Spinal Diagnosis with an SAT Intention

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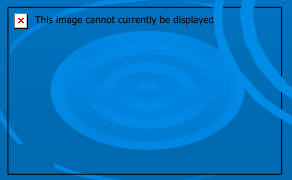
What are we doing?

Total Health

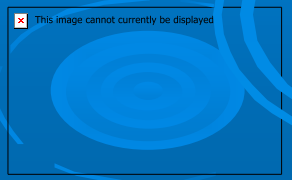
The 1st impression is:-

The body’s best attempt to be well



Osteopathic contact

- Osteopathy is about relationship first
- It’s a unique interchange
- The body intelligence assesses the knowledge in your hands.
- The information you get back is the information that the body feels comfortable telling you.



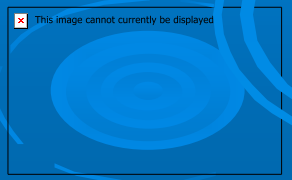
SAT History and Concepts

History

Definition

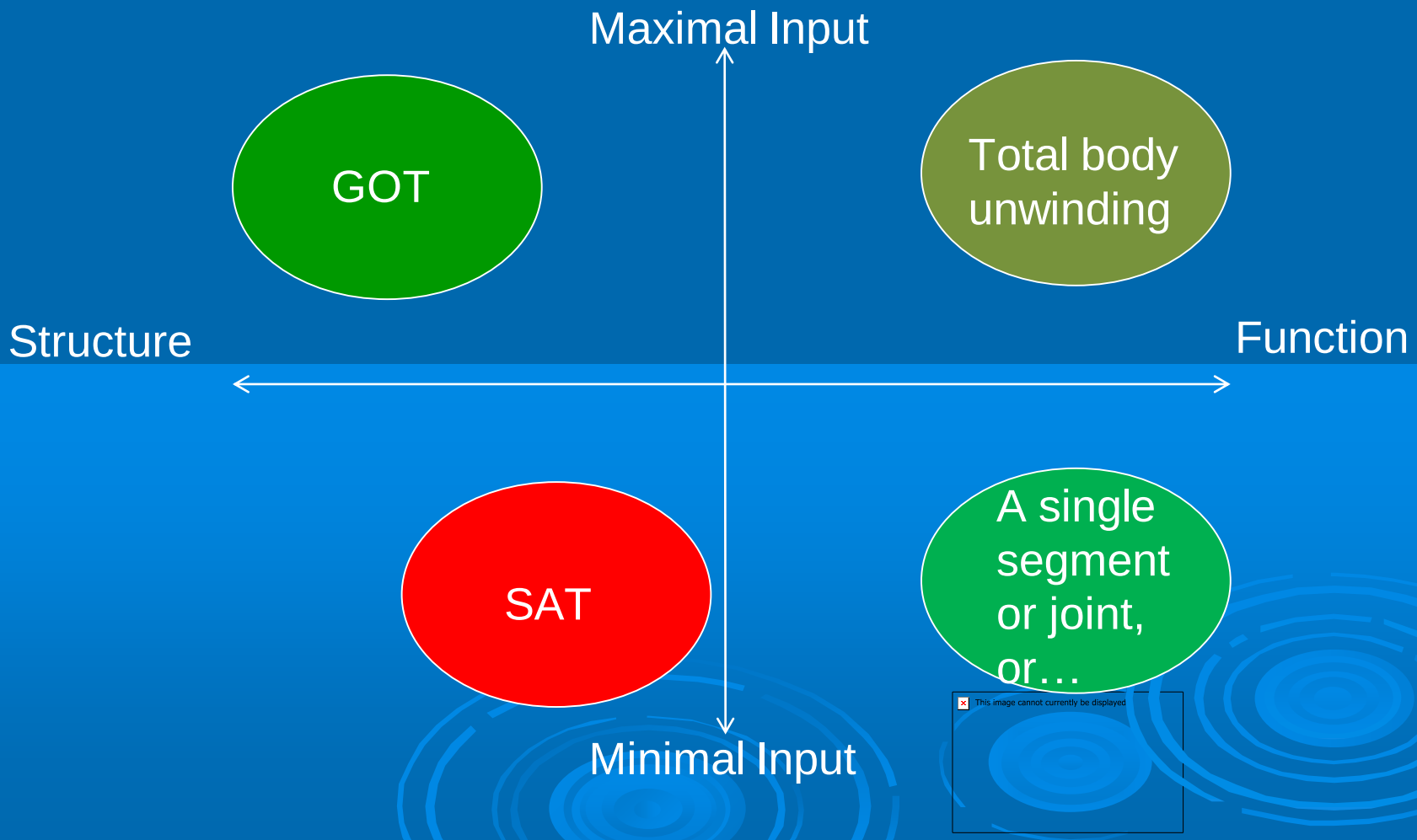
Choosing the segment

Minimal Treatment



SAT continuum concept

An approach to treatment through:



