2023

Proceedings of the 14th Sacro Occipital Technique Research Conference

New Orleans, Louisiana

April 28, 2023

Sacro Occipital Technique Research Conference

New Orleans, Louisiana
April 28, 2023

Hosted by:

Sacro Occipital Technique Organization – USA

CONFERENCE PROCEEDINGS

Conference Chair
Charles L. Blum, DC
Research Director: Sacro Occipital Technique Organization – USA

Acknowledgements:

It is with the utmost gratitude I wish to thank all the various authors of these submitted abstracts and papers. Only with their selfless efforts can we share what we are finding in clinical practice and help build our evidence base of literature. I also wish to thank those who have donated to the Sacro Occipital Technique Organization – USA Research Fund which has helped pay for the printing of this conference's proceedings. Thanks to the SOT Research Committee (Drs. William Boro, Pamela Woodward, and Joanna Quintana) who participated with editing of SOT® Research and this SOT Research Conference's Proceedings. A special thanks goes to NCMIC for supporting this research conference as well as helping to advance chiropractic and allied healthcare evidence based research.

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2023 SOT RESEARCH CONFERENCE

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Table of Contents

2023 CONFERENCE PROCEEDINGS

Paper Title, Author(s) *(Listed Alphabetically by Lead Author)*

2023 SOT RESEARCH CONFERENCE

Invited Articles for the 2023 SOT Research Conference Proceedings

Proceedings of the Sacro Occipital Technique Research Conference

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Introduction

For Major Bertrand DeJarnette, DO, DC, research was an essential part of being a chiropractor and essential to the future of the chiropractic profession. As early as July 1935 Major Bertrand DeJarnette was a featured speaker at the 40th Anniversary Convention 1895-1935 of the National Chiropractic Association presenting clinical research. Always research was his passion and in an interview in 1982 DeJarnette reiterated, "as far back as chiropractic college, I saw the need for a more scientific basis for chiropractic theory. My own personal physical problems had not been solved by medicine, osteopathy, or chiropractic; so I began experimenting on myself. I'm still at it, and I can see no end of the need for continuous research in chiropractic [1]."

Dr. DeJarnette saw the importance of sharing clinical experience through case report and self-analysis. This started as he first began to find that things he instinctively did for a patient would disappear from his memory if he did not outline them carefully. So before our day and age of computers, he recommended that to begin the first step in research, you would need to buy a notebook, an eraser and long pencil. He emphasized that, "those would be your first three pieces of research equipment. You use your notebook because it is not expensive. You use a pencil because it can be erased, and of course mistakes will be made so you must own an eraser [2]." With those three pieces of equipment he sat down one evening and wrote his first case report of an unusual patient presentation and his treatment rendered. He recollected that he did not sit down to write until perhaps three months after that patient's presentation. Dr. DeJarnette could not believe how much he had forgotten about the details. The lesson he learned was "write the unusual down now [2]".

When Dr. DeJarnette began to study the treatment he had rendered he realized that if any meaningful information were to evolve from his experience, he would have to resolve it himself. Dr. DeJarnette suggested that research has to be a free agency. Basically he saw a need and worked to fulfill that need. He realized that explaining how his discoveries evolved was more difficult than the process of developing new diagnostic and therapeutic interventions [2].

Chiropractic techniques, innovative integrative collaborations, and methods such as sacro occipital technique, temporomandibular disorder co-management, chiropractic manipulative reflex technique, and cranial techniques need an arena to share clinical and other forms of research. Critical study of techniques and innovative methods are what will help propel healthcare forward in this era of evidence informed practice and best practice research.

The SOT Research Conference looks to offer a venue for research papers; specifically those, which investigate sacro occipital technique, dental chiropractic co-treatment, cranial techniques, viscerosomatic/somatovisceral, reflex techniques, and new ground-breaking creative ways of helping humanity without necessarily the use of drugs or surgical intervention. This year's proceedings, like all prior conferences, will be shared with the chiropractic profession, for review, dissemination, and in-depth study.

> "*Research is a study of what you have, and what you need to make it better, and how to make it better is the final research step. S.O.T. never wants to be just good. It always wants to be better and best and greatest and most dependable* [3]."

> "*Research in Chiropractic must go on forever. Someone must do this type work, for it simply will not take care of itself. A profession cannot stand still. Momentum must constantly be generated. Chiropractic research needs many things it does not now have* [4]."""*Sacro Occipital Technic, like all Chiropractic Technics, needs further study. We certainly do not have all the answers to all of man's problems, and neither does any other group of people* [4]."

As a parting comment for his chiropractic colleagues Dr. DeJarnette said, "We must respect each other's beliefs. We must support our colleges and associations. We must work together and unite as a profession. And we must at all times be proud of chiropractic and proud of our calling as chiropractors [1]."

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1. DeJarnette MB. **Cornerstone**. *The American Chiropractor*. Jul/Aug 1982; 82: 22,23,28,34.

2. DeJarnette MB. **The Sacro Occipital Technique Bulletin**. Mar 1975.

3. DeJarnette MB. **The Sacro Occipital Technique Bulletin**. Mar 1978: 2-3.

4. DeJarnette MB. **The History of Sacro Occipital Technic**. Private Practice: Nebraska City, NB. 1958:27.

Evidence-Based Practice

Evidence-based practice (EBP) refers to a decision-making process which integrates the best available research, clinician expertise, and client characteristics. EBP is an approach to treatment rather than a specific treatment.

Evidence-based practice (EBP) involves complex and conscientious decision-making which is based not only on the available evidence but also on patient characteristics, situations, and preferences. It recognizes that care is individualized and ever changing and involves uncertainties and probabilities [1].

EBP develops individualized guidelines of best practices to inform the improvement of whatever professional task is at hand. Evidence-based practice is a philosophical approach that is in opposition to rules of thumb, folklore, and tradition. Examples of a reliance on "the way it was always done" can be found in almost every profession, even when those practices are contradicted by new and better information [1].

> "*It's about integrating individual clinical expertise and the best external evidence* [2]."

However, in spite of the enthusiasm for EBP evinced over the last decade or two, some authors have redefined EBP in ways that add other factors to the original emphasis on empirical research foundations. For example, EBP may be defined as treatment choices based not only on outcome research but also on practice wisdom (the experience of the clinician) and on family values (the preferences and assumptions of a client and his or her family or subculture) [1].

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1. Buysse V, Wesley PW. **Evidence-based practice: How did it emerge and what does it really mean for the early childhood field?** *Zero to Three*. 2006;27(2), 50-55.

2. Sackett DL, Rosenberg WMC, Muir Gray JA, Haynes RB, Richardson WS. **Evidence based medicine: what it is and what it isn't.** *BMJ.* 1996;312:71-72.

Evidence Based Practice: The Hierarchy of Evidence

In biomedical science there is general agreement over an evidence based hierarchy: the higher up a methodology is ranked, the more robust and closer to objective truth it is assumed to be. The orthodox hierarchy looks something like the following table:

Rank:	Methodology	Description
1	Systematic reviews and meta-analyses	Systematic review: review of a body of data that uses explicit methods to locate primary studies, and explicit criteria to assess their quality. Meta-analysis: A statistical analysis that combines or integrates the results of several independent clinical trials considered by the analyst to be "combinable" usually to the level of re-analyzing the original data, also sometimes called: pooling, quantitative synthesis.
2	Randomized controlled trials	Individuals are randomly allocated to a control group and a group who receive a specific intervention. Otherwise the two groups are identical for any significant variables. They are followed up for specific end points.
3	Cohort studies	Groups of people are selected on the basis of their exposure to a particular agent and followed up for specific outcomes
4	Case-control studies	"Cases" with the condition are matched with "controls" without, and a retrospective analysis used to look for differences between the two groups.
5	Cross sectional surveys	Survey or interview of a sample of the population of interest at one point in time.
6	Case reports	A report based on a single patient or subject; sometimes collected together into a short series.
7	Expert opinion	A consensus of experience from the “good and the great.”
8	Anecdotal	An interesting story.

Evidence Informed Practice

The term evidence based medicine (EBM) has traditionally been used to describe a means of treating patients based on research published in biomedical journals. Even though EBM also incorporated expert opinions and a doctor's clinical experience, it was common that insurance companies and other agencies - presumably seeking to protect patients or save money - would focus solely on the randomized controlled trial as the backbone of EBM.

When EBM appeared to be too restrictive or just clearly misinterpreted new terms such as Evidence Based Practice and now Evidence Informed Practice (EIP) have appeared. The value of EIP is that it takes research into account when making a clinical decision but also utilizes patient values and preferences, risk benefit ratio of related or chosen therapy, and the doctor's clinical experience. Because this represents a clearer depiction of an actual clinical experience and at the same time seeks to offer the patient the highest level of care, the belief is that EIP is the best of what EBM has to offer.

It is important that a practitioner is aware of the current research on effectiveness of their care so that they do not inadvertently make false or exaggerated claims regarding the potential benefits of the treatment rendered. Therefore keeping up to date on the research and literature, while time consuming, is an ethical obligation of doctors in practice.

Ideally doctors practicing EIP would best be able to predict and provide outcome expectations against which progress could be measured. In essence we all, as patients or doctors, should receive or offer treatment based on research and clinical experience. New research can uncover therapeutic interventions or benefits of certain types of care that were never before discovered. Also this research may determine that prior care that was customarily rendered is now inappropriate.

The challenge with chiropractic and its various techniques is that we are functioning from a situation where we have limited funds and limited methods to adequately study our innovative therapeutic applications. This conference attempts to offer a tempered and reasonable voice for practitioners on the forefront of care, such as has been the case with Sacro Occipital Technique (SOT) for years. Incorporating current research performed in the patient's best interest with one's own clinical experience is the hallmark of a responsible and ethical physician. Allied healthcare practitioners, chiropractors, and particularly SOT doctors have a responsibility to lead the way with EIP and focus first and foremost on patient based care.

Major Bertrand DeJarnette DO, DC developed SOT with outcome based assessment protocols and with research accountability as its backbone. The onus is upon us, those who learn and utilize his methods, to be informed of the evidence and evolving research and utilize this in the clinical application of SOT and its related methods.

The Case Report: How the Doctor in Practice Communicates to the Research Community

While low on the evidence-based practice hierarchy of evidence the case report is an extremely valuable manner for doctors in clinical practice or "in the trenches" to communicate what is taking place in their practices. Until the doctors in clinical practice publish their case reports, researchers in a college setting can only attempt to guess what is taking place out there in the field.

There are significant limitations to case reports, such as no control subjects, the doctor and subjects are not blinded to the study, and the doctor's bias may cloud the study. So while the case report is an important tool for communication, the doctor authoring these studies needs to exercise caution to not over-interpret his or her findings. Dr. Robert Ward of Southern University of Health Sciences and past editor of *The Journal of Chiropractic Education* answers the question:

"Why it is important to write a case report?"

"Most persons believe that the case report is used to describe unique, or at least highly rare, clinical presentations or diagnostic entities (e.g., "prostatic hypertrophy mimicking as ingrown toenail"). This is the most common use of the case report. However, equally important is the use of the case report to describe novel management approaches to more ordinary conditions.

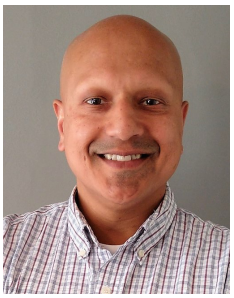
"Another aspect of why case reports are written involves the audience. Case reports are generally considered as a communication from clinicians to scientists. The pointy-headed ivory tower population doesn't get to see the interesting things that happen in clinical practice. They often rely on case reports from the field in deciding what sorts of pilot studies to run, and those often lead to real full-scale clinical trials (the sort of research that field clinicians generally don't have the time, resource or interest to undertake).

