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Mandibular Torsion: Category 1 of the Jaw

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Narrative: It has been found by this author that mandibular torsion may be responsible for recurring cranial fault patterns and their attendant symptoms and that correction of this pattern can yield lasting correction in sometimes difficult and challenging cases. The challenge and therapy localisation of this condition are similar in nature to that found for a pelvic Category I.

Indexing terms: Chiropractic; jaw; TMJ; Category I; jaw torsion; cranial fault; mandibular torsion.

Introduction

Any doctor who has been treating patients with cranial faults for any length of time has come across resistant, recurrent or difficult cases that do not respond as expected or hoped for with resolution of symptoms and improved or restored function.

> *'... it has been found that torsion of the mandible must be corrected to gain lasting correction for the cranium ...'*

In the treatment of these patients with jaw or head pain, or recurring cranial faults and their associated far-reaching effects, one may look to the dura, the pelvis, the feet, and anywhere in between to find the solution. These cases may be particularly frustrating to the doctor and the patient due to the less than desired for response.

In dealing with just such a case, I recalled that in making the correction for the Pineal Cranial Fault which was first described by Goodheart in 1979, (1) it was necessary to correct the mandible by spreading, in order to prevent it from re-compressing the sphenoid. It occurred to me, that if the mandible could be compressed medially and effect the cranium, then perhaps it could be torqued and have a similar detrimental cranial effect.

The patient in question had unremitting and recurring trigeminal neuralgia in the V2 and V3 and occasionally in the V1 dermatomal areas which had not responded to usual cranial techniques. I challenged the mandible for torque by pressing inferior on the left while simultaneously pressing superior on the right, causing a clockwise (my view) torsion around the menton.

There was an immediate weakening of the indicator muscle. Following the 'rebound challenge' rule of the cranium and axial skeleton, I attempted correction using firmer pressure with my gloved left thumb on the left lower molars pressing inferiorly and my right hand contact under the right ramus pressing superiorly, enhanced by inspiration, four or five times until I sensed resilience. Immediately, the intractable pain was gone, as were all of the previously identified and recurring cranial faults. Happily for the patient and me the correction was lasting.

Subsequent to that initial observation, I have found the problem of mandibular torsion to be fairly common and to resolve a number of persistent cranial faults.

Method

> The challenge for this Mandibular Torsion fault is to press inferiorly on the bony ridge of the inferior aspect of the mandible, approximately 2.5 cm anterior to the angle of the mandible on one side, while simultaneously pressing superiorly from under the same landmark on the opposite side, using the pressure one would normally use for cranial challenge (0.5 lb. or less).

It is important that the teeth not be clenched and that the jaw is in a relaxed state during challenge. A positive response is indicated by a change in the indicator or previously associated weak muscle. So far, I have only observed the positive torsion challenge to be in a clockwise direction, even though I consistently screen for counter-clockwise as well if I do not find it in the clockwise direction. This may have to do with handedness, as my subjects to this point have all been right-handed. It may also have to do with the same common patterns of dural torsion which cause the Universal Cranial Fault to be predominantly one direction as well.

Therapy Localisation will be positive with the patient's index fingers over both TMJs simultaneously, one on each side, and over only one side when done separately. The TL is also positive with one index finger over the positive side TMJ and the other index finger on top of the nail of that finger. Once again, the pattern has demonstrated only on the left in the patients I have found it in so far, but variation cannot be ruled out. This pattern is reminiscent of that found in the Category I fault of the pelvis, which is also due to torsion of the pelvic structure, and this is why I have referred to this pattern of mandibular torsion as 'Category I of the jaw'.

Correction is achieved by using a gloved thumb over the mandibular molars on the side which challenged inferiorly, applying approximately three to four pounds of pressure inferiorly, while simultaneously applying similar pressure in a superior direction from under the opposite mandible with the intent to cause torsion around the menton. This is repeated three to five times on inspiration, or until resilience is palpable.

Discussion

It has been well documented that malocclusion can be an important factor in cranial dysfunction, and dental equilibration has been used both successfully and unsuccessfully to attempt correction.(2) The technique discussed in this paper has been found useful for resolution

of recurring cranial faults, particularly the rotational faults (internal and external frontals, temporal bulge, parietal decent and universal cranial faults).(3)

Using the same logic applied with the need to separate the mandible in order to gain lasting correction for a compressed sphenoid (Pineal Cranial Fault), it has been found that torsion of the mandible must be corrected to gain lasting correction for the cranium. The challenge and therapy localisation are similar in nature to that found for the Category I of the pelvis, and as Goodheart has been heard to say, 'the jaw is the pelvis of the skull', I feel comfortable with the 'Jaw Category I' reference and designation.

Of interest is that I have also seen resolution of a Pelvic Category I after this procedure, even though no corrections were made to the pelvis. The body truly is an integrated structure and everything is connected to everything.

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Also by Dr Burger

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