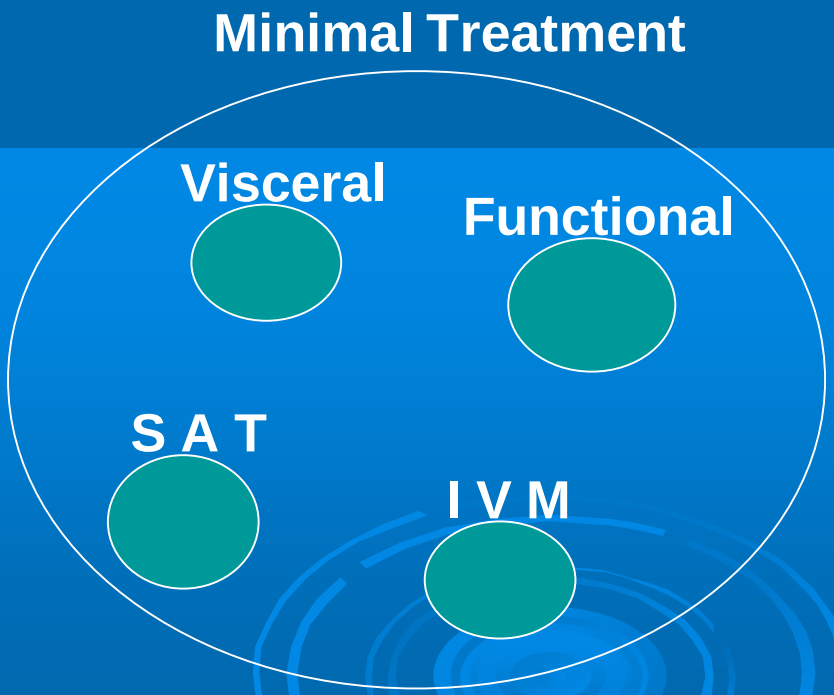
Minimal Treatment

Do just enough to the point where the body says…

"ok, I got it, I'll take care from here".

It is truly a matter of just the right amount of Treatment

You'll find minimal treatment in many fields



SAT is minimal by definition

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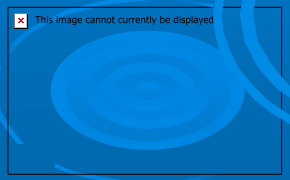
LITTLEJOHN and SAT

LITTLEJOHN's Theory AND Philosophy:

If you regulate the curves the pivots will release naturally.

SAT view point is:

if you can adjust the pivots (or get the pivots working) then the curves will come into a better balance.



Curves and Pivots

Structural point of view:

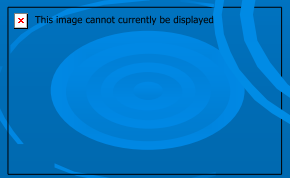
Forward bending curve to a Backward bending curve.

There must be a force change !

In a sense, at the point of change, there is a still point or a neutral point.

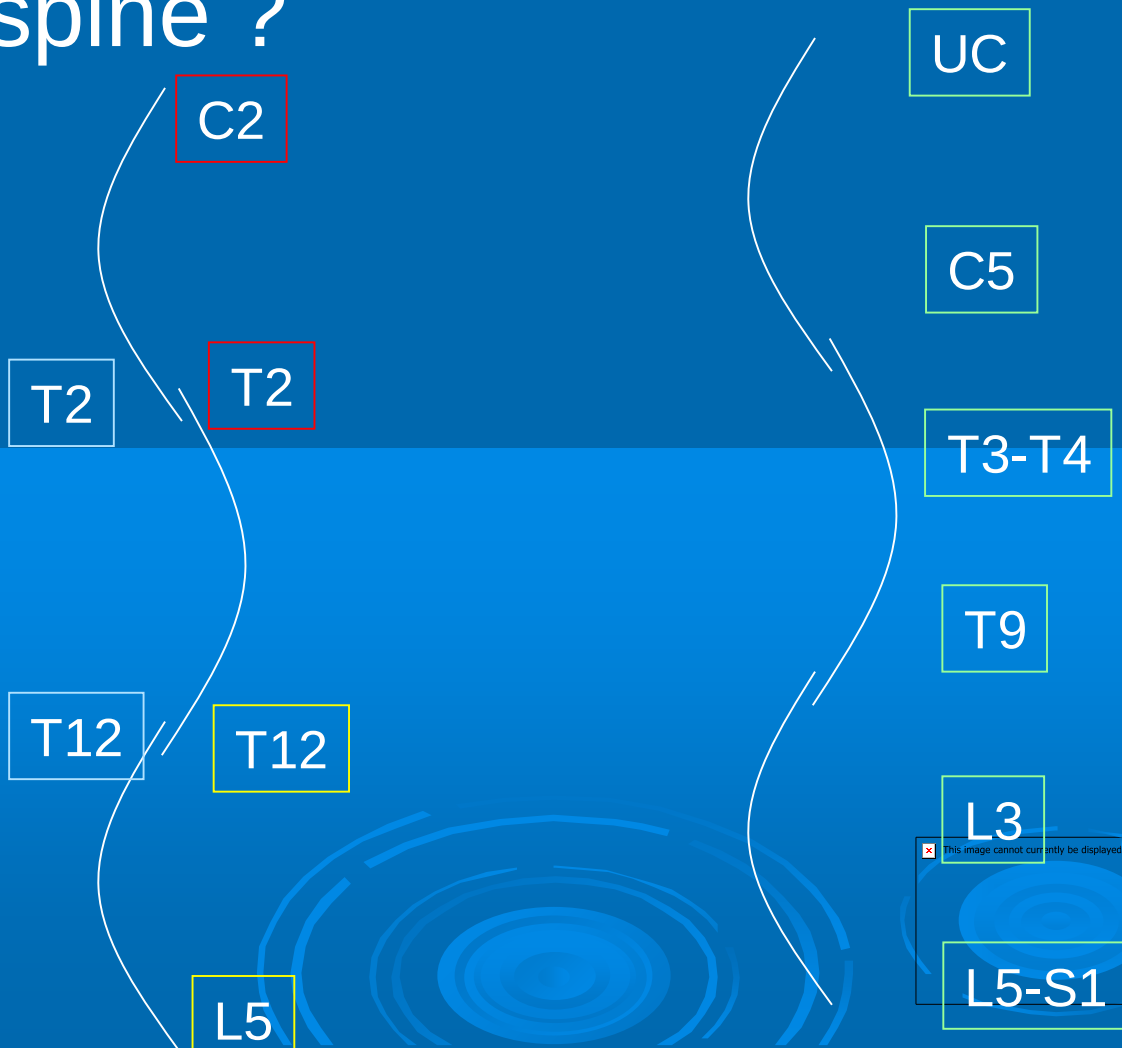
A Pivot is the interface between a forward bending curve and a backward bending curve.