"Case reports are a vital aspect of our literature base, and more of our practitioners need to write them. Until you write up that wonderful method that works in your office, the rest of the world cannot share in its benefits. Without publication, when you die or retire, your discoveries die with you [1]."

1. Ward RW. **Why it is Important to Write a Case Report**. *Dural Connection Internet Edition*. 2006;3(3). [http://soto-usa.com/writing-a-case-report/] Last accessed April 30, 2018.

SOT Research Conference Proceeding Author Biographies
(Listed in alphabetical order)

Olga Alvarez, DC, CSP, CSCP is a family wellness Chiropractor in Hoboken, NJ. She is certified in the Webster Technique, the Sacro Occipital Technique and completed advanced certification in craniopathy. In seeking to elevate care for infants and dyads, she became a Certified Breastfeeding specialist. Dr. Alvarez was chosen by New Jersey Family magazine as one of "New Jersey's Favorite Kids' Doctors" in 2018-2022.



Ramneek S. Bhogal, DC, DABCI graduating from Palmer College of Chiropractic in 2002, Dr. Bhogal has been active in both education and private practice and is currently the Associate Dean of Academics in the College of Chiropractic at Life University in Marietta, GA. His diverse academic and curricular focus revolves around chiropractic technique and neuromuscular skeletal diagnosis, and functional nutrition. Dr. Bhogal blends his academic background with clinical experience and helps patients that have been labeled "complex cases". Dr. Bhogal is published in several peer reviewed journals, published in a chiropractic textbook, serves on the Scientific Review Board for DaVinci Labs, and on the Editorial Board of the Natural Medicine Journal.

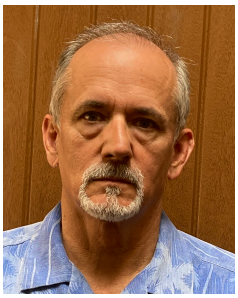
Thomas Bloink, DC, CSP, CSCP specializes in cranial-dental integration in Silicon Valley at the California Cranial Institute, which was founded in 1992. Dr. Bloink was on the board of advisors to help create SOTO USA and is actively involved in promoting the organization, presenting at research conferences throughout the world, and developing novel treatment approaches for functional neurological conditions. He works closely with many different specialists including dentists, orthodontists, and oral-maxilla surgeons. ENT's and others to ensure the best possible outcome for his patients.

Charles L. Blum, DC, CSP, CSCP is in private practice Santa Monica, California and past president of SOTO – USA, now their research chair. Adjunct research faculty at Cleveland Chiropractic College, associate faculty at Southern California University of Health Sciences and Palmer College of Chiropractic West teaching the SOT Elective. Dr. Blum is a Certified SOT Cranial Practitioner, and on the peer review board of the Journal of Craniomandibular and Sleep Practice (CRANIO), Association of Chiropractic College Conference Peer Review Committee, and Journal of Chiropractic Medicine. He has lectured nationally and internationally, has written various SOT related texts, compiled SOT and cranial related research, and has extensively published in multiple peer reviewed indexed journals and at research conferences from 1984 to the present.

Jeffrey D. Blum is a graduate student completing his Master of Arts (MA) in Clinical Mental Health Counselling, with a concentration in *Somatic Counseling: Body Psychotherapy* from *Naropa University* in Boulder, Colorado. He is currently doing his clinical internship at the *University of Colorado* Boulder as an *Alcohol and Other Drug Early Intervention Facilitator*. Additionally, he has coached rock climbing for the last 10 years, working with children and adults to help support present moment experience and arousal regulation.

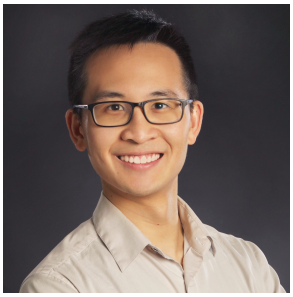
William J. Boro, DC has been in private practice in Annapolis, Maryland for over 30 years. Dr. Boro uses sacro occipital technique, applied kinesiology, and Van Rumpt technique, in addition to using other standard methods of diagnosis, for the evaluation of structural, chemical and mental aspects of health. He is intent on increasing other doctor's knowledge and understanding of how chiropractic is beneficial in cases other than strictly musculoskeletal problems. He has taught and presented papers nationally and internationally and looks forward to presenting more case studies in the future.

Laura Brayton, DC, CSP, CSCP, CACCP, is a graduate of New York Chiropractic College and the I University of North Carolina at Chapel Hill. As a holistic chiropractor and speaker, she holds certifications in Chiropractic Pediatrics, Webster Technique for breech presentation, Sacro-Occipital Technique (S.O.T.), Craniopathy, is an advanced level practitioner of Nambudripad's Allergy Elimination Technique (NAET) and a Tupler Technique® trainer. She is the owner and founder of Hoboken Family Chiropractic + Wellness, in Hoboken, New Jersey.



Richard C. Gerardo, DC, CSP, CSCP has been in private practice in Burbank, California, since 1985 and in the past years with a second private practice in Thousand Oaks, California. He is a certified Sacro Occipital Technique Cranial Practitioner and a Cranial TMJ Specialist. He has lectured nationally for 25 years on the interdisciplinary approach to treating TMJ and associated issues. Dr. Gerardo has authored several published case studies as well as a paper on the Cranial Dental Functional Model and has co-treated over 3000 TMJ and orthodontic patients with numerous dentists over the last 25 years.

Michelle Greene, DC graduated from Cleveland Chiropractic college in December 1992. She has been practicing in the Los Angeles area since that time. She was introduced to chiropractic as a teenager while running with the Santa Monica Track Club. She continues to compete in the aqua-bike division of Triathlons and focuses her practice on combining soft tissue work with chiropractic adjustments.



Ethan Lee, DC, CSP, originally from Taiwan, moved to Seattle with his family at the age of 18. Immediately following graduation from Palmer Chiropractic College, Dr. Lee worked in an intense clinical environment focusing on nutritional protocols treating complex pain conditions such as Lyme, SIBO, and fibromyalgia. Aside from nutritional health, Dr. Lee utilizes kinesiology muscle testing and Vector Point Cranials to help patients maintain neuromuscular integrity. He has certifications in Sacro Occipital Technique (SOT) and Applied Kinesiology (AK) and is currently completing a PhD in Integrative Medicine.

Margie Mirell, Ph.D., LMFT has been a psychotherapist for over 37 years and is currently practicing in Santa Monica, California. She has a specialty in treating eating disorders, addictions and most recently, she expanded her expertise earning a Ph.D. in Clinical Sexology from Modern Sex Therapy Institutes. She has extensive training in Jungian dream work, relationship counseling, hypnosis at Semel Institute UCLA and Somatic Experience Trauma Therapy. Her clinical focus has been on the intersection of neuropsychology, affect regulation and the impact of family systems with a psychodynamic approach.

Jesse Nichols is a second generation Chiropractor and is currently a student at Parker University in his 7th Trimester. His chiropractic college studies are focused on post-partum sacropelvic recovery, and organizing sacro occipital technique (SOT) mini-seminars, supporting the SOT club and SOT elective class. He is currently taking a deep dive into studying SOT being mentored by his mother Keila Nichols, DC who has been a long time teacher and practitioner of this method of care.

Keila Nichols, DC has been practicing in the Northeast Dallas, Texas suburbs since 1989. She utilizes traditional chiropractic techniques, including Sacro Occipital Technique, Craniopathy, and Chiropractic Manipulative Reflex Technique (CMRT), as well as homeopathy and functional medicine. She enjoys spending any spare time she has with her 5 "almost-adult" children.

Lisa Stowell, DC focuses on the safest and most natural approach to chiropractic care ~ utilizing cutting edge techniques such as SOT (sacro-occipital technique). Having studied nutritional components of health related interventions she incorporates “Food First” as part of her approach to customize personal dietary needs. She also utilizes a computerized diet analysis for absolute personal dietary needs and goals. Besides head, neck and low back pain Dr. Stowell addresses conditions such as diabetes, fibromyalgia and even depression and fatigue.

Daniel Tuttle, DC, MSW, is both a Chiropractic Physician and Licensed Clinical Social Worker. He is a licensed QEEG Diplomate and has practiced Neurofeedback for 16 years. He led the first randomized control study on the effects of SOT chiropractic adjustments on the brain using qEEG analysis. He practices in Clearwater, Florida using both licenses to develop innovative methods of treating both the mind and body. Dr. Tuttle has extensive experience in treating patients utilizing SOT, cranial, and innovative TMJ treatment and assessment procedures.

Gilbert Weiner, DC is a graduate of New York Chiropractic College, now called Northeast College of Health Sciences in 1978 going directly to Puerto Rico to begin his private practice. There he had an interest in scoliosis and noticed various comorbidities, mainly temporomandibular joint disorders (TMD). Since beginning his private practice he has actively been investigating scoliosis, its cause and treatment.

A 5 ½ month old female successfully treated for plagiocephaly/brachycephaly with sacro occipital technique cranial protocols: A case report

Olga Alvarez, DC

Introduction: A 5 ½ month old female presented with a left head tilt, preference to look right and flattening along the right side of the head. Parents observed flattening at 2 months and shared she did not tolerate tummy time. At 4 months, she could roll from back to belly. Also noted, mother labored for 48 hours, baby's head was "lodged" into the mother's right hip, and was delivered via an emergency cesarean.

Methods/Interventions: Sacro occipital technique (SOT) Cranial and spinal chiropractic adjustments were performed which included: Left anterior sacrum, left occipital slip and flexion correction, vagus release on the left, dural release of atlas on the left, dural release of axis on the right, T1 adjusted into extension, bilateral shoulders and 1st ribs release, sphenobasilar, frontal-zygomatic, maxillary-zygomatic, fruit jar, bilateral sphenoid wings with the sphenomaxillary suture release, frontal bone molding and CSF technique.

Photographs and measurements using a Mimos craniometer and measuring tape were taken every 6th visit. After the 12 office visit a right internal frontal adjustment was added to deal with the patient's brachycephaly.

Results: Initially plagiocephaly measurements were improving, while the brachycephaly index increased so after the 12th visit right frontal adjustment was added which address the patient's left head tilt. The patient was treated for 5 months and during that time was seen for 23 office visit. As the patient's head measurements improved during that five month period of care her parents concurrently noted that she was reaching her developmental milestones.

Conclusion: With difficult births it is not unusual to have cranial compression causing plagiocephaly/brachycephaly type presentations, so implementing cranial measurements and taking photographs regularly can offer objective findings that are effective in monitoring patient progress. Cranial asymmetry may be a component in affecting childhood psychomotor development as well as optimal development of the cranium for neural function.

Treatment of a patient with cervicogenic and craniocervical related tinnitus: A case report

Thomas Bloink, DC, Charles Blum, DC

Introduction: A 83-year-old male patient presented with severe bilateral tinnitus, progressively worsening over the past 20-years. Initial examination revealed significant decreased cervical ranges-of-motion, particularly rotation and lateral flexion. Patient had a maxillary deficiency resulting in significant malocclusion. Evidence of clenching, significant mandibular tori was present, along with dysfunctional translation of his right TMJ.

Methods/Intervention: The patient received six-treatment with sacro occipital technique (SOT) protocols over a three-week period. Upon the first-treatment immediately after adjusting his C5, he reported profound reduction in left-sided tinnitus. He was referred to a dentist for a lower

mandibular splint to stabilize his TMJ and reduce inner ear pressure. He was treated once-a-week, three-weeks in a row by the dentist to balance his lower split with each visit preceded by chiropractic care at this office. Chiropractic treatment focused on his cervical spine, occipital region and associated TMJ/cranial distortions.

Results: After the sixth-visit his cervical spine ranges-of-motion improved dramatically with no left-sided tinnitus and a 75% reduction of right-sided tinnitus.

Conclusion: Further research is needed to determine if other patients presenting with tinnitus might respond to similar dental chiropractic care.

