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CLINICALEVIDENCE
Peer-reviewed Case Report

Sacro Occipital Technique (SOT):

Gastroesophageal Reflux Disease (GERD) ~ A Case Report

Harvey Getzoff

Narrative: The objective of this paper is to study the Sacro Occipital Technique (SOT) Chiropractic care of a female patient experiencing a chronic sore throat, persistent heartburn and at times difficulty swallowing.

Additionally, she reported various digestive symptoms such as abdominal cramping and bloating along with some upper abdominal pain.

The patient had been experiencing these signs and symptoms for approximately four years, during which she was medically diagnosed with Gastroesophageal Reflux Disease (GERD) and has been receiving medical treatment for this condition.

Author note: It is my hope that this case report "will serve as a mini tutorial for others" (1) not only those caring for patients with Gerd but also for chiropractors adjusting patients with other organ and spinal related problems.

Indexing Terms: Sacro Occipital Technique (SOT); MB DeJarnette DC; Occipital Fibers; Chiropractic Manipulative Reflex Technique (CMRT); Gastroesophageal Reflux Disease (GERD).

Introduction

> *… This paper studies a successful outcome (a reduction of the signs and symptoms) of a patient experiencing the effects of GERD that was treated by SOT Chiropractic methods. …'*

GERD is most often caused by changes in the barrier tissue between the stomach and the esophagus, known as the lower esophageal sphincter (LES). '*The LES typically keeps the top of the stomach closed, preventing the acid content of the stomach from ascending back up into the esophagus*', (3) where it can cause burning, inflammation and damage to the sensitive esophageal tissue. '*GERD is a condition where the acid in the stomach washes back, ascending into the esophagus*'. (4) '*Since the esophagus lacks the protective mucosal lining of the stomach it is easily irritated by the digestive juices*'. (5)

The medical diagnosis is usually based on the patient's presentation and symptomatology. (3, 4) The usual medical treatment for Gerd includes lifestyle modifications, medication and possibly surgery. Initial medical treatment often involves a protein pump inhibitor, such as Omeprazole (Prilosec). '*Omeprazole is used to treat certain conditions where there is too much acid in the stomach. It is used to treat gastric and duodenal ulcers, erosive esophagitis and gastroesophageal reflux disease (GERD)*'. (4)

SOT Chiropractic

SOT was founded and developed by Dr MB DeJarnette. (4, 6, 8) We honour DeJarnette for his 70 plus years of extensive research and study all presented and explained in detail in his yearly seminar notes, numerous additional writings and his yearly conferences. SOT is based on the identification, via SOT indicators (specific tests and observations), of the state of function of three primary systems of the body, known as categories, and the SOT adjustments considered necessary to improve their function. The three SOT categories are each clinically definable but at the same time interrelated. (26,27)

- Category one pertains to the Primary Cranial Sacral Respiratory Mechanism (PCSRM). The term respiratory refers to the intrinsic motion of the cranial and sacral components of the PCSRM which facilitates tension of the dura and the subsequent circulation of cerebral spinal fluid (CSF). This process is essential for the protection and the nourishment of the central nervous system (CNS). (4, 26, 33) The SOT indicator Heel Tension serves as the chief indicator for category one being the category most in need of adjustment. (4, 26, 33) Heel tension represents a deficiency in the respiratory function of the sacrum and the inability of the atlas vertebrae to respond sufficiently to the needs of the PCSRM. (4, 6, 31)
- Category two refers to ligamentous sacroiliac weight-bearing instability, resulting from the accumulation of instability throughout the entire structural system, inclusive of the sutures of the cranium.(4, 6, 26) The SOT Arm/fossae test monitors the nervous system's sensory/motor response to the instability of the weight-bearing portion of the sacroiliac joint and if indicated, category two is the category most in need of adjustment, superseding heel tension if present.(4, 26, 28)
- Category Three pertains to lumbar subluxations, lumbar disc lesions and the condition of the sciatic nerve, along with functionally necessary adaptations primarily of the piriformis muscle and possibly of the psoas muscle and the upper cervical region. The primary indicator for category three is the Step Out Toe OUT (SOTO) test which assesses the function of the piriformis muscle in relationship to a lumbar disc lesion or a potential entrapment of the sciatic nerve. (6, 7, 33) When SOTO is present and the arm fossae test is negative category three is the category of choice.