A Pivot is a point of change or a junction.



Structural and Functional Curves and Pivots

Littlejohn: What actually functions as a pivot in the spine ?



The Functional Pivots and important vertebrae

C1: Ring of bone that works with the occiput

C2-C3-C4: Distinct functional group of segments

C5: Translates the difference in functioning from above to below.

T3-T4: End of the action of the neck

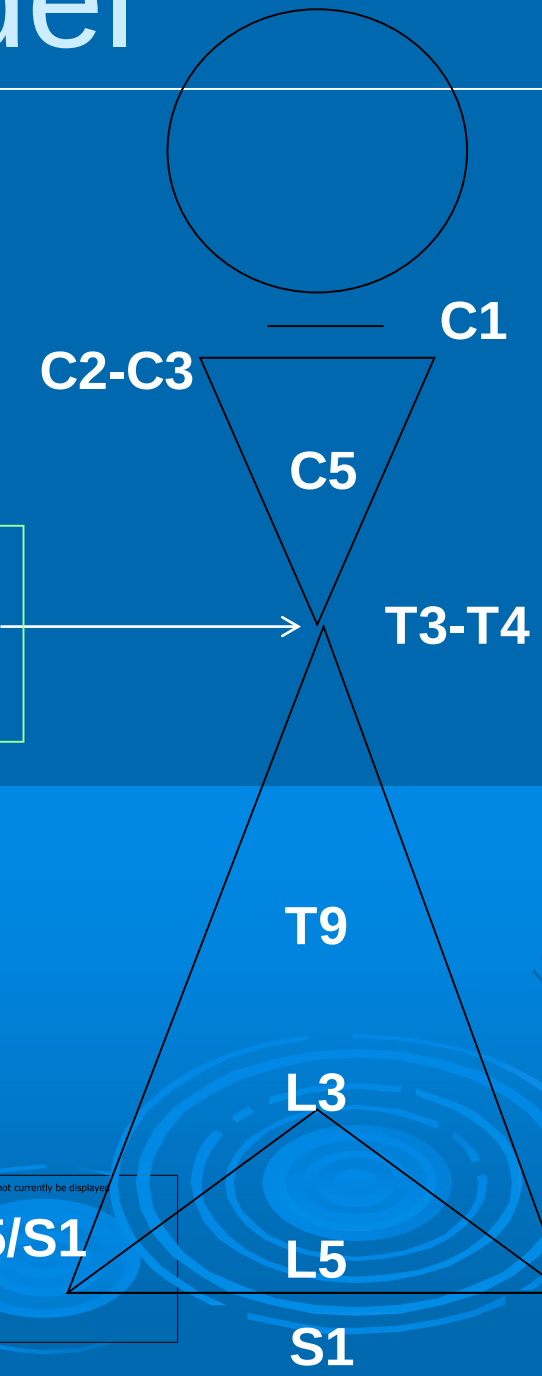
L5-S1: True pivot for both structural and functional curves

L3: Centre of the lumbar arch and the apex of the Littlejohn's small triangle of force

T9: Centre of the long arch and the Adrenal supply

Littlejohn Model

It contains the whole of the message



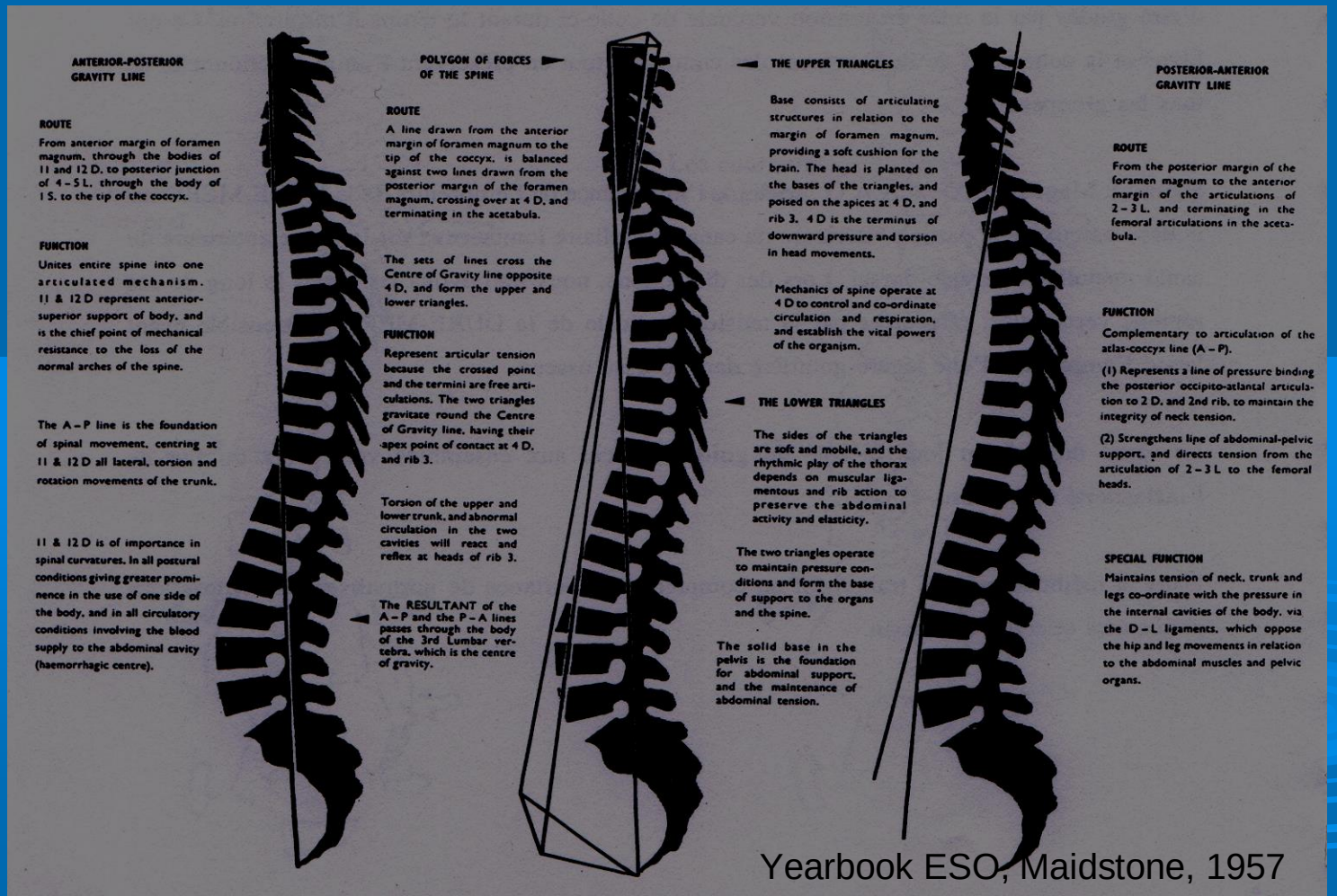
Point of balance Between triangles of forces