Treatment of a patient with cervicogenic related vertigo: A case report
Thomas Bloink, DC, Charles Blum, DC

Introduction: A 70-year-old female patient presented with persisting (months) unresponsive severe left neck pain and vertigo. The patient had been successfully treated at this office six-years earlier for left-sided TMJ dysfunction, so returned for an assessment when her symptoms became unbearable. Current examination revealed significant left-sided neck pain (C5-C7) without radiculitis. She also received treatment at Stanford Medical Center from an allopathic pain management doctor who diagnosed her with cervicogenic vertigo. He treated her with acupuncture and advised her to continue with chiropractic treatment.

Methods/Intervention: The patient received nine sacro occipital technique (SOT) treatments over a period of six-weeks. Along with SOT care, adjustments focused to C5, cervical-traction therapy, myofascial treatment to her left scalene muscles, and LED infrared therapy.

Results: Over the course of treatment as her neck pain diminished her vertigo symptoms diminished concurrently. By the sixth-week of treatment the patient reported no further vertigo symptoms.

Conclusion: It is difficult to rule out placebo effects, regression to the mean, or other confounders so further research is needed to determine what patients with cervicogenic vertigo might be good candidates for this collaborative care.

Successful comanagment of a patient with C7/8 nerve dysfunction scheduled for surgery: A case report
Charles Blum, DC

Objective: To discuss chiropractic and orthopedic surgical co-management of a patient with C7/8 nerve dysfunction scheduled for surgery.

Clinical Features: A patient presenting with right-sided C7/8 nerve dysfunction consistent with radiating neck pain, reduced grip strength and finger (4/5th digits) approximation/separation, and scheduled for orthopedic surgery. Chiropractic evaluation suggested there were also some

ascending (lumbar) and descending (TMJ) contributions to his cervical spine imbalance and a report was sent to his orthopedic surgeon.

Intervention/Outcome: Surgery was going to be performed if his pain increased or grip strength did not improve. He was treated with chiropractic using sacro occipital techniques for lumbo-cervical involvement, TMJ/craniocervical relationships, and using the cervical stairstep technique. He was given home exercises to stimulate his C7/8 nerve and cervical (Pronex) traction. Following the second office visit (2 weeks apart) he reported no pain and improved dynamometer graded grip strength. He was seen by his orthopedist a few days following the second office visit and surgery was cancelled.

Conclusion: During periods of time when a patient is awaiting surgery a trial of chiropractic care would seem prudent. Ideally chiropractic and orthopedic surgery collaborative care would be expected to yield greater patient outcomes.

Asymmetrical lumbar facets complicating a diversified HVLA lumbar side posture adjustment: A case report
Charles Blum, DC

Objective: How asymmetrical lumbar-facets complicated a diversified HVLA lumbar-side-posture adjustment in a patient.

Clinical Features: A 22-year-old male patient presenting with chronic pain, aching, and numbness following a chiropractic lumbar side posture adjustment. Since the trauma he had received multiple chiropractic and physical therapy treatments over a year, but his condition had not progressed so he was unable to work and quality of life was compromised. Assessment of presenting radiographs indicated he had asymmetrical lumbar facets and prior care did not take that factor into account. While the radiographs did show an intersegmental lumbar vertebral rotation the side posture adjustment multiple thrusts had been preformed into the coronal facet that ultimately limited the rotational correction.

Intervention/Outcome: Sacro occipital technique orthopedic block placement for lumbar rotation was used until related cervical indicators resolved. Following treatment he reported immediate pain relief and improvement of function for the first time since his trauma. However he was not able to remain long enough in the country for follow up care.

Conclusion: When a patient has a poor response to a lumbar side posture HVLA adjustment it may be important to radiograph the lumbar region to assess any facetal symmetry.

Grade three anteriolisthesis L5/S1 of a 28 year old female: A case report
Charles L. Blum, DC

Introduction: A 28 year old female patient presented for chiropractic care secondary to having a side posture lumbar adjustment to her lumbar spine causing

her severe lower extremity radicular syndrome and weakness. She was scheduled for a surgical intervention but was encouraged to be seen at this office for a second opinion.

Methods/Intervention: The patient was treated with sacro occipital technique orthopedic blocking procedures specific for anterolisthesis, release of psoas muscle tension to L5, suction cupping to draw L5 in a posterior direction, and a series of exercises seeking to encourage directing abdominal muscles to stabilize L5 in a posterior direction on all body movements.

Results: After 2 weeks of care the patient cancelled her surgery and after 2 months of care, seen 1-2 times per week she was fully functional with no limitations or pain of movement or lifting heavy objects. At the three month mark she was being seen once a month for supportive care and a follow-up x-ray was taken which revealed no change in the grade three anterolisthesis. A 10-year follow up MRI also revealed no change in the anterolisthesis, suggesting that her condition was stable.

Conclusion: The majority of anterolisthesis presentations are stable and this case illustrated a patient's positive response to conservative chiropractic care directed at reducing stress on the anterior "pull" of the vertebra and improving the posterior stabilizer muscle function. With some anterolisthesis cases it is important to focus more on improving function and less on whether or not a structural change will occur.

Emotional or Mechanical: Assessing for Referral and Co-treatment of Jaw Pain as a Body Psychotherapist

Jeffrey D. Blum

Temporomandibular Disorder (TMD) is a common and impairing form of musculoskeletal pain that involves chronic pain and tension of the jaw and facial muscles. In spite of its pervasiveness, TMD's exact causes remain uncertain and optimal treatments are undecided. Current evidence suggests that stress and emotional experiences may be related to experiences of TMD, and some research suggests that psychotherapeutic approaches may be beneficial for TMD. However, minimal research specifically examines how somatic therapy may be applied to TMD.

In this paper, we review current ways of defining TMD and methods of treatment. In addition, we look at how somatic theorists view these symptoms, and review evidence that suggests body psychotherapy could be a useful intervention for TMD, either on its own or in conjunction with other care. We offer suggestions and considerations for body psychotherapists when working with jaw pain.

Based on current research, it appears that body psychotherapy may be uniquely positioned to support clients with TMD, given its ability to help clients process their relationship to pain, bring awareness to underlying stressors, and support self-care practices. However, additional research is needed to further explore the potential benefits of body psychotherapeutic approaches for this

population, as well as the development of more accessible assessment tools to support body psychotherapists in working collaboratively with other allied health care practitioners.

Chiropractic care of a 6-year-old male child presenting with severe eye trauma: A case report
William J. Boro, MA, DC

Introduction: Eye trauma that causes the loss of vision in one eye for a young child can be devastating and finding any possible avenue for help is something all healthcare providers would want to investigate. A 6-year-old male child presented with his parents wearing an eye patch on his right eye. Apparently while playing in his back yard, he found a rusty knife on the ground, threw it at a tree, and it bounced off and hit him in his right eye obliterating his lens, damaging his cornea and retina. He was seen at John Hopkins University (JHU) Hospital and had 4 surgeries, told he would be blind in his right eye, and monitored him for 2 years without any treatment. After that time, glasses were begun to be prescribed.

Methods: Treatment included Directional Non-Force Technique, Sacro Occipital Technique, Applied Kinesiology, Clinical Kinesiology, and Ontological Kinesiology.

Results: Within 12 treatments during the first year of treatment he said to his father that he could detect movement, shapes and colors with his right eye. During treatment that has spanned over 7 years he has received 64 treatments, an average of 9 visits per year. While his vision was slowly improving at 6 years, at his parent's request, his visual acuity was re-tested at 20/125. Seven months later with glasses he measured at 20/70. At this time (2023) he is now a star pitcher in Little League and travelling baseball teams striking out 17 of 19 batters and is the 2nd or 3rd best hitter on his team. He is also the leading scorer (scoring 1/3 of the team's points) on his basketball team.

Conclusion: While JHU referred to this patient as a "statistical outlier" the positive gradual improvement that began with chiropractic care and progressed over the years suggests a possible temporal relationship. Greater study is needed to determine if other children or adults with visual disturbances might be helped with this type of chiropractic intervention.

2023 Annual World Congress of the Society for Brain Mapping and Therapeutics: Los Angeles, California
William J. Boro, DC

I recently attended and presented two case studies at the Annual World Congress of the Society for Brain Mapping and Therapeutics in Los Angeles, California. It was a four-day smorgasbord of presentations by and attended by physicians, scientists, policymakers, and industry to further the advances and applications in brain and spinal cord mapping and image guided therapies. The conference aimed to create synergy amongst interdisciplinary researchers and practitioners to understand brain function and the nervous system.

The audience included neuroscientists, neurosurgeons, neurologists, radiologists, pathologists, oncologists, chemists, engineers, stem cell and molecular biologists, nanotechnologists, pharmacologists, psychiatrists, psychologists, and rehabilitation medicine scientists, and two chiropractors. Unable to attend all the sessions, I mostly stuck with the section on Visual Processing where I presented "Practical Assessment Tools for Visual Dysfunction Analysis" to mostly a group of optometrists. I would highly recommend that everyone go the SBMT website (www.worldbrainmapping.org) and view the list of all the presentations.

Ehlers-Danlos Syndrome: Co-Treatment of SOT Chiropractic, The Tupler Technique and Microcurrent

Laura Brayton, DC

Introduction: This case study presents co-treatment of a chronic Category II patient with Ehlers-Danlos Syndrome (EDS) using sacro occipital technique (SOT) chiropractic, Tupler Technique and microcurrent. A 56-year-old female long-standing chiropractic patient had frequent exacerbations of her sacroiliac joints. She was referred to a specialist to rule out EDS as she had multiple hypermobile joints, including the sacroiliac (SI) joints and has a history as a dancer. She was definitively diagnosed with the EDS a few years ago. She began the Tupler Technique program to address diastasis recti that was contributing to her core weakness and pelvic instability.

Intervention: In addition to biweekly SOT chiropractic adjustments, patient began the Tupler Technique, which involves an 18-week program to address diastasis recti.

The Tupler Technique is a 4-step program that includes:

1. Specific Tupler exercises for strengthening the transverse abdominus muscle
2. Wearing and holding splints
3. Holding in on the transverse muscle on the work of everything you do
4. Getting up and down correctly

Additionally, Microcurrent (Dolphin NeuroStim) was utilized over her cesarean section scar as well as along her midline (linea alba) at every Tupler appointment (Week 1, 3, 6, 9, 12, 15, and 18) for scar mobilization and to strengthen the weak connective tissue along her midline. [See clinician's description of treatment rendered in the "Clinical Corner" section of these proceedings]

Results: Significant improvement was noted in patient's SI joint pain and dysfunction as well as improvement of the patient's diastasis recti that appeared to be affecting her core and pelvic stability.

Conclusion: Further research is indicated to determine if other EDS patients might benefit from this multi-interventional care incorporating SOT Chiropractic, Tupler Technique and Microcurrent methods.

Sacro occipital technique (SOT) cranial techniques incorporating myofascial tongue therapy for acute neck restricted motion: A case report
Richard C. Gerardo, DC

Introduction: A 72 year old man was referred to my office for non-traumatic induced acute neck pain and severe limited rand of motion of two weeks duration. He essentially awoke two weeks prior with a stiff neck that progressively stiffened up through the day and eventually "locked up," virtually not allowing him any motion. At his best during this time he might have no more than 10 degrees of movement. Other than the neck pain and stiffness he reported no other issues with his body thought he did have a history of global arthritic stiffness poor balance and has fallen several times recently

Methods/Intervention: Since the patient was so guarded and apprehensive with pain and limited motion, after a brief examination, it was clear that I wouldn't be able to use any forceful manual adjusting to his upper thoracic or cervical spine directly. Due to the limitations in what I could do therapeutically I experimented by using a tongue myofascial technique that I had developed. I had him stick out his tongue and focused care on the adjacent glossal myofascia as well as pulled and stretched his tongue in specific directions. He was seen three times and on the second and third visit I was able to incorporate some SOT procedures.