Chart #1: Two portions of the sacroiliac joint

Portion of Sacroiliac	Category	Sacroiliac Joint	Movement	Features
Respiratory (AKA Boot)	One	Synovial membrane	Respiratory movement	Part of the PCSRM
Weight-bearing	Two	Hyaline cartilage	Limited movement if any.	Ligament supported

SOT Categories= A Model of Function + A State of Dysfunction + A Method of Adjustment

Case Report

Initial Office Visit

History

A 43-year-old woman of average weight presented in my office experiencing a sore throat, heartburn, difficulty swallowing and various digestive symptoms such as cramping, bloating and some upper abdominal pain. She also reported left-sided neck pain with bilateral upper back pain (in the mid thoracic area), seasonal allergy symptoms and periods of anxiety that she felt were associated with her GERD symptoms. This was her first visit to a Chiropractor. She was referred by her mother who at the time was a patient in my office.

The patient was regularly taking Omeprazole (Prilosec) for the past two months and Xanax for clinical anxiety along with over-the-counter allergy medication as needed, all prescribed by her treating medical specialist. The patient consumed a gluten free and dairy free diet. All symptoms presented were chronic, more pronounced and inhibitory over the last four years, even with the diet modifications and medical intervention. An ultrasound examination was performed four months prior to her initial visit to the office but revealed no abnormalities.

The patient expressed a deep concern about her inability to fulfil her role as a mother (two young children) and as a part-time occupational therapist, all due to her symptoms.

Examination

An examination with an emphasis on SOT methods of analysis was performed at the initial visit. (4, 6, 33)

While standing in front of a plumb line, on a fixed foot plate, with her eyes closed and the examiner standing behind her the following was observed. The patient exhibited lateral motion in excess, along with a dominant left thoracic /first rib joint swelling with greater movement than the right, indicative of the body struggling to gain stability. (4,6,33) The patient's spine curved to the left, initiated at the lower lumbar spine, while her right ear was inferior when compared to her left ear.

In the seated position, performing cervical ranges of motion, the patient exhibited limitations in both left lateral flexion (40 degrees) and right rotation (80degrees). (6,7,26)

In the prone position a line two area 3 occipital fibre was detected on the left, coupled with a spinous process compression subluxation of thoracic 5/6. Occipital fibres, line 2 are considered to be defensive, reacting in a reflex pattern associated with a spinal subluxation and a related organ. (2,16,32). '*Spinal postural accommodations were mediated through the visual and vestibular righting reflexes and reflected in related specific suboccipital muscle fibre contracture (occipital fibres)*.'(2) '*Occipital fibre technique locates and identifies subluxations and can be utilised to help identify specific viscerosomatic/somatovisceral reflex organ disorders, incorporating specific soft tissue visceral and somatic therapies*', (2,11) referred to as Chiropractic Manipulative Reflex Technique (CMRT).

> Occipital fibre therapy can facilitate the management of dis-ease while at the same time providing a philosophy of care. (11, 13)

A line two occipital fibre, area three, in conjunction with a thoracic 5/6 subluxation identifies a gastric dysfunctional problem. '*The resulting system designates the horizontal vector as lines, the vertical vector as areas*'. (11)

Chart # 2*:* Line Two Occipital Fibres and their related vertebrae/organ

Line two finding	Vertebrae	Related Organ
Area one	Thoracic 1,2,10	Coronary, Myocardial, Intestines.
Area two	Thoracic 3, 11, 12	Lungs, Kidneys
Area three	**Thoracic 4, 5, Lumbar 1**	**Gall bladder, Gastric, ileocecal**
Area four	Thoracic 6 Lumbar 2	Pancreas, Cecal
Area five	Thoracic 7 Lumbar3	Spleen, Glandular
Area six	Thoracic 8 Lumbar4	Liver, Colon
Area seven	Thoracic 9 Lumbar 5	Adrenal, Prostate/Uterus

In the supine position there was a right leg deficiency with a left lower arm/fossa finding. The arm/fossae test denotes the response of the arm when placed in a specific upright position and pulled on command while placing simultaneous pressure on specific portions of the inguinal ligament. The inguinal ligament receptor system responds to disturbances at the weight-bearing portion of the sacroiliac joint. Thus, the arm/fossae test accesses the stability of the weight-bearing portion of the sacroiliac joint, which is primary in identifying an SOT category two in need of adjustment. (6 ,7, 26) A leg length discrepancy in conjunction with the arm/fossae finding determines the need for blocks and where to place them.