This model gives us a Methodology to approximate the truth

Atypical vertebrae: C1,C2,C3 and L5/S1
Interarch pivots: C5,T9 and L5

Polygons of Force

Two polygons are created from the A/P line and the P/A lines



ANTERIOR-POSTERIOR GRAVITY LINE

ROUTE

From anterior margin of foramen magnum, through the bodies of 11 and 12 D, to posterior junction of 4 – 5 L, through the body of 1 S, to the tip of the coccyx.

FUNCTION

Unites entire spine into one articulated mechanism. 11 & 12 D represent anterior-superior support of body, and is the chief point of mechanical resistance to the loss of the normal arches of the spine.

The A – P line is the foundation of spinal movement, centring at 11 & 12 D all lateral, torsion and rotation movements of the trunk.

11 & 12 D is of importance in spinal curvatures. In all postural conditions giving greater prominence in the use of one side of the body, and in all circulatory conditions involving the blood supply to the abdominal cavity (haemorrhagic centre).

POLYGON OF FORCES OF THE SPINE

ROUTE

A line drawn from the anterior margin of foramen magnum to the tip of the coccyx, is balanced against two lines drawn from the posterior margin of the foramen magnum, crossing over at 4 D, and terminating in the acetabula.

The sets of lines cross the Centre of Gravity line opposite 4 D, and form the upper and lower triangles.

FUNCTION

Represent articular tension because the crossed point and the termini are free articulations. The two triangles gravitate round the Centre of Gravity line, having their apex point of contact at 4 D, and rib 3.

Torsion of the upper and lower trunk, and abnormal circulation in the two cavities will react and reflex at heads of rib 3.

The RESULTANT of the A – P and the P – A lines passes through the body of the 3rd Lumbar vertebra, which is the centre of gravity.

THE UPPER TRIANGLES

Base consists of articulating structures in relation to the margin of foramen magnum, providing a soft cushion for the brain. The head is planted on the bases of the triangles, and poised on the apices at 4 D, and rib 3. 4 D is the terminus of downward pressure and torsion in head movements.

Mechanics of spine operate at 4 D to control and co-ordinate circulation and respiration, and establish the vital powers of the organism.

THE LOWER TRIANGLES

The sides of the triangles are soft and mobile, and the rhythmic play of the thorax depends on muscular ligamentous and rib action to preserve the abdominal activity and elasticity.

The two triangles operate to maintain pressure conditions and form the base of support to the organs and the spine.

The solid base in the pelvis is the foundation for abdominal support, and the maintenance of abdominal tension.

POSTERIOR-ANTERIOR GRAVITY LINE

ROUTE

From the posterior margin of the foramen magnum to the anterior margin of the articulations of 2 – 3 L, and terminating in the femoral articulations in the acetabula.

FUNCTION

Complementary to articulation of the atlas-coccyx line (A – P).

(1) Represents a line of pressure binding the posterior occipito-atlantal articulation to 2 D, and 2nd rib, to maintain the integrity of neck tension.

(2) Strengthens line of abdominal-pelvic support, and directs tension from the articulation of 2 – 3 L to the femoral heads.

SPECIAL FUNCTION

Maintains tension of neck, trunk and legs co-ordinate with the pressure in the internal cavities of the body, via the D – L ligaments, which oppose the hip and leg movements in relation to the abdominal muscles and pelvic organs.