Results: After the first visit when the myofascial tongue treatment was applied we were both surprised that he had improved his cervical range of motion 10-15% immediately over 40% by the 2nd visit, which was also associated with decreased pain. After the second visit his range of motion was 80% improved and following the third visit he had full range of motion with no reports of pain. He was seen three times during a one week period. Patient also reported that his balance improved

Conclusion: This case demonstrates care of a patient with acute cervical spine pain and restriction unresponsive to chiropractic and physical therapy being treated with SOT techniques incorporating myofascial tongue therapy. With intractable patients incapable of receiving direct care for acute traumatic/nontraumatic neck pain further research into myofascial tongue therapy may be of value.

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60 year old female presenting in acute pain wheeled into an office on a dolly: A case report
Michelle Greene, DC

Introduction: A late-60s year old female was brought into the office on a dolly because she was in acute pain, completely incapacitated, and unable to be weight bearing. She reported that she had been out for a walk and bent to pet a cat when her hip seized up and she was unable to walk. She called her assistant who, along with her husband, got her onto a dolly and wheeled her into the office.

Methods/Intervention: With her husband and assistant we were able to get her off the dolly and prone on the treatment table. She was then placed on category three blocks according to sacro occipital technique (SOT) and permitted some gentle massage to her lower back allowing her body to relax somewhat. Her gluteus medius and piriformis muscles were goaded on the involved side and manual traction to her lower back was applied, while on the blocks, and then she was able to turn supine. From the supine position myofascial therapies were applied to the hip joint capsule and the surrounding musculature. Muscle testing revealed that her affected femoral head appeared to be displaced in a posterior direction so with her knee bent the femoral head was directed posterior-anterior.

Results: Following the supine femoral head adjustment the patient was asked if she would stand and was able to do so and walked out of the office without distress. She was seen for one follow up office visit and it appeared that her symptoms had completely resolved.

Conclusion: An incapacitated patient in acute pain responded to SOT category three blocking, traction, myofascial techniques, and femoral head adjustment. It was quite dramatic to witness a patient wheeled into the office on a dolly crying out in pain and then following treatment being able to walk out without demonstrating any distress.

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50 year old male overweight veteran presenting with acute low back pain, discopathy, and PTSD successfully treated with sacro occipital technique and myofascial techniques: A case report

Michelle Greene, DC

Introduction: A mid-50s male overweight (> 300 pounds) 6 feet tall veteran presented to the clinic for evaluation and treatment of acute lower back pain radiating down the posterior leg to the foot. As a veteran he also suffered from post-traumatic stress disorders (PTSD) and was on complete disability. Examination findings were consistent with disc pathology with radicular syndrome.

Methods/Intervention: The focus of care was solely on pain reduction and was initially treated as a sacro occipital technique (SOT) category three using blocks under her pelvis while prone. While on the blocks myofascial release techniques were applied to his lumbar paravertebral muscles until he noted more ease. A large myofascial contracture was found on one side of L3 that he reported was significantly painful but the trigger point was goaded until relaxation was noted. Next the lumbar spine was tractioned in rhythm with with his breathing,

Results: He returned in 2 days with more than 50% resolution of pain. He was seen 2 times a week for 6 weeks, however after the third visit he experienced a complete resolution of his pain. Care continued for 12 visits since he began exercising and fairly quickly dropped some weight. By the 6 week mark he increased his activity and during that time his condition stabilized and his pain had not returned.

Conclusion: A 50 year old male overweight veteran presenting with acute low back pain, discopathy, and PTSD was successfully treated with SOT and myofascial techniques. Further research is needed to determine if other challenging cases with patients suffering from acute low

back pain, overweight, and PTSD might benefit from this type of care. As a practitioner working with veterans it is very rare that someone actually puts their hands on them and actually touches the areas that hurt.

Sacro occipital technique care for a 7-year-old male patient with ADHD: A case report
Ethan Lee, DC

Introduction: Sacro-Occipital Technique (SOT) is a chiropractic technique that restores normal CNS function through correction of the cranial sacral respiratory mechanism. The aim of this case study is to explore the effectiveness of SOT in the treatment of ADHD symptoms in a 7-year-old male patient. The patient had been diagnosed with ADHD and was experiencing symptoms such as hyperactivity, impulsivity, thoracic pain, neck muscles tightness and afternoon fatigue from poor sleep quality.

Methods/Intervention: The patient underwent 4 sessions of SOT treatment over a 3 month period, with each session lasting approximately 30 minutes. [See clinician's description of treatment rendered in the "Clinical Corner" section of these proceedings]

Results: The results of this case study showed a significant improvement in the patient's ADHD symptoms. Parent reported a behavioral improvement on hyperactivity and impulsivity. Patient also reported no pain at thoracic region and no tightness at neck muscles. Additionally, the patient's parents reported a significant improvement in sleep quality and day time energy following the SOT treatment.

Conclusion: These findings suggest that SOT may be an effective treatment option for pediatric patients with ADHD. Further research is needed to confirm these results and to determine the optimal treatment frequency and duration of SOT for ADHD. Nevertheless, this case study provides initial evidence for the potential effectiveness of SOT in treating ADHD symptoms in pediatric patients.

Sexuality in Our 55 Year Old and Older Patient Population
Margie Mirell, PhD

I would like to share my insights from my doctoral dissertation, "Sexual Desire and Good Enough Sex in the Fifty-Five and Over Population." On extensive review I found a paucity of information on sexual health for this population subgroup. Therefore, I thought it would be very interesting to see the results if this population was encouraged to have healthy sexual desire. It is clear that as we transition through the aging process that our body's change and with that change our understanding of sexuality also needs to modify.

For heterosexual men and women, as they enter into their later decades of their life, it is often crucial to expand the concept of sexuality and sensuality beyond a penis and vagina. Sometimes men might need to look beyond the penis since their function might not be the same as when they were in their twenties and women might not have the same comfort levels with their vaginal

functioning. So my thesis sought to explore finding a way of supporting sexual desire in the fifty-five and older population by offering a different perspective to what might constitute romantic sexual intimacy. Therefore, when our patients hint that their sexual romantic life is not the greatest, how can we integrate some possible solutions into the conversation and support the whole person which includes their sexual health?

My study was a sample size of 200 male and female heterosexual adults addressing desire in this population. My intervention was a video explaining a basic psychological principle called "Good Enough Sex." After surveying these individuals, I found the "Good Enough Sex" [1-3] or as I call it the "Seduction of the Slow Dance" intervention had an overall positive impact on desire levels among all study participants, particularly for those 55 to 65. Solitary (self-stimulation) desire levels increased significantly for participants overall, those 55 to 65, those over 65, and men overall.

Based on these findings, I suggested that practitioners should infuse knowledge of "Seduction of the Slow Dance" into the medical practice, informing older patients about the potential benefits of embracing their transition into a different way of interpreting sexuality and sensuality. My study found that there is a need to educate men about specific aspects of "Seduction of the Slow Dance" aimed at meeting the needs of their female partners as well as educating women about how to meet the needs of their male partners. Furthermore, I posit that, as a psychotherapist specializing in sexology, we need to help normalize the sexual conversation for men and women in the older population.

When we apply the concept of transitioning to "Seduction of the Slow Dance," this takes the anxiety out of performance and focuses on sharing mutual pleasure. Pleasure requires mistakes. Pleasure requires understanding as we age that our sexual experience likewise needs to mature. Pleasure is how we make connections with ourselves and with the other. Sexuality with one's self or within a couple is about making connections with our whole body and spirit. It is about keeping the sexual organs of the body vital and stimulated. Science tells us that with masturbation or sexual play individual anxiety is reduced and healthy hormones are produced [4,5]. Therefore, an age congruent sexuality can lead to a healthier mind and body and, ultimately, the quality of life is improved.

The implications of renewed connections may reach beyond the bedroom and become part of fostering wellbeing for a population who even pre-pandemic suffered from an epidemic of loneliness. While more research is needed, it is not too much to claim that "Seduction of the Slow Dance" can and should be shared with people in the aging population in order to help foster their sexual and even overall wellbeing.

To learn about the "Seduction of the Slow Dance," instructional video that was used in my study please go to the following two links, one is the shorter and the other is the longer version. You may find this video of value personally or when indicated by sharing it with your fifty-five and older patient population. To view the video go to: mirellpsychotherapy.com/videos

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The effect of sacro occipital technique (SOT) category one procedures on Chiari type 1 and cystic syringomyelia: A case report

Keila Nichols, DC, Jesse Nichols, Chiropractic Student at Parker University

Introduction: The purpose of this investigation was to determine if sacro occipital technique (SOT) category one procedures, cervical stairstep technique, and cranial manipulation have an effect on a Chiari malformation with Cystic Syringomyelia. A 42 year old female noted that with cervical spine flexion she had symptoms of blurred vision, radiating pain, weakness and neuralgias of bilateral upper extremities (especially with coughing), cervicothoracic stiffness and pain, and tension at base of skull, head and jaws.

An MRI of cervical spine (March 2019) revealed a cystic syringomyelia of the cervical spinal cord from C3-T2, occupying the majority of the spinal cord from C6-T2. Chiari Type 1 malformation was also noted with inferior displacement of the cerebellar tonsils 7-8mm. The goal of care was to reduce cerebellar tonsil displacement, slow, halt, or reverse advancing development of spinal syringomyelia cyst, improve CSF circulation to cervicothoracic spinal cord and related nerve roots, thus reducing the patient's symptoms and improving mobility.

Methods/Intervention: Examination revealed anterior/posterior body standing sway with bilateral T1 costovertebral tenderness and hypermobility. With gentle pressure of the doctor's thumb over the prone patient's L5 spinous, found upon their coughing that the thumb "jerked" headward (SB- cough test) consistent with a sacrum restricted in counternutation/flexion. The patient's symptoms were aggravated with cervical traction, better with cervical stair step procedures and restricted motion was noted in the upper thoracic spine.

Treatment focused on basic one cranial technique, frontal occiput pumping, sphenobasilar range of motion, and cervical stairstep technique, which were performed to potentially reduce the drag on the cerebellar tonsils. SB- blocking with sacral base pressure on sustained exhalation and bilateral arm traction (by the patient) were repeated in sets of three when SB- cough test was indicated. This was performed in an effort to improve the craniosacral pumping mechanism and reduce dural torsion as well as improve cerebrospinal fluid circulation and meningeal function around the spinal cyst. Eventually, gentle osseous mobilization of the upper thoracic spine was successfully performed and the chiropractic manipulation was relatively effortlessly received. The patient was treated generally twice monthly between the first (December 2019) and last (November 2022) MRI.

Results: The inferior displacement of the cerebellar tonsils reduced from 7-8mm (December 2019) to 7mm (December 2020) then 6-7mm (November 2022). Syringomyelia remains unchanged (April 2019 – November 2022). Thoracic spine began gaining more mobility with SB- blocking technique preceding gentle osseous manipulation. By November 2022 she noticed significant improvement in upper extremity weakness, neuralgias, radiations, cranial torsion, cervicothoracic stiffness/pain. Unfortunately the symptoms that were unchanged were visual disturbances with cervical flexion.

Conclusion: This case illustrates conservative chiropractic care providing relief for a patient with Chiari type 1 and cystic syringomyelia. The patient has made good progress under care however warrants continued therapeutic surveillance since these conditions may be degenerative in nature, particularly if there is ever trauma either acute or chronic (e.g. ergonomic) to the upper cervical and cervicothoracic regions.

Chiropractic in a integrative medical health practice
Lisa Stowell, DC

On March 28th, 2022 I signed on with Wiseman Family Practice ~ an integrative medical practice in Austin, Texas. Wiseman Family Practice is one of if not the largest and most successful integrated practices in the entire state of Texas. It is a highly respected and sought after integrated practice for patients. I would hear great accolades about them while telling my friends about my experience going through the interviewing and hiring process.