Also identified in the supine position were cranial findings involving the right maxillary/malar suture resulting from underdevelopment of the right mid facial bones, primarily the malar. (8, 29) Cranial sutural dysfunction often initiates disturbances in the head righting reflexes that can create imbalances and instability throughout the body. (2, 29, 31)

All of these findings were interrelated, systems oriented (category two) (27, 28) and addressed the patient's concerns. Based on these findings, most specifically the occipital fibre findings line two, area three, thoracic five/six as well as the patient's established commitment to lifestyle modifications, it was my belief that SOT Chiropractic would provide effective care and necessary improvement.

Chart # 3*:* SOT primary category indicators

Indicator	Category one	**Category two**	Category three
Plumb line analysis, eyes closed for 10 seconds.	A/P sway with bilateral T1/ first rib motion on head flexion.	**Lateral sway with a unilateral T1/first rib motion on head flexion, coupled with some swelling**	No sway with bilateral fixed (no motion) of T1/ first ribs on head flexion.
Arm/fossae test	Maintains resistance when the arm is pulled as the fossae is activated	**Loses resistance when the arm is pulled as the fossae is activated**	Maintains resistance when the arm is pulled as the fossae is activated

SOT category two adjusting procedures were implemented.

- Category two supine blocks (6, 7, 28)
- Category two basic 2 cranial adjustment (6, 7, 28)
- Retesting of arm/fossae, leading to the removal of the blocks (6, 26, 28)
- SOT cervical stairstep and figure eight adjusting (12, 26)
- Category two sutural adjusting focused on the right maxillary/malar suture. (8, 14, 29)

As previously discussed incorporated into the SOT category two adjusting method was the occipital fibre line two technique (stimulation of line two area 3) adjustment of thoracic 5/6 for inferior spinous process and CMRT of thoracic 5 soft tissue indicators.(2, 16, 25) All examination findings were retested at each office visit and were recorded accordingly. (30)

> 'Nothing in SOT is done without a reason and no action is complete until it is re-evaluated, all guided by indicators'. (26, 33)

Initially the patient received 13 adjustments over a 2-month period of time. Some lateral sway and a unilateral difference of the first thoracic vertebral articulation with the first rib was noted throughout the 13 adjustments.

- Blocks were utilised on 11 of the 13 office visits indicated by the arm/fossae test
- Basic 2 cranial adjusting was utilised when blocking was utilised (5, 28)
- Cervical stairstep, figure 8 adjusting was utilised at each adjustment even though sitting cervical findings, lateral flexion, right rotation, were normal after the fifth adjustment
- Cranial sutural adjusting continued throughout the 13 adjustments based on the cranial findings of the day, right head position, limited cranial ranges of motion on the right maxillary/malar suture compared to the left and the presence of underdevelopment in the facial structures on the right side of the face. (29) A 5-step adjusting procedure was utilised focused in the right maxillary/malar suture. (29)
- The occipital fibre, line 2 area 3, thoracic 5/6 interspinous space and the thoracic 5 soft tissue reflexes (CMRT) were utilised throughout the 13 adjustments. (2, 16) Occipital line two fibres and their related vertebral subluxations are considered defensive and therefore remain throughout care. (2, 16, 32) '*The occipital fibre is purely defensive and the result of other happenings. It is not causative, as long as the fibre responds, the body's defense is normal*'. (7)

The patient was advised throughout care to swallow all liquids in small amounts intentionally, therefore utilising the voluntary muscles of swallowing reflex and to maintain her eyes on the horizon for her neck posture. Also discussed was a supportive sleeping posture for the cervical anterior curve. The patient was compliant with instructions throughout care. She continued her gluten free and diary free diets along with her consciousness of eating a sound and healthy diet.

