuncture point will have positive therapy localization. It can usually be located by

palpation and is exquisitely tender. Treatment is generally applied by digital pressure, which is a rather hard digital manipulation of the point for approximately fifteen seconds. After treatment, therapy localization to the point should be negative.

Often there is a foot subluxation associated with the active acupuncture point. If present, it should be corrected. If foot dysfunction is not corrected, the active acupuncture point and positive gait test will probably return.

Memory Key

A memory key to help remember the location of the meridian points correlates with the first five letters of the city, Palo Alto, beginning on the medial side of the great toe:

Posterior = Shoulder and hip extensors

Anterior = Shoulder and hip flexors

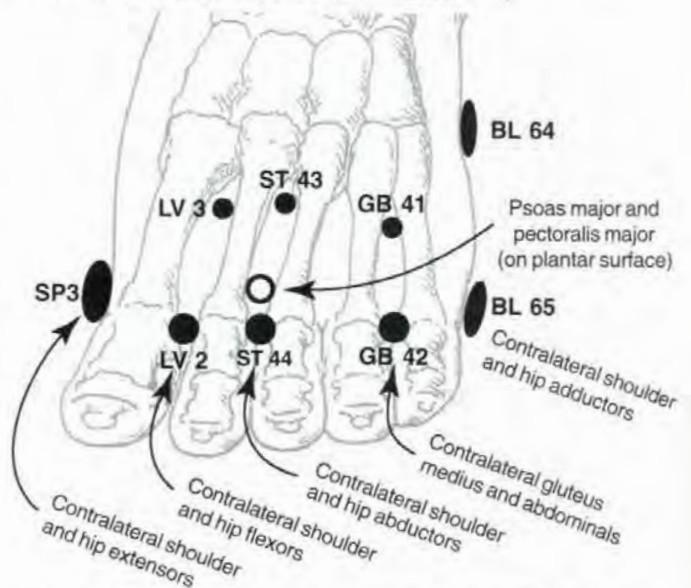
Lateral = Shoulder and hip abductors

Oblique = Gluteus medius and abdominals

Adductors = Shoulder and hip adductors

The remaining point for the psoas major and pectoralis major — KI 1 — is the only meridian point on the plantar surface of the foot.

Gait testing and correction of dysfunction are indicated whenever a patient has a recurring subluxation or other dysfunction after walking, feels worse after standing or walking, or has apparent foot dysfunction. (See Chapter 11 for foot discussion.)



6—56. Meridian acupuncture points for treatment of gait mechanism as observed by manual muscle testing. The large dots are the primary points where involvement is usually found; the smaller dots are the secondary areas to evaluate for treatment. Treatment is hard digital stimulation over the meridian point. Negative therapy localization indicates adequate and effective treatment. There usually are foot subluxations or other foot dysfunction present which should be evaluated and treated for lasting correction.