By background was steeped with sacro occipital technique (SOT) since I studied and utilized SOT since I was an intern in college. I am blessed and grateful to have the great privilege to have studied under Drs. Charles Blum, David Simmons, Jeffrey Mersky and several of the other extremely talented chiropractic doctors who mentored me in my early years of chiropractic when I began my study of SOT, cranial adjusting, and chiropractic manipulative reflex technique (CMRT). Early on I also assisted Dr. Simmons when he was teaching SOT at the Southern California University of Health Sciences (SCUHS) in Whittier, California, since teaching is a powerful way of embedding knowledge and practicing chiropractic techniques such as SOT.

At Wiseman Family Practice patients are always amazed and impressed by my style ~ which I contribute all to the SOT method. They often tell me how my style is so inclusive and expansive

compared to any of the other chiropractic doctors they've ever been to and it makes my life meaningful and work satisfying to hear how I'm helping them with my services. As my patients improve and appreciate the care I render my allied health colleagues gain respect for what chiropractic can bring to interdisciplinary relationships.

Correction of Pigeon Toe or In-Toeing in a 2 ½ year old Female with Chiropractic Treatments: A case report.
Lisa M. Stowell, DC, Charles L. Blum, DC

Introduction: Pigeon-toe or in-towing is a relatively common condition in childhood causing the toes to point inward or feet to excessively internally rotate when standing or walking. While this condition usually resolves as the child ages it does appear to affect a child's gait, causing repetitive falls. Sometimes a child's self-esteem may also be adversely affected by this condition. This case report discusses care rendered to a 2 ½ year old female child presenting for chiropractic care with bilateral in-toeing in an interdisciplinary clinic.

Methods: Treatment was rendered that included "low force techniques," Sacro-occipital technique, and cranial techniques to address spinal, lower extremity, and postural imbalances ~ possibly contributing to the patient's in-toeing.

Results: Following the third treatment, the patient was able to walk with one foot pointing straight ahead and by the fourth office visit was walking and standing with both feet pointing straight ahead. Further care continues to sustain progress with intervals between treatment extended as the patient's progress is maintained.

Conclusion: This case may demonstrate a conservative, effective treatment for a subset of children presenting with in-toeing ~ particularly when watching and waiting is not preferred and the child's gait, repetitive falls, and self-esteem is being adversely affected by this condition.

40-year-old female presenting with chronic bruxism, menorrhagia and digestive issues successfully treated with sacro occipital technique methods and eye movement desensitization reprocessing: A case report
Daniel Tuttle, DC, MSW

Introduction: A 40-year-old female presented with chief complaint of bruxism (temporomandibular joint disorder – TMD), menorrhagia and digestive issues since childhood that had been treated by a variety of therapies including spinal manipulation, diaphragm release, naturopathy, homeopathy, Neuro Emotional Technique, and Nambudripad Allergy Elimination Technique. None of these therapies had a lasting effect on presenting symptoms. Sacro occipital technique (SOT) analysis showed category two presentation with significant restriction in the diaphragm and pseudohiatal hernia as well as multiple distortions in the cranium and teeth #18 and #27. After correction of these patterns her mouth guard was determined to be recreating the distortion of the cranium and she stopped using it.

The patient was effectively treated with SOT focused on category two correction, diaphragm release and cranial corrections, however relief would not last more than a few days. The same subluxation findings occurred over 16 visits in a four-month period with no lasting resolution. Further exploration of the patient's mental status showed symptoms of Post Traumatic Stress Disorder (PTSD). The patient agreed to undergo a treatment of Eye Movement Desensitization Reprocessing (EMDR).

Methods: The patient underwent 2 EMDR sessions. Chiropractic analysis was done before and after each session. Chiropractic adjustments were made as indicated after each session. There was a visit in-between the two EMDR sessions where a chiropractic correction was made. EMDR was done with bilateral tactile input through the hands at patient's preferred settings. As defined in traditional EMDR protocols, focus was on cognitions, emotions and somatic sensations around trauma.

Results: On the day of the first session of EMDR, the patient presented with the same category two, diaphragm and cranial-dental indicators. The reprocessing of the trauma was incomplete at the end of the first session and chiropractic analysis was repeated. All chiropractic findings before the session were gone after first session and a new finding of atlas subluxation was presented and corrected.

The patient displayed the same atlas finding at the next chiropractic visit which did not include EMDR. The atlas was corrected. The patient returned for another EMDR session the next visit and pre-EMDR treatment chiropractic analysis displayed the same atlas finding. Reprocessing was completed and post-reprocessing chiropractic analysis showed elimination of any subluxations and restoration of motion to the cranium.

The patient was tracked over a 6-month period with no recreation of any subluxation findings or symptoms she presented with. This included being under periods of high stress. She was treated for gallbladder dysfunction with Chiropractic Manipulative Reflex Technique (CMRT) and was co-managed with a naturopath with symptom relief when patient was compliant with care plan.

Conclusion: Chronic sacroiliac joint problems can present a challenge to the SOT practitioner. This case presented with concurrent symptoms of PTSD. Cases of bruxism chronic category two TMD cases should be checked for underlying emotional factors that may be contributing to their condition and referred to a licensed mental health professional when not responsive to chiropractic techniques.

Improvement in nasal turbinate and adenotonsillar hypertrophy and its concomitant symptomatology with pediatric chiropractic care: A case study

Gil Weiner and Timothy Murzycki

Introduction: Nasal turbinate and adenotonsillar hypertrophy appears to be common complaints for infants, toddlers, even adults. From a chiropractic standpoint, subluxation-based care that ensures optimal neural function can contribute to both immunological and hormonal balance.

This can be found to be a successful initial conservative low risk intervention as opposed to surgery. We present here a case study of a 4-year-old girl whose mother reports her experiencing, since birth, nasal turbinate and adenotonsillar hypertrophy with sleep and respiratory disturbances, dental bruxism, chronic upper respiratory tract infections, and behavioral issues.

Methods/Interventions: Subluxation-based care was rendered that utilized sacro occipital technique (SOT) pelvic block placement, orthopedic block adjusting of L3, and cranial techniques along with Thompson Technique leg check for pre and post assessment purposes. Also utilized at one visit was a diversified side posture adjustment with minimal general torque at L3, and sustained digital pressure with cervical spine range of motion assist to adjust any subluxated cervical vertebra. [See clinician's description of treatment rendered in the "Clinical Corner" section of these proceedings]

Results: The chiropractic care proved to be highly effective in a relative brief period of time. The results were documented and verified independently by the patient's otorhinolaryngologist and dentist who initially were unaware of chiropractic care.

Conclusion: Chiropractic care for the correction of pelvic, spinal, and craniofacial bone subluxations may provide a viable alternative to long term antibiotic treatment and surgical intervention for nasal turbinate and adenotonsillar hypertrophy. Further studies are needed to further corroborate these findings.

SOT Research Conference Invited Articles

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Blum C. Channeling healing energy: The value of compassion in the chiropractic clinical setting. Part one. URL Asia-Pac Chiropr J. 2022;3.2. [apcj.net/Papers-Issue-3-2/#CompassionCharlesBlum]

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Blum C. Channeling healing energy: The power of touch in the chiropractic clinical encounter, Part three. Asia-Pac Chiropr J. 2023;3.3 [apcj.net/Papers-Issue-3-4/#BlumHealingEnergy3]

Blum C. Building interdisciplinary relationships with chiropractic care of post-concussion syndrome patients: Incorporating salivary biomarker assessment. Submitted for Publication

Blum C. Safety considerations of using gadolinium as a contrast agent for MRIs: A Commentary. Submitted for Publication

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Operationally defined chiropractic care for a 6-year-old male child presenting with severe eye trauma

William J. Boro, DC, MA

The process of sharing my mindset and protocols to treat this patient with a traumatic visual disorder is an interesting one. What I am using is based on over 40 years of clinical experience which is a mix of methods I have learned and clinical intuition gained over that time. While I always attempt to utilize pre and post assessment tools to guide care and make sure my care is evidence based and focused, I realize that some of the care I rendered with this patient might leave many wondering about the exact protocols..

With that as a disclaimer I have studied with many chiropractic teachers over the decades including Van Rumpt, DeJarnette, Goodheart, Beardall, and Solihin Thom. These different teachers all had as part of their pre and post assessment process types of methods to "ask the body" with therapy localization, assessing functional motion, and even asking a question mentally. The checking of regions of the body by asking a question within my mind and assessing muscle strength and reactive leg lengths is the one that gave me great pause. I was reluctant to even consider using those methods but after a few decades of slowly trying that procedure and then monitoring patient outcomes, while I have no idea how it could work, I have seen positive patient outcomes from these procedures.

So with that as a backdrop I have been invited to share my thought process and try to operationally define the procedures I used and continue to use for a treatment regime of a patient with a lacerated right eye, obliterated lens and retinal damage with a prognosis of permanent blindness. The young male (date of birth November 2009) had been a patient since June 2010. His original complaints were ear infections and acid reflux and had received 24 treatments for other various and sundry childhood fevers and injuries through July 2015.

He was brought in on December 2015 with complaints of occasional knee and leg pain at night which interrupted his sleep. I inquired why he was wearing an eye patch on his right eye. The parents reported that on September 2015 he had been playing in the back yard, found a rusty knife in the grass, and threw it against a tree. It ricocheted off the tree and lacerated his right eye, obliterated his lens and damaged his cornea and retina. John Hopkins University (JHU) Hospital had performed 4 surgeries to repair the damage and told the parents to expect that he would be blind in that right eye the rest of his life. JHU monitored his condition for the first two years but offered no treatment. Within 12 chiropractic treatments at this office the boy said to his father that he could detect movement, shapes and colors. In December 2016, JHU commented "poor visual prognosis". At the request of his parents, JHU tested his visual acuity at 20/200. In June 2017 glasses were prescribed. In November 2019 it was noted that "some letter identification" was possible. He could read large (8") letters and was regaining peripheral vision.

His vision continued to improve. In February 2021 his new prescription was for 20/125! By September 2021 his acuity was measured with "shocking improvement" at 20/70 with glasses. JHU referred to him as a "statistical outlier." At this time (2023) he is a star pitcher in Little League and travelling baseball teams with a record of striking out 17 of 19 batters and is

the 2nd or 3rd best hitter on his team. He is also the leading scorer (1/3 of their points) on his basketball team.

From December 2015 to the present January 2023, he has received 64 treatments, an average of 9 visits per year. Analysis of subluxations were made according to Van Rumpt (1904-1987) the founder of Directional Non-Force Technique (DNFT) utilizing bone, joint, and muscle challenges and reactive leg reflex response, Sacro Occipital Technique's (SOT) method of analysis and treatment (DeJarnette 1889-1992), and muscle testing incorporating the works of George Goodheart (1918-2008) founder of Applied Kinesiology, Alan Beardall (1938-1987) founder of Clinical Kinesiology, and Solihin Thom (1950 -) founder of Ontological Kinesiology.

To understand treatment notes (see below) better, I will attempt to describe the procedures used and how to interpret the treatment notes below.

As stated above, I utilize Van Rumpt's challenges and reactive leg reflex response to determine where subluxations are and how to adjust. Van Rumpt discovered a reflex by a change in unilateral leg length when the ankles are rotated such that one foot is over-everted and the other foot is under-everted. Once this reflex is established, one can challenge any contactable tissue in the body to determine if nerve interference is present which will interfere with the inhibition of the reflex. A "challenge" is performed by contacting the tissue using a "positive' or 'negative" finger. The positive finger acts like a "pushing force" to the tissue and the negative finger acts like a "pulling force" to the tissue in the direction in which the challenge is being made.