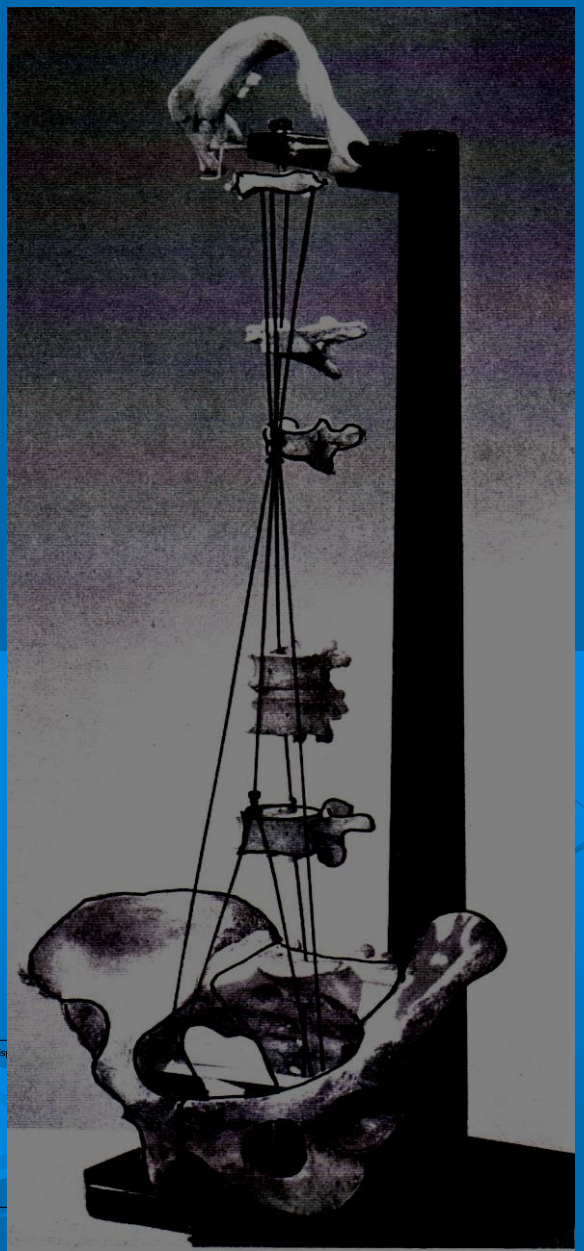
Yearbook ESO, Maidstone, 1957

Polygons of force

Upper Triangle:
T4 to C0

Lower Triangle:
T4 to Pelvic Base

Small Triangle:
L3 Apex of
pelvis motion



Wernham, J., Mechanics of spine, Yearbook, Maidstone, 1956

General Examination

Initial inspection:

-Sense of a balance of the curves

-Look at the whole from the side

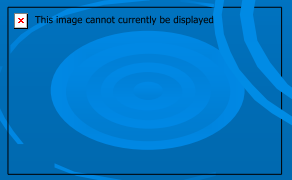
-Use your instinctive mind (no words)

-Quiet mind and soft vision: Look through the person

Look to the side of the body

-Catch it from the corner of your eye

-Look at the whole field around the person



General Examination C, D.

C) Weight bearing and mobility tests

-AP

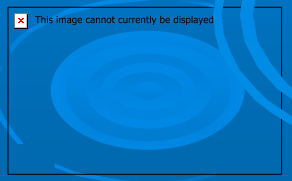
-Lateral

-Neck flex + Rot + SB

-Pelvic Alignment

-Forward bending test

D) Hip drop test



4- Criteria of Observation: Position, Symmetry, Amplitude

Look at the initial position and get a sense of the quality.

Look at the function of the curves and how the motion takes place around the pivots

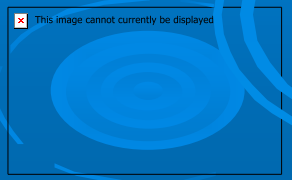
Look at the pivots for mobility and triangles in terms of **symmetry** around the mid line.