Occipital Fibre line #2 Technique

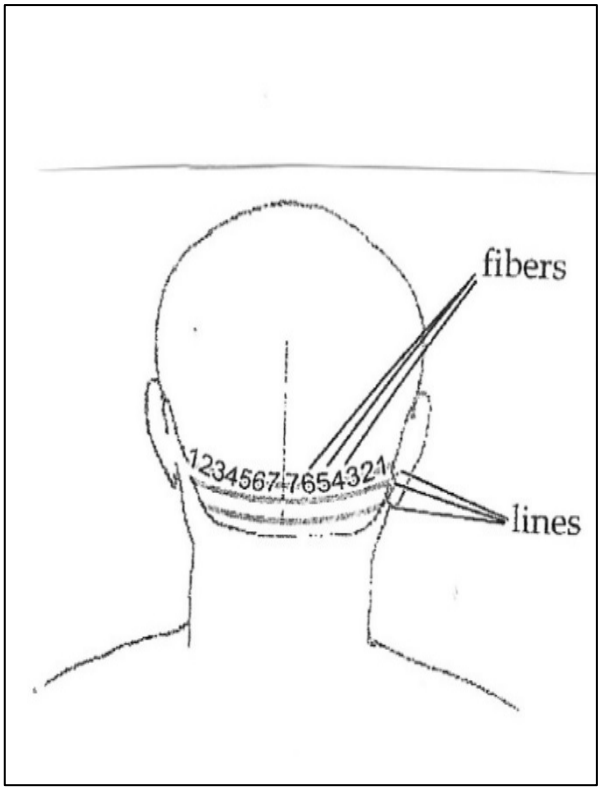
The occipital fibre technique is both a diagnostic and treatment approach, that utilises Golgi tendon organ reflexes located on the posterior aspect of the occiput. DeJarnette found that occipital fibres were reactions to spinal cord pressures which either creates or responds to neurologic disturbances at specific regions of the autonomic nervous system (ANS). (2) The imbalance in the ANS activity causes a compensatory visceral or somatic reflex at the spinal segment involved. (2, 16) Occipital fibres line two utilises a finger stroke to stimulate the involved line #2 fibre and a superior directed adjustment of the Thoracic 5 spinous process. Normally line 2 vertebral adjustments involve a posterior transverse process, but in this case the spinous process, associated with a line one fibre, was predominant and in need of adjustment.

Across the occiput there are three lines of occipital fibres, with seven on each side stretching from the External Occipital Protuberance (EOP) (Number 7) to where the posterior superior occipital mastoid suture begins (Number 1). Occipital line one sits above the second and third lines. Each line corresponds to a particular type of vertebral subluxation. (2) When involved, these fibres become tender and swollen.

Chart # 4: Occipital fibre subluxations

Occipital Fiber Line	Type of Subluxation	Vertebrae Listing
#1	Cerebrospinal/Meningeal	Spinous Inferior Compression
#2	Vertebral/Visceral	Transverse Process Posterior
#3	Structured Vertebrael	Pedicle Destruction

DeJarnette's premise of treatment beginning with the occipital fibre neutralisation, vertebral adjustment and reflex manipulations was that there was an imbalance between the organ, the spine and within the autonomic nervous system. (2)



Outcomes

Chart # 5: This patient

Timeline	Plumb line	History of the day as reported	Blocks Arm Fossae (A/F) testing	Cervical, range of motion (ROM))	Cranial suture, 3-part exam	Occipital fiber line 2 technique*
Initial Visit findings	Lateral sway in excess, T!/rib unilateral finding	GERD symptoms	A/F test positive for SI weight bearing unstable	Limited, lateral flexion, rotation	Right maxillary/ malar (M/M) suture	Line #2, T5/6 sub. left thumb web abdominal reflexes
After initial thirteen adjust. Over 2 months	Limited sway, Left T1/rib finding	Symptoms improved	Positive 11of the 13 adj.	ROM acceptable after 5 adjustments	Indicators for M/M suture present	All findings present but less tender
16 months, additional 19 adjust.	Limited sway, limited T1/ rib finding	Further symptom improved	No A/F findings	ROM acceptable, reduced pain	Improved M/ M ROM and head tilt less pain	All line 2, vertebrae, and soft tissue reflexes, less tender
4 ½ years after initial visit	Limited sway limited T1/ rib finding	Symptoms infrequent and less severe	A/F not present	ROM acceptable, infrequent discomfort	Cranial ROM less tender, no head tilt	All findings less tender but present

Discussion

Timeline

Initial visit, 13 adjustments over 2 months, followed by one adjustment approximately every 3 to 4 weeks for 16 months, and then mainly monthly adjustments over 4½ years.