If the tissue is "normal", not experiencing "nerve interference", then when a directional challenge is made to the tissue, the leg reflex when performed will function "normally" and there will not be any reactive short leg response. If there is "nerve interference" at the site of and in the direction of the challenge, then when the leg reflex is performed, one will see the reflex exhibited with a concurrent shortening of the leg, and it is assumed that a subluxation is present. A three dimensional corrective double thumb toggle thrust is then made to the "subluxated tissue" and it can be tested after the "adjustment" to ascertain that a corrective resetting of the neurology at that tissue has been made.

Manual muscle testing as developed by Goodheart allows the practitioner to identify "subluxated" tissues by therapy localization. Therapy localization, or touching a body area, when combined with testing a strong muscle can be utilized to identify a problem area of the body, if the muscle goes weak when tested.

Beardall developed a diagnostic technique involving what he called "the biocomputer". With the use of "hand modes" (or mudras) one can access the location of "bad data" being produced by aberrant sensors in the body. This "bad data" is received and/or stored in the biocomputer and used to produce "bad output" observable as abnormal function.

Thom, studied and worked with Beardall, modified Beardall's storage and processing 'locking mechanism' and simplified it to a tapping at the glabella three times at a rate of once per second. I expand the concept of therapy localization as a challenge to include any "testing" of the

nervous system which creates a “weak” muscle response. This “testing” might include a sound, thought, visual stimulus, taste, smell, “hand mode (mudra)”, movement and/or body position.

In combining techniques developed by Van Rumpt, DeJarnette, Goodheart, Beardall and Thom I have been able to come up with a protocol to work with my patients. Following collecting data from my examination of the patient, I begin by clearing the organo-musculo-skeletal system of “subluxations” as found using Van Rumpt’s challenges and adjusting procedures. Identifying where to adjust is determined by a scanning procedure utilizing a “positive” or “negative” finger to a body area followed by a specific reactive leg length comparison. For example, scanning the lateral aspect of the neck, bilaterally, and identifying the presence of a leg length shortening indicates the need to go back and challenge each cervical vertebra, muscle and disc separately to determine how to make a corrective adjustment. For example, if a challenge is made with a “positive” finger pointing laterally from the left side towards the right side of the neck, and there is a shortening of the leg, then one needs to make a corrective horizontal thrust to the left to remove the “nerve interference”. This scanning procedure can be utililized to any area of the body.

Once those “easy to find” subluxations are corrected, I would then dig a little deeper to find further interference patterns. Using muscle testing, I would then challenge the patient’s visual system checking for subluxations in visual convergence, eye tracking clockwise or counterclockwise, interference created by looking at an “X” or “//”, flashing a light into their eyes, and using colored films over their eyes. If any of these tests create a weak muscle response, I then would use the “glabellar tap” to lock in the interference pattern and using Van Rumpt or SOT analysis I would identify subluxations and correct them.

The next section of this report describes what was done in each of the treatment sessions. Following all the dates of service is a “Key to Abbreviations” to help interpret the therapies listed. For instance the following three examples will demonstrate the “decoding” over these visits.

1. On the December 2015 visit, adjustments were made to the sphenoid, frontal, parietal, temporal, nasal, zygomatic, maxilla, and mandible and occiput (using the acronym DRFM). Following the DRFM adjustment then adjustments were made to both iliums, sacrum, L5,4,3,2, T12 and its ribs and any discs (using the acronym LB), and then as indicated to his femur heads, psoas, quadratus lumborum, erector spinae and abdominal muscles.

2. On the March 2016 visit, the patient was challenged to follow my finger as it is brought from a distance of several inches towards the eyes to test for visual convergence. If a strong muscle weakened, this would indicate the need for correction. The test was repeated and immediately following the muscle weakening, the glabella was tapped three times at one second intervals to “store” the awareness of the “subluxation” created by convergence. Then utilizing Van Rumpt analysis, subluxations were located wherever they might be in the body. In this case, it was DRFM, and the craniofacial bones were corrected. Following that correction, LB subluxation was identified and corrected also utilizing both Van Rumpt and SOT protocols.

3. On the February 2020 visit, adjustments were made to correct DRFM; then a colored film with wavelength of 440 nm was placed over the patient's eyes, and a strong muscle tested weak, Van Rumpt analysis was performed and determined that a LB subluxation was present and an adjustment was necessary. In the same visit a 619 nm wavelength colored film was placed over the patient's eyes and using van Rumpt analysis subluxations were identified and adjustments were made to both femurs, tibias, fibulas and patellas and associated muscles. Then a 480 nm colored film was placed over the patient's eyes and subluxations were identified and a correction was made to C1, C2, and C5 (using the acronym UP C).

Below each treatment is described:

12/07/15	DRFM; LB
12/17/15	LB; GB/LIV
12/28/15	LB; BILAT LEG, FEM,& M'S
01/14/16	LB; E-CONV DRFM; E-CLOCKWISE BILAT A/FA
01/26/16	E-CONV LB; UP C; GB/LIV
03/14/16	E-CONV DRFM; LB
04/26/16	E-CONV DRFM; CAT II; ICV, LI, PAN; BILAT A/FA
06/17/16	DRFM, #LB
07/15/16	*E-CLOCKWISE T-6,8,10,12; E-X BILAT A/FA; CR REL
07/22/16	RED – LB; RED/GREEN R-EYE ICV, LI, GB; CR REL
10/12/16	**TL-EYES DRFM; EM
11/08/16	TEETH, MANDIBLE,MAX STRADDLE; LB; GB/LIV, LI, ICV (DR P)
12/26/16	CAT II, LB-S, GB/LIV
01/23/17	PERIPHERAL AND CENTRAL NS…
04/14/17	UP C, E-CONV T4,6,8,10; E-COUNTERCLOCKWISE SHOULDER GIRDLE; TEETH, MAX SPREAD AND MANDIBULAR SPREAD; (DENTIST SAID TEETH WERE CROWDING)
07/26/17	&E-CONV DRFM
11/13/17	LB; TEETH, MAXILLA, PALLATE SPREAD
03/29/18	LB
08/31/18	E-CONV ICV, LI, GB/LIV; E-// SHLDR GIRDLE; DRFM
12/17/18	#T3,5,7,9,11; DRFM
12/26/18	T2,4,6,8,10; #UP C; E-FLASH BILAT LEG, FEMUR
03/05/19	BILAT A/FA; E-FLASH (L-EYE) DRFM; GREEN/RED (R-EYE) BILAT LEG/FEM
06/03/19	***DRFM, UP C
06/10/19	&& 545nm DRFM; 3313 T4,6,8,10,12
07/03/19	***DRFM, MAX SPREAD, PTERYGOID, TEETH; BILAT LEG/FEM
11/18/19	UP C; #UP C; L-DISC; CR REL

11/26/19	CAT II; #LB; #DRFM
12/19/19	DRFM; GB/LIV; PSS; BILAT A/FA
01/09/20	#DRFM; #LB AND DISC
02/21/20	DRFM, FOOT, #T2,4,6,8,10 AND DISC
02/28/20	DRFM; 440nm LB; 619nm Bilat LEG,FEM ; 480nm UP C
04/08/20	LB; T11,9,7,5,3; E-CLOCKWISE LB
07/10/20	DRFM, UP C, #LB
07/16/20	UP C, #DRFM, BILAT A/FA, BILAT LEG/FEM
07/17/20	DRFM, UP C, UP D W/SUP,PRO,DORSI; #BILAT LEG/FEM
08/10/20	UP C, BILAT LEG/FEM; E-X T'S
09/18/20	*#*CENTERING UP C, T'S, DRFM; LB
10/09/20	T'S, ANT L DISCS, #LB
11/09/20	LB; UP C; #BILAT A/FA; #DRFM
01/26/21	LB; E-CONV UP C BILAT A/FA; E-CLOCK BILAT LEG/FEM
03/09/21	*# LB; #UPC, BILAT A/FA; 106 BILAT LEG/FEM
03/26/21	ICV, LI, GB/LIV, HH; LB; #UP C
04/21/21	LB; CAT II; E-// DRFM
05/18/21	BILAT LEG/FEM; T'S; ADRENAL-DRFM
06/10/21	LB; #T'S; UP C
07/21/21	LB; E-CONV DRFM; # UP C; MAXILLA AND MENTUM SPREAD, TEETH
07/29/21	# T'S; BILAT LEG/FEM; R-EYE-FLASH DRFM; L-EYE 41 T8,9
08/19/21	UP C; E-CONV LB; BILAT A/FA
09/16/21	#* UP C; MAX AND MAND SPREAD, TEETH; #106-LB; #357-DRFM; TOES
12/17/21	UP C; BILAT A/FA; E-CONV BILAT LEG/FEM; #317 BILAT LEG/FEM; #389 ICV/SI/SPL
01/13/22	LB; BILAT A/FA; UP C
01/18/22	BILAT LEG/FEM; UP C; LB
02/04/22	#LB; # T6,8,10
02/17/22	BILAT LEG/FEM; DRFM; E-355 T4,68,10, 12
03/18/22	DRFM; MAX & MANDIB SPREAD; E-CONV LB
04/14/22	DRFM; UP C; TEETH, MAX SPREAD; CR REL
05/10/22	LB; T3,5,7,9; #UP C
05/12/22	#UP C; BILAT LEG/FEM; #DRFM
05/17/22	LB; T4,6,8,10; #BILAT LEG/FEM; TEETH, MAX AND MAND SPREAD
08/10/22	T4,6,8,10,12; UP C; LB; CR REL
09/06/22	#468-LB; BILAT A/FARM; E-CLOCK BILAT LEG/FEM
10/07/22	LB; #BILAT A/FA; #T4,6,8,10,12
11/08/22	LB; T4,6,8,10; #UP C
01/05/23	LB; #BILAT LEG/FEM; #UP C

Key to Abbreviations

*	Fall/Concussion
**	Still has stitches in eye
***	Got hit in face with baseball
&	Started seeing slightly
#	Beardall Entry
#	Vertigo symptoms; centering for tonic neck, ocular, labyrhinthine, and ear reflexes
*#	Parents requested vision testing - improved to 20/125
#*	Vision is 20/70 with new glasses
E-X AND E-//	Visual challenge with X AND //
E-CONV	Eye Convergence Test
E-CLOCK OR COUNTER CLOCKWISE	Eye Function Following Challenge
E-FLASH	Flashlight to eye
GREEN/RED	Red, Green, Green/Red Colored Filters Covering Eye (440nm, 480nm, 545nm, 619nm, 106nm, 357nm, 3313nm) Colored Filters by Roscolux, Stamford, CT 06902
CR REL	Cranial Sacral Cranial Correction
DRFM	Adjustment to sphenoid, frontal, parietal, temporal zygoma, maxilla, mandible, and nasal bones
MAX AND MANDIB SPREAD	Manually spreading the maxillary and/or mandibular suture
LB	Adjustment to “LB pattern” – L5, L4, L3, L2, T12, sacrum, and iliums

UP C	Adjustment to C1, C2, and C5
L-DISC	Lumbar Disc
BILAT A/FA/ST/CL	Adjustment to shoulder girdle, including arms, forearms, strenum, clavicle
BILAT LEG, FEM	Adjustment to femur, lower leg and knee
ICV, SI, LI, GB/LIV, HH, SP	Organ adjustments
SUP, PRO, DORSI	Standing challenges of feet in supination, pronation, and dorsiflexion

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Addressing Soft Tissue Imbalances to Improve Alignment

By Laura Brayton, DC, CSP, CSCP, CACCP

As chiropractors, we are well aware of how a weak core can impact a patient's ability to hold a chiropractic adjustment. The strength of the abdominal and pelvic floor muscles, especially the transverse abdominis (TA), plays a crucial role in maintaining spinal and pelvic alignment. However, for most of the population, inactivity, poor posture, or incorrect exercises have caused these muscles to be deconditioned, and the rectus abdominis muscles are separated at the midline, called a diastasis recti. Although diastasis recti is very common because of pregnancy, nonpregnant adults and even children can also suffer from diastasis recti with symptoms including back pain, incontinence, digestive issues like constipation or bloating, and umbilical hernia. It is important to check every patient for diastasis recti if they are complaining of any of the previously mentioned symptoms.