Hip Drop Test

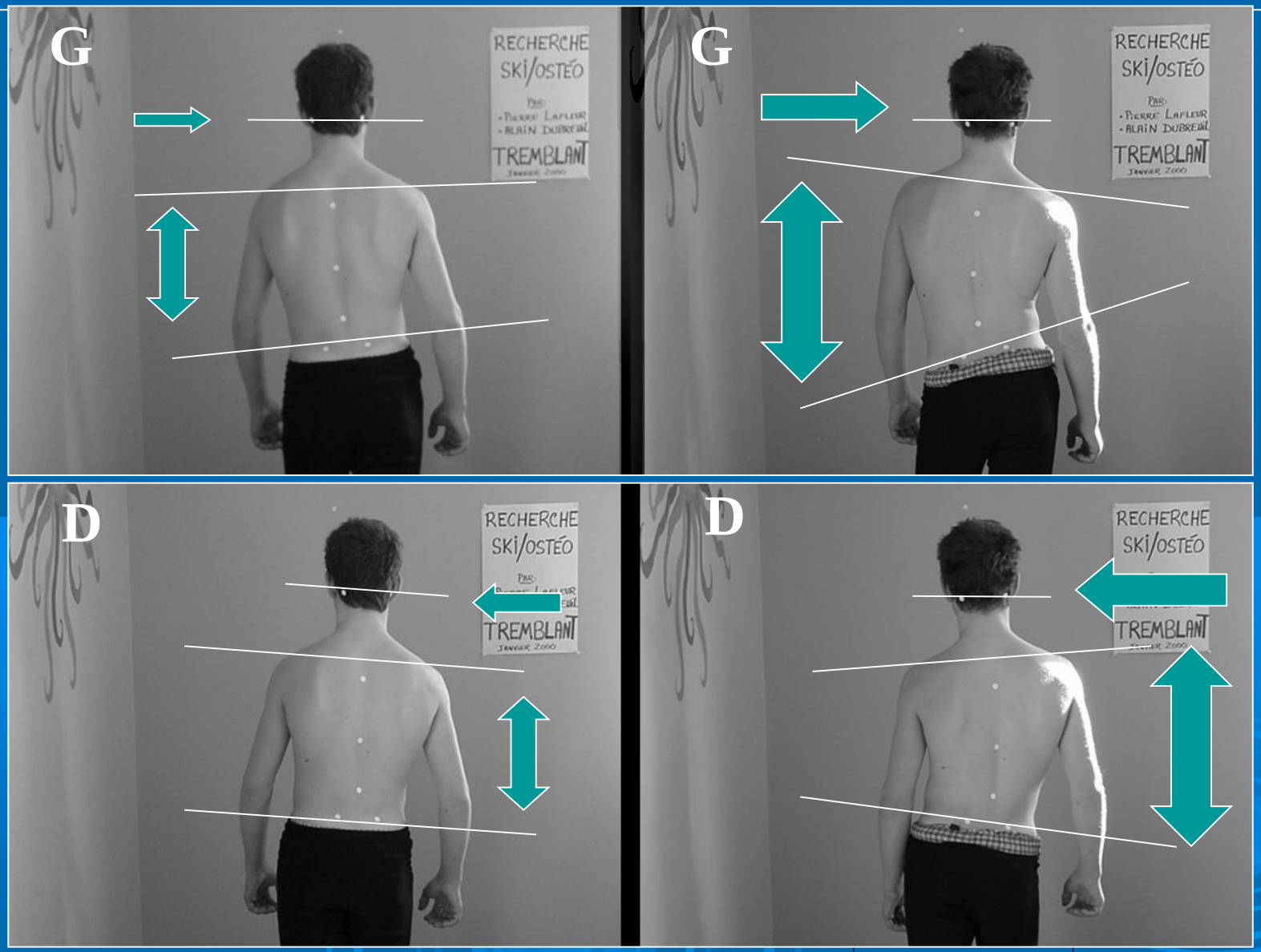
Test performed three times

1) Once for a sense of the whole,
2) Once with attention focussed on - T3
3) Once focussed on - L3

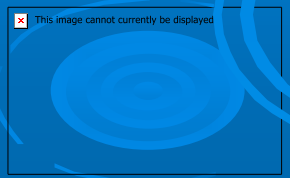
Optional focussing on (T9) & (Mastoid Line)



Shoulder and Pelvic Girdles Dissociation



7- Dots and triangles

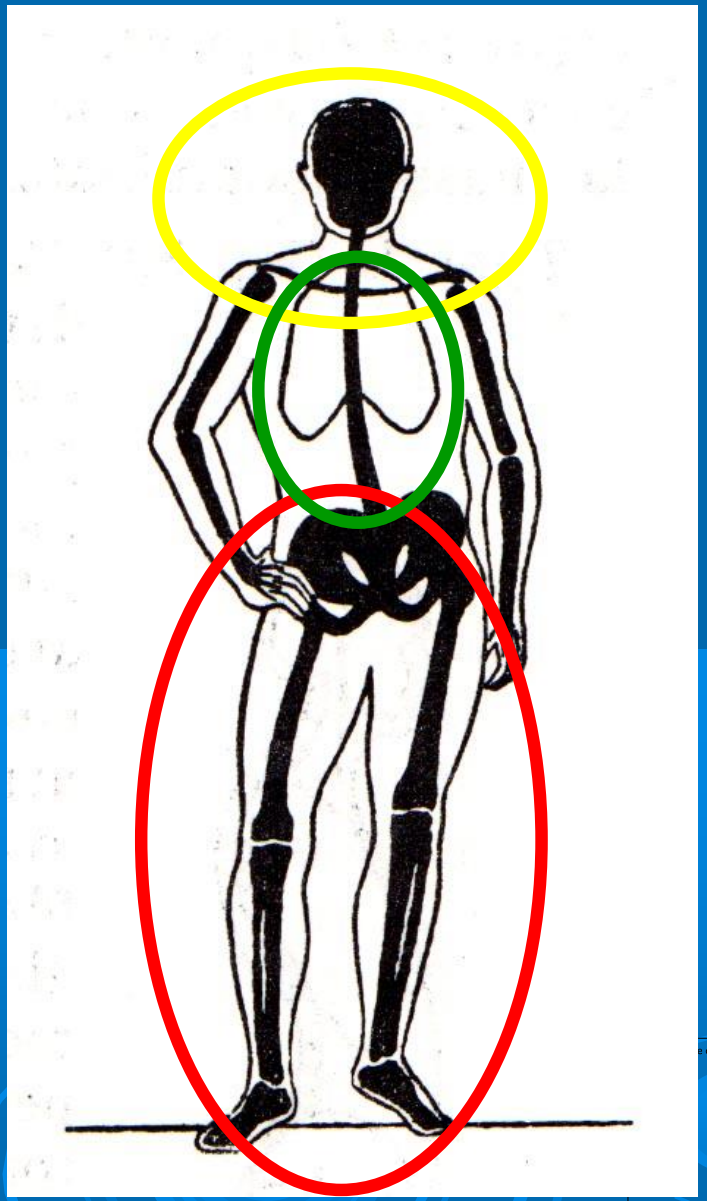


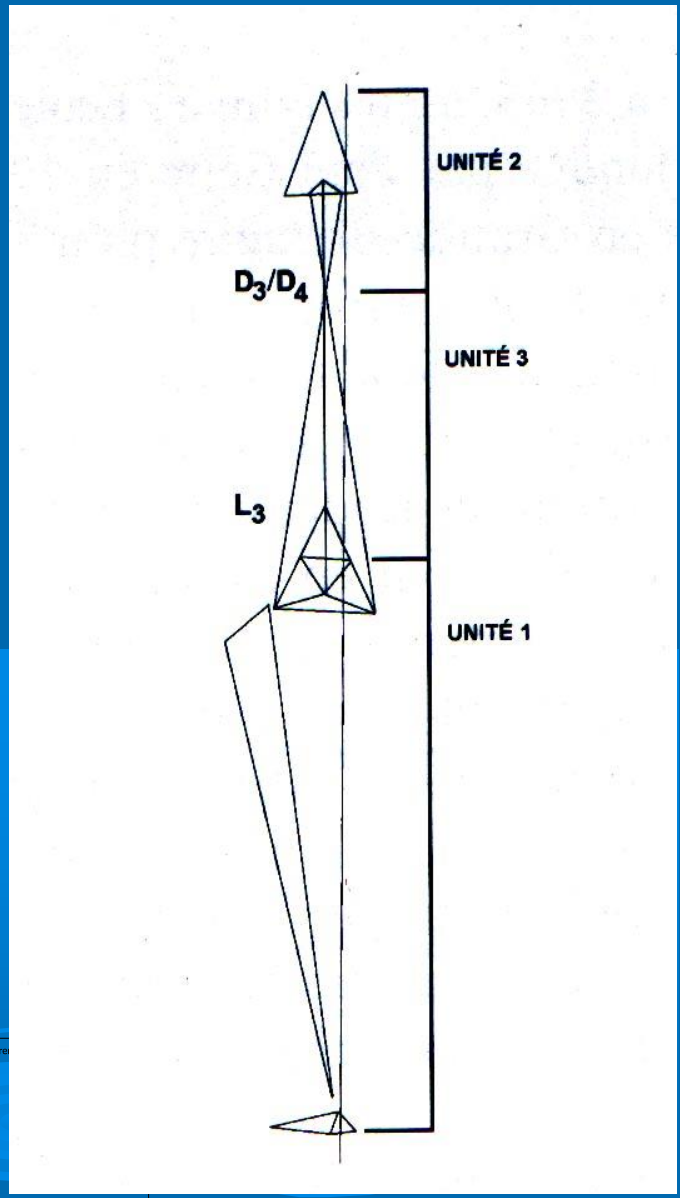
The Triunity concept

Unity 2
Head+Neck to T3,
Upper limbs
"Creative"

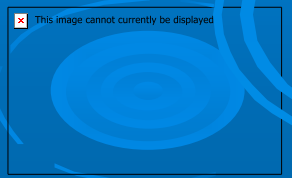
Unity 3
C5 to L3,
Thorax + Abdomen
"Visceral+ Emotional"

Unity 1
L3+Pelvis+Lower limbs
"Locomotion"





Unity # 1 Routine



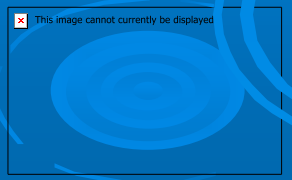
Unity 1 - Testing

1. Standing PSIS - Gossip
   - Normal speed
   - Very Slowly
   - Double Thumb Contact
   - Spindle Test

(2. Sitting)

(3. Prone)

(4. Sidelying)



Unity 1 - Testing

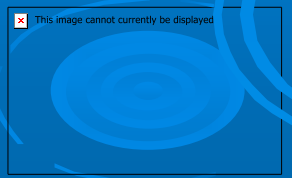
2. Sitting Forward bending (contact PSIS)
Lumbar spine AP mobility

3. Prone Ely's test
Lumbar rotation test} head to side
S.I. Test } being tested

4. Sidelying S.I. AP
Flex/Ext
Combination(Nutation)
Lumbar Flex/Ext

ALL TESTS MUST CONFORM = A LESION

Unity # 2 Routine

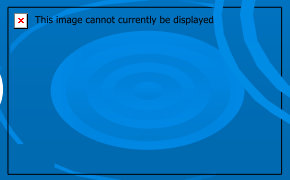


UNITY # 2 ROUTINE

1. Sitting

			Contact
(i)	O/A	Rocking (Flex/Ext)	Occ/TP
(ii)	C1/C2	Rotation	On C2
(iii)	C2/C3	Sidebending; rotation should follow	On C2
(iv)	C3/C4	Sidebending; sideshift should follow	On C3
(v)	C4/C5	Flexion/extension	Sp's 4/5
(vi)	C5/C6	"	Sp's 5/6
(vii)	C6/C7	"	Sp's 6/7
(viii)	C7/T1	Rotation	On C7

(ix) Test down to T4 in Flexion/Extension (including sidebending/rotation as required)

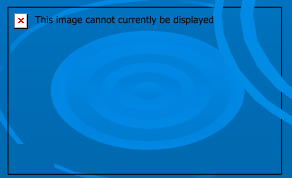


Unity # 2 Routine (cont)

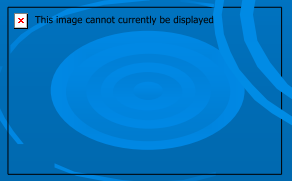
2. Supine

(i) Flexion/Extension (N.B. neck in neutral)

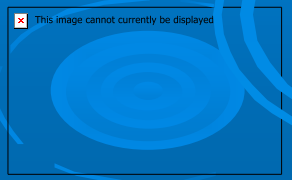
(ii) Side-shift (composite rotation/sidebending)



Motility Palpation



Unity # 3 Routine



Unity # 3 Routine

Sitting

1. Hands on and listen — contact: thumbs at T3
   Check; amplitude and quality of breath

2. A/C jt + S/C jt — contact: bilaterally
   Test with breathing

3. Ribs 1-4 — contact: anterior and
   Interdigitate

4. Ribs 5-10 — contact: mid axillary line

5. Floating ribs — check muscle tonus

Unity # 3 Routine (cont)

Sitting (cont)

6. General Spinal Examination (C4/5 – L3)

Contact: full hand contact on continuous arc

a) Flex/ext

b) Rot/Sidebending

7. Relationship AP: Mid Thoracic-Sternum

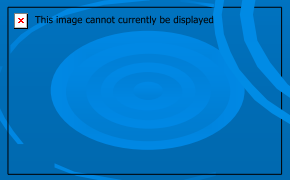
8. Segmental Movement testing as required

Unity # 3 Routine (cont)

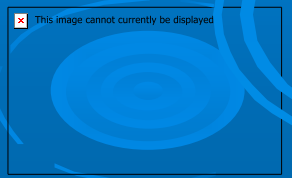
Supine

1. Test A-C joint }
   S-C joint }
   Upper ribs }
   contact: direct, using arm as a lever

2. Breathing Movement
   (i) Ribs 1-4 contact: interdigitate
   (ii) Diaphragm/crura/central tendon
   (iii) AP diaphragm - sternum