Plumbline Findings

Less lateral sway, less tenderness and swelling of T1/first rib throughout the 4½ years of care, all indicative of the weight-bearing system regaining stability. (4,6,26)

History of the day

At each office visit, I asked the patient, '*How are you feeling?*' and recorded her reply in my daily notes, as per my recording system outlined in my paper previously published in this journal. (30) Her symptoms related to GERD gradually diminished, leading her to discontinue Omeprazole and instead use a natural digestive enzyme with her evening meal. There were no reported episodes (flare up of symptoms) during her care, but she did report right jaw pain and was referred to an orthodontist for care. She did continue the usage of Xanax but did express that she was happily working her preferred 20-hour shift as an occupational therapist at a nearby rehabilitation hospital.

Arm/fossae testing for category two blocks

The arm fossae test was initially positive, left leg deficiency with a left upper fossa response, indicating the need for blocks. The arm/fossae test was negative overtime indicating no need for blocks. This indicated progress, as the functioning of structures improved and the weight-bearing aspect of the sacroiliac joint achieved greater stability. (26, 28)

Cervical ROM

Improved as of the fifth adjustment and maintained normal function throughout her care. Nevertheless, cervical range of motion was checked at each adjustment and stairstep and figure 8 adjusting was continually utilised to maintain function. The patient continued to comply with her home-care instructions. (6, 7, 33)

Cranial Sutural

The cranial range of motion for the malar (zygoma) remained present throughout care but was considered by both me and the patient to be less restricted and less tender when tested. Cranial adjustments: maxillary rotation, straddle and sutural release, in conjunction with malar lift were utilised to expand the maxilla/malar sutural contraction. (13, 14, 15) Sutural expansion is considered functional while sutural contraction is considered dysfunctional. Head tilt was improved, often not present, cranial adjustments remained addressing the facial underdevelopment of the right malar and her history of right jaw pain.

Occipital Fibre Line 2 Technique

Line 2 fibres serve a defensive role, so treatment aims to enhance function in both the vertebra and viscera, as well as to prevent these areas from becoming pathological (line 3). (2, 3) In this case, improved function is reflected by the patient's reported history for the day, less tenderness and sensitivity and notably decreased tenderness along the line 2 fibres, the spine and CMRT tissues. Clinically this is found to be associated with improvement of gastric function.

The Occipital Fibre Line 2 technique consists of the following steps

- Stimulate the line two fibre (2)
- Adjust the T5 spinous process in a superior direction (2)

- Using one hand, rub the web between the left index finger and thumb while gently massaging the area between the patient's umbilicus and xiphoid process with the other hand (2)
- Simultaneously hold the trapezius region of the shoulder and the area above the umbilicus, look for relaxation in the contacted tissues. (2)

Conclusion

As previously stated, the objective of this case report is to provide an educational resource regarding the SOT method of Chiropractic care and to illustrate its application in managing an organ-related condition, following the JBI (Joanna Briggs Institute) model of Evidence-Based Healthcare for case reporting, as described by Cuthbert and Ebrall. (1)

The JBI model is a cycle that fosters the synthesis of evidence and then its transfer to where it is needed and its subsequent implementation. (1) This study seeks to adhere to the guidelines of the JBI model by presenting thorough contextual information and offering a comprehensive evaluation of both the process and outcomes associated with the SOT methods of Chiropractic care.

Since the symptoms and the examination findings that determined the diagnosis have been significantly reduced it appears that the interventions as presented in this single case study were successful. She subsequently referred both her husband and son to my office for care.

I recognise Dr DeJarnette for his dedicated research and tireless work in advancing the understanding of the connection between bodily structure and organ systems, leading to the discovery of occipital fibres, specific vertebral adjustments, and the Chiropractic manipulative reflex technique.

Harvey Getzoff
DC
Private Practice
Marlton, NJ, USA
ihgetz55@gmail.com

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Also by this author

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