Checking for Diastasis Recti

Professionals should look for two things when they check for a diastasis recti — the distance between the separated muscles and the condition of the connective tissue.

Most professionals check the distance of the diastasis at its smallest instead of at its largest because when they look for a diastasis, they ask the client to lift their head and shoulders. When the head and shoulders come off the floor, the muscles come closer together, and it is then examined at its smallest. Before assessing the distance of the diastasis, it is important to see if the person has a doming of their abdominal muscles when they lift their head or if they have an umbilical hernia. The presence of either or both conditions indicates that they need to be checked in a different manner. If they do have doming or a hernia, then the distance is evaluated on each side of the umbilicus. If they do not have it, then the distance is checked in the middle of the belly. Either way, the diastasis is examined in three places. It is checked at the umbilicus, above the umbilicus (halfway between the sternum and the umbilicus), and below the umbilicus (halfway between the umbilicus and the pubic bone).

Looking for a diastasis is done in a back-lying position with the knees bent. If checking on each side of the belly for a large diastasis, you use eight closed fingers with the fingers pointing toward the toes. The distance is evaluated after having them then relax their abdominal muscles and engage them by bringing their umbilicus to the spine. When they bring the umbilicus to the spine, the muscles will come closer together, and you will feel the ridges of the muscles. When they are relaxed again, you follow the muscles to where they go in a relaxed position. In this relaxed position, you are measuring the

separation at its largest. The muscles are engaged and relaxed several times so you can feel the movement of the muscles.

You do each side and then add the number of fingers together to get the total distance. If there is not a doming of the muscles or umbilical hernia, then you put 10 closed fingers in the middle of the belly and measure it the same way in the same three places previously mentioned. You start with 10 fingers, and can always take fingers out if it is smaller. When checking the condition of the connective tissue, the deeper the finger goes down into the tissue, the weaker that tissue is. Put the finger in the umbilicus with the abdominal muscles relaxed, and then see where the skin goes against the finger. This can be marked with a pen on the finger; shallow is up to 2 cm, moderate is around 4 cm, and deep is 6 cm or greater. The condition of connective tissue is checked in the same places above and below the umbilicus, like when checking the distance. You will know that the connective tissue is healing when it gets shallower, and the finger does not go down as far.

> ..." Since soft tissue attaches to the skeletal system, it is imperative for this support when addressing imbalances and subluxation patterns throughout the entire body...."

Treating Diastasis Recti Without Surgery

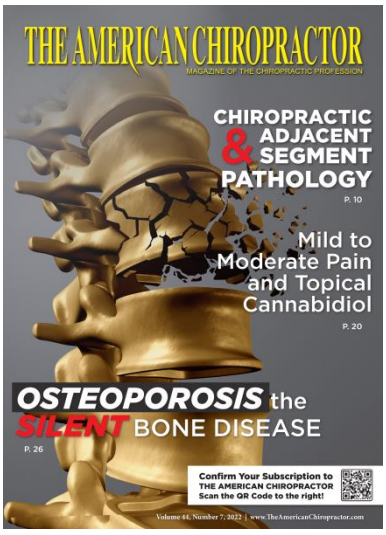
The good news is that there is a nonsurgical approach to treating diastasis recti called the Tupler Technique®. It is four simple steps that empower a patient to restore core strength, and therefore, effectively hold their alignment while weight bearing. Not only does this lead to less back pain and improved digestion, but the patient will also notice improved posture and theoretically decrease the degenerative joint disease progression that occurs when joints are receiving repetitive stress while misaligned. The outcome of the Tupler Technique® is to make the linea alba strong enough to hold the recti muscles in a close together position. It utilizes three key components in healing diastasis recti.

1 Repositioning both the separated muscles and the weak connective tissue. It is important to align the separated muscles close together so that both the muscles and connective tissue move in the sagittal plane when engaging the transverse muscle during activities of daily living and when doing the Tupler Technique® exercises. When the muscles are four fingers apart or more without being approximated, they move in a side-to-side direction instead of front-to-back direction. The connective tissue needs to be continuously put in a narrow position to take the stretch off it and allow it to heal.

2 Protecting the connective tissue from getting stretched in either a forward or sideways direction. To protect the connective tissue from getting stretched in a forward direction, the transverse muscle needs to be engaged during activities of daily living, exercise routines, and sporting activities. Also, exercises done in a downward-facing abdominal position should be avoided.

To prevent the connective tissue from getting stretched in a sideways direction, avoid activities where the back is arched. This flares the ribs, and besides stretching the connective tissue, makes it impossible to engage the transverse muscle. The forward crossover movement should also be avoided.

The American Chiropractor | **JULY 2022**



3 Strengthening the abdominal muscles and connective tissue with the Tupler Technique® exercises. Research on connective tissue by Dr. Helene M. Langevin, a neurologist at the University of Vermont, formulated a medical hypothesis suggesting that connective tissue might comprise an elaborate communication system within the body, which influences the function of all the other physiological systems. In her article, "Connective Tissue: A Body-Wide Signaling Network?" she explores the possibility that there might be a series of remote effects in seemingly unrelated parts of the body stemming from activity in the connective tissue. She also talks about the connective tissue generating electric currents through mechanical activity, including compression, which could change the cellular activity in any given interconnected parts of the body. Hypothetically, the compression in the specific Tupler Technique® exercises creates a microcurrent in the connective tissue, and that remodels and heals the connective tissue.

Proper Alignment While Weight Bearing

We all have seen those patients who are challenged when it comes to holding their chiropractic adjustments. They feel amazing when they get off the table, and after a couple of days, they slowly return to their old subluxated self. When joints are unable to "stay in place" after being aligned, we need to investigate the root cause(s).

In addition to addressing a weak core by knitting together a diastasis recti, patients also need to be checked for collapse of one or more arches of the feet. Like splinting the abdominal muscles to support the correct position of the soft tissue in a patient with diastasis recti, custom-made orthotics that provide three-arch support remind the fascia and connective tissue of where they are optimal. Since soft tissue attaches to the skeletal system, it is imperative for this support when addressing imbalances and subluxation patterns throughout the entire body. After all, it is *all* connected.

Laura Brayton, DC, CSP, CSCP, CACCP, is a graduate of New York Chiropractic College and the University of North Carolina at Chapel Hill. As a holistic chiropractor and speaker, she holds certifications in Chiropractic Pediatrics, Webster Technique for breech presentation, Sacro-Occipital Technique (S.O.T.), Craniopathy, is an advanced level practitioner of Nambudripad's Allergy Elimination Technique (NAET) and a Tupler Technique® trainer.

She is owner and founder of Hoboken Family Chiropractic + Wellness, in Hoboken, NJ. Follow her on FB and IG @drlaurabrayton and at www.drlaurabrayton.com.

Dr. Gerardo's Myo-Fascial Tongue Protocol
Richard D. Gerardo, DC, CSCP

The protocol has been developed as a response to the need of TMJ therapy to improve tongue function and reduce the need for, and the duration of myo-fuctional exercises. The problem that I experienced was how long it took to get any quantifiable improvement in tongue position or tongue function. The by-product of this technique is how it affects the cervical spine and the muscles involved in swallowing. The following is an overview of the method:

1. The procedure used on the case presented at this 2023 SOT Research Conference was performed with the patient in a seated position. The technique can be performed with the patient sitting or supine.

2. Patient is asked to stick tongue out, and with a gloved hand the doctor will attempt to pinch the tongue tip between thumb and index fingers, and stretch tongue anterior. Sometimes it helps to use a paper or cloth towel or face paper to grip the tongue and maintain a good contact to securely hold the tongue

3. With the doctor's other press on the lateral margin of the tongue with pressure medially, stretching the tongue between the 2 contacts (tip of tongue and its lateral margin).

4. While the tip of the tongue is being stretched the other contact is feeling for the tension by moving anterior and posterior along the tongue's lateral margin, creating tension from the root of the tongue to the tip, feeling for the release of the soft tissue attachments to the tongue.

5. It is often very hard to feel the release of the tension on the tongue. Therefore this should be done slowly and gently until you develop a feel for a release in the tongue and its related soft tissues. You must be aware of patient's pain tolerance and let them know it will be uncomfortable at the best and often painful.

6. Following releasing of the tongue (its tip, lateral margins, and root) then palpate and if indicated release any suprahyoidal muscle tension.

7. Place one finger under the chin while another intraoral finger pushes down on the floor of the mouth under the tongue, compressing and manipulating the myofascial soft tissues between the two fingers until a relaxation is palpated. Then continue around any suprahyoidal attachments and release any tension felt in the suprahyoidal muscles and surrounding soft tissue

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Sacro occipital technique and other care for a 7-year-old male patient with ADHD
Ethan Lee, DC

With this 7-year-old male ADHD patient the first two treatments focused on treating cranial aspects of his category two presentation. This patient presented with a positive arm fossa test, an

increased left sided psoas tension, and left knee medial knee tenderness to palpation. However the patient's legs were even so supine blocking was not performed but vector point work, trapezius fiber work, and cranial basic two was. Both his sternocleidomastoids and rhomboids were hypertonic as determined by a combination of palpation for pain and direct muscle tests and treatment was focused on having them relax and demonstrating reduced pain.

Many of the SOT doctors with whom I have studied discuss how category two can be a fundamental problem due to creating an over-sympathetic response from persistent sacroiliac joint (SIJ) instability. With this in mind, I routinely start with category two treatment and then go back to recheck my indicators. In the first couple office visits I prefer to focus on the dura mater tension so I always make sure the SIJ is stable and cranial bones and sutures are compliant. For SIJ stability, I also do direct muscle tests on all lower extremities including hip flexors, extensors, adductors, abductors, popliteus, tibialis, and peroneal muscles. If I see any muscle weakness I know there is some level of instability happening so I always recheck the category two indicators after treatment. With cranial tension, after utilizing the cervical stairstep to check range of motion at the neck, then sutural and cranial motion palpation is used to determine what part of the cranium needs more treatment.

I found both adrenal and liver chiropractic manipulative reflex technique (CMRT) reflex positive along with positive meridian pulse point evaluation, where were assessed by muscle testing. The patient's parents also mentioned the patient has a bowel movement every other day, sometimes every three days. With that, I recommended Body Guard Supreme from Supreme Nutrition Products to help stimulate some liver detoxification which I think may have been associated with his irregular bowel movements. Regarding adrenal function, the parent mentioned their child was a restless sleeper with nightmares and attention span drops throughout the day. To support his adrenal function Ashwagandha from Supreme Nutrition Products was recommended. The parent reported that the patient responded very well to the supplements. Within a week of starting chiropractic care and nutritional supplementation he began to have daily bowel movements and was no longer having any nightmares. Parents also noticed that his mood and attention were more stabilized throughout the day.

By the third office visit his arm fossa test was negative, there was no medial/lateral knee sensitivity, equal over the head arm check indicated balanced psoas, and leg lengths were even. So at this point I moved to focusing more on maintenance care. I started blocking the patient as a SB+ since he was still overly energetic, even though he had better ability to control his attention and energy. SB+ blocking I do believe helps reduce sympathetic dominance and helps to calm and stimulate some parasympathetic activity. In conjunction with the SB+ pelvic work I also focus on sphenobasilar symphysis technique cranial treatment which is found on cranial range of motion testing and corrected most commonly using indirect cranial techniques by contacts to the sphenoid and occiput.

At each office visit the parent reported that their child was more stable with their moods and activity. he had more regular bowel movement and the regions of his muscle tension had resolved. Following the fourth treatment the patient entered a phase of maintenance wellness care and has none of the initial ADHD behavior/tendency.