SAT Treatment
+ Adjustment



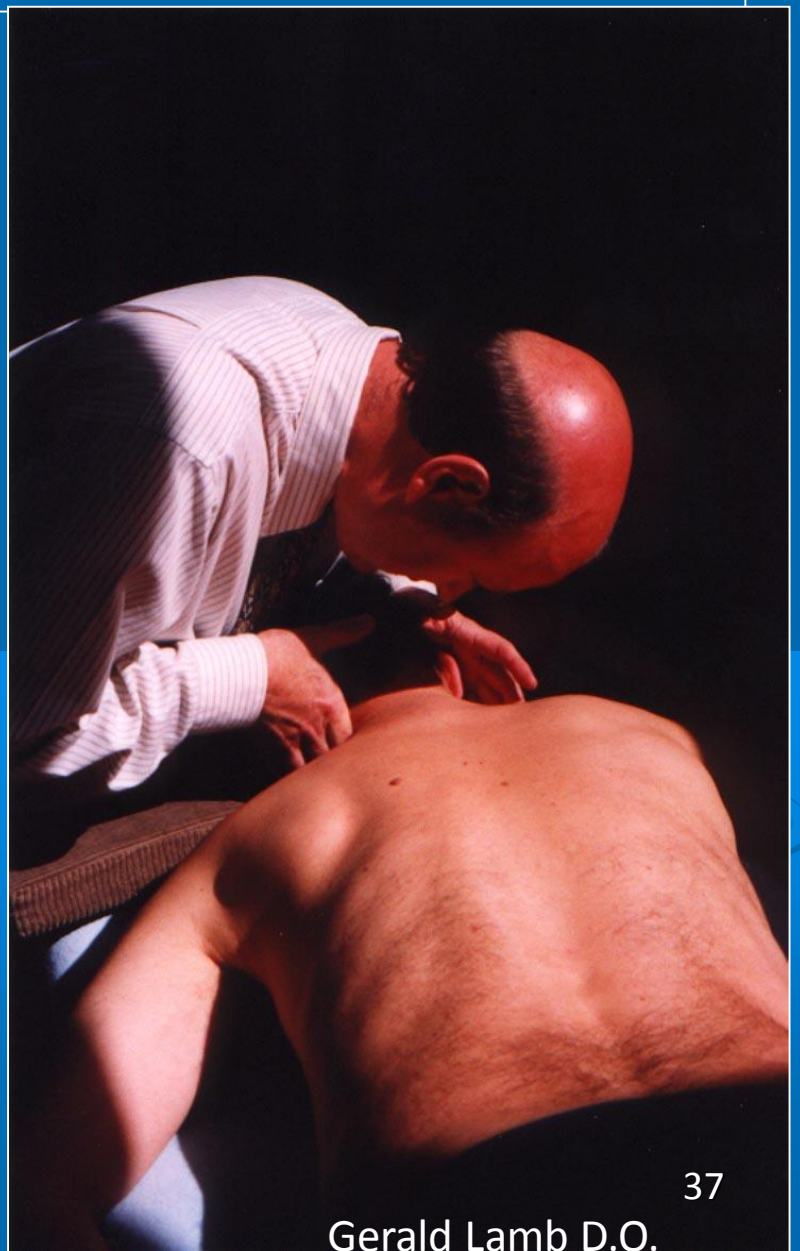
Prone Cervical 'Floating Field' Adjustment

1- Concepts

2- Technique

3- “Floating-Field”

4- The Ajustment



Gerald Lamb D.O.

Par: Gerald Lamb D.O. (U.K.) et Alain Dubreuil D.O. (QC.)

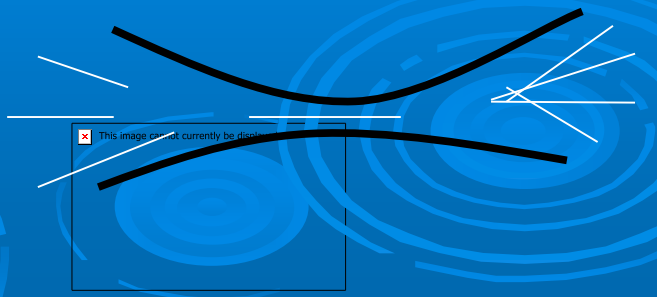
1- Floating-Field

- Bring the segment to the physiological barrier, experimenting with the vectors, so you know now where the physiological locking occurs.

- Then release the compression so that it leaves the lining up with some space in which to manoeuvre. Let it Float !

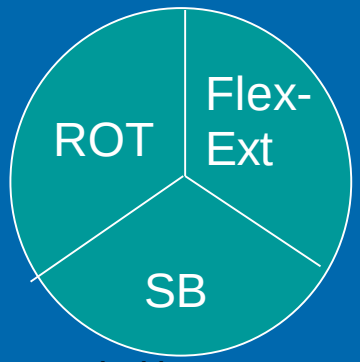
- The mobilisation then occurs by “closing in”. You “gather in” the forces with the intention of compressing into the physiological locking and you carry on through and out the other side.

- Take your hands off to allow recoil of the tissues



2- Technique

- It's a direct technique reversing the vectors by intention.

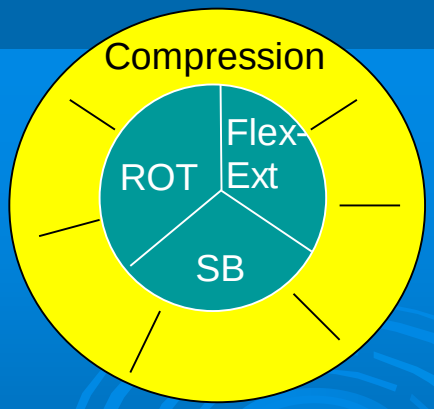


L. Hartman

- The set up takes care of varying degrees of the components.

  Ex: You can increase the SB and thereby decrease the other components.

- The secret is the Compression which holds into the physiological locking



By adding compression to the right mix of Components you reduce the pie to a much smaller circle.

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3- Concepts