I always work with my patients to help them achieve their goals. Since everyone has different expectations of what their ideal goal might mean for their health, once the patient's main complaint is resolved and has no functional problem (patient is able to perform actions and activities they couldn't before due to pain or discomfort) that's when I usually let them know they are entering the phase of care I call “wellness maintenance.”

For a more generic patient base, if I see the patient able to hold the treatment (especially category two) for at least 4 weeks, then I consider their body stable. Many patients come in feeling some tension here and there, and with them I incorporate either massage, acupuncture therapy, home exercises, referral for Pilates, -- all to help them manage daily muscle tension and imbalance. I feel it is important that patients value their health and that they shouldn’t depend solely on me to make them feel "healthy." For some professional athletes and martial artists I work with, wellness care requires more. It means they are aiming for peak performance and that all muscles need to stay “firing” and performing with proper body mechanics. With these types of patient sometimes I see them more frequently, maybe once every other week. For some other patients, wellness care means they are ready to move forward to a more holistic improvement of their health which means they want diet and/or supplement recommendations with lifestyle modifications.

I try to meet my patients “where they are” and try to help them reach their healthcare goals. I always teach my patient that making the pain go away is the easy part. How to prevent the pain from returning is why extra assessments and evaluations are needed to better understand how their individual body works. Patients with a similar mindset resonate with this idea and are more than willing to take some responsibility for their own health status.

Clinical Corner: Improvement in nasal turbinate and adenotonsillar hypertrophy and its concomitant symptomatology with pediatric chiropractic care

Gil Weiner and Timothy Murzycki

When adjusting a small child there is a specificity and gentleness necessary as to keep the child engaged, yet not uncomfortable. This intervention is an eclectic approach to sacro occipital technique (SOT) and cranial techniques incorporating other chiropractic and osteopathic type methods and assessments.

The assessment and treatment process began with Thompson Leg Length checks. The Thompson Leg Check is performed with the patient prone. Legs are measured by the doctor at the medial malleolus. In this leg check the short leg is the center of observation. This, in my mind, links this test to SOT’s category one. Category two either the short or long leg will be key depending on the arm-fossa tests. Category three does not hinge solely on a short leg finding.
Upon finding the apparent short leg, the patient is then asked to turn the head facing to one side and then the other. If the short leg becomes equal in length to other leg, a cervical subluxation is indicated. This can also be found with gaze to left (Left Cervical Syndrome), right (Right

Cervical Syndrome) or both (Double Cervical Lock). Thompson observed and conceptualized that the turning of the head will exacerbate the cervical subluxation and hence cause dural torque and a subsequent short leg.

The increased tension on the dural reciprocal tension membrane will affect the motion of cranial bones, which are especially of interest in this case. The torsion will be passed throughout the meningeal structure through to the sacral anchor of the meninges. The system will reduce the meningeal tension, through the postural reflex arc, by altering pelvic position; hence changing apparent leg lengths. A second link between Thompson Leg Check (TLC) and SOT category one, is that both are primarily evaluating dural torque.

Finally, Thompson requires secondary check where the legs are flexed at the knee, bringing the patient's legs to 90 degrees. If the apparent short leg remains short; it is considered a "negative." If, however, the legs become equal or the short leg is now measuring longer at the 90-degree flexion, this is considered a "positive" indicating a sacral complication which could be rotational and/or flexion/extension - nutation/counternutation.

Upon finding the presence of a cervical syndrome in the patient treated in this case study, we understood that the cervical subluxations were primary to the patient's pelvic subluxations and therefore should be cleared first. Treatment was initiated with soft tissue correction of the cervical subluxations. Adjustments were performed by sustained digital pressure with cervical spine range of motion assist. When palpation indicated the release of the cervical subluxation(s), the leg checks were reevaluated. In this case leg length changed very subtly. However, heel tension and hamstring weakness persisted. Therefore the patient was blocked as a category one after the cervical subluxation(s) were corrected. At this visit the patient was blocked as a category one and their 3rd lumbar was adjusted while on pelvic blocks with respiratory assist into the spinal curve's concavity. Thoracic spine subluxations were adjusted with digital pressure using a respiratory assist.

On the second visit having noted a positive response in the patient and her mother's report, we repeated the day one routine. The cervical syndrome was still present along with category one findings so these were treated and we found this pattern to be successful. Later in care, when the child came with an acute flare-up, and had a fever and sore throat, we utilized a low force adjustment finding L3 again subluxated though the SOT categories had remained balanced and unremarkable.

The L3 adjustment was in side posture with minimal general torque at L3. Following the L3 adjustment the patient assumed a prone position and thumb pressure with respiratory assist was applied at T10. Then the patient was turned supine and C1 and C2 were adjusted with pressure and range of motion assist until palpable resolution of subluxation was noted, sometimes accompanied by a subtle cavitation sound. As this slightly more aggressive technique was effective in reducing inflammation within 24-48 hours, and was well tolerated by the patient we continued in this mode of adjustment.

At each treatment cranial and craniofacial structures were assessed for distortions, asymmetry, and general orientation. Intraorally, the soft and hard palate were observed. In the soft palate the

palatoglossal arches were observed anteriorly, and the palatopharyngeal arches posteriorly. We assessed the position of the uvula, evaluating intraoral tissue tensions and structural balance. The position of uvula can also be an indicator of vagus nerve integrity. The hard palate was examined observing the palatine process of maxilla and the midline suture. We assessed equality of the palatine processes and horizontal plate in size, orientation, and arch dimensions with special attention given to symmetry. These assessments provided insight into possible orientation of vomer, ethmoid, and sphenoid. Since in this particular case we did not initially find cranial distortions no cranial manipulation was introduced, so we continued forward with the understanding that the problems in this case were likely spinal in nature.

SOTO-USA Research Update

SOTO-USA is dedicated to bringing you the most updated and comprehensive research relating to Sacro Occipital Technique (SOT). Research is the future of chiropractic and SOT. Publishing this research sets the foundation for the future of SOT and protects its future worldwide. Understanding the published research allows us to grow, learn and modify our technique and diagnostic methods to fit our discoveries and stay current in the scientific community. The research department of SOTO-USA is goal oriented and focuses on action and results. **Please consider a tax-deductible donation to SOT research so SOTO-USA can help us further SOT's prominence in chiropractic healthcare**.

SOTO-USA is an organization dedicated to the advancement of SOT and the work of Major Bertrand DeJarnette, DO, DC. One of the many ways in which we at SOTO-USA contribute to the chiropractic profession is through the publishing of articles, newsletters, compendiums, and manuals relating to the art, science and philosophy of SOT (please visit our website for a complete listing of publications: www.SOTO-USA.org).

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Thomas Bloink, Charles Blum. Treatment of a patient with cervicogenic related vertigo: A case report. J Chiropr Educ 2022;37(1):3.

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Charles Blum. Benign joint hypermobility (BJHS) and sensory processing sensitivity syndromes (SPSS): A survey of patients over 5 years. J Chiropr Educ 2022;36(1):59.
Charles Blum. Sacro Occipital Technique assessment and treatment of two patients pre and post bilateral hip replacement surgery: Two case reports. J Chiropr Educ 2022;36(1):59.

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The SOT Research Conference Proceedings (Now indexed and searchable!)

Many of the SOT Research Conferences have now been or will be published in the Annals of Vertebral Subluxation Research as well as in the Asia Pacific Chiropractic Journal and are available for searching through chiroindex.org (a major chiropractic search engine).

1st Annual Sacro Occipital Technique Research Conference Proceedings. Las Vegas, Nevada October 22, 2009. Annals of Vertebral Subluxation Research ~ Sept 29, 2011 ~ Pages 104-132.

2nd Annual Sacro Occipital Technique Research Conference Proceedings. New Orleans, Louisiana 2010. Annals of Vertebral Subluxation Research ~ October 17, 2011 ~ Pages 133-164.

3rd Annual Sacro Occipital Technique Research Conference Proceedings. Nashville, Tennessee May 19, 2011. Annals of Vertebral Subluxation Research ~ Nov 10, 2011 ~ Pages 165-182.

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11th Annual Sacro Occipital Technique Research Conference, Nassau, Bahamas, February 27 – March 1, 2019 Ann Vert Sublux Res: Jan 2020(2020:): 1-10

Many thanks go to the editors of the Annals of Vertebral Subluxation Research, Drs. Pamela Stone and Matthew McCoy for their continued support of chiropractic clinical research and SOT is greatly appreciated.

13th Annual Sacro Occipital Technique Research Conference, New Orleans, LA April 27, 2022. Asia Pacific Chiropractic Journal. Third Quarter July 2022; Issue 3.1. [https://www.apcj.net/sot-abstracts-2022/]

14th Annual Sacro Occipital Technique Research Conference, New Orleans, LA April 28, 2023. Asia Pacific Chiropractic Journal. [in print]

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At the inaugural 2009 Sacro Occipital Research Conference, Las Vegas, Nevada we had 28 abstracts accepted. At subsequent Sacro Occipital Research Conferences many of the submissions have led to paper submissions to various other research conferences and peer review journals. All SOT practitioners and allied healthcare partners are encouraged to be a part of our future research conferences. Check the SOTO-USA website [www.SOTO-USA.org] or be aware for the call for papers.

Our ongoing commitment continues into the future with papers submitted to chiropractic and allied healthcare conferences and journals. One of the easiest ways research can be facilitated by a doctor in clinical practice is through the publishing of individual research papers and case histories. These lay the groundwork for future research directions and projects. If the need arises, we will be happy to assist the doctor in writing the paper or case history in order to get it submitted for publishing.

Please take a moment to review our landmark SOT and cranial research conference proceedings and texts, which will eternally preserve SOT and related published research. These can all be purchased online at www.soto-usa.org or by calling (336) 793-6524.

1st Sacro Occipital Technique Research Conference Proceedings: 2009.

2nd Sacro Occipital Technique Research Conference Proceedings: 2010.

3rd Sacro Occipital Technique Research Conference Proceedings: 2011.

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9th Sacro Occipital Technique Research Conference Proceedings: 2017.

10th Sacro Occipital Technique Research Conference Proceedings: 2018.

11th Sacro Occipital Technique Research Conference Proceedings: 2019.

12th Sacro Occipital Technique Research Conference Proceedings: 2019.

13th Sacro Occipital Technique Research Conference Proceedings: 2022.

14th Sacro Occipital Technique Research Conference Proceedings: 2023.

In Print:

The Compendium of Sacro Occipital Technique**: *Peer-Reviewed Literature 2000-2005.***

The Compendium of Sacro Occipital Technique**: *Peer-Reviewed Literature 1984-2000.***

The SOT Collection: *To the Year 2000.*

The SOT Collection: Supplement: *To the Year 2000.*

Coming Soon

More than forty years ago, Major Bertram DeJarnette encouraged Nebraska City newspaperman Ivan Beaumont to write a biography of his life. The doctor shared stories and documents with his hometown friend, and a rough draft was written. Each of the busy men added a few notes, but as time and interest slipped away, the stalled project was shelved.

Complete with sign, Dr. DeJarnette's office at 722 Central Avenue in 1936

Although information from the unfinished manuscript found its way into articles and time-lines over the decades, this fascinating investigation of Dr. DeJarnette's formative years and early influences has been gathering dust until now.

The title of the biography was and will remain "The Making of a Chiropractor," because its focus is on the people, places and events that put "the Major" onto the road to his destiny. For those elements of the book that were sketched out too vaguely, our editor's thousands of hours of sleuthing has uncovered details that clarify many misunderstandings and fill in details that have been missing in the history of Dr. DeJarnette.

We're sure you'll find "The Making of a Chiropractor" fascinating to read, and that it will provide you with an intimate look at a man whose research and guidance continues to help ease the suffering of millions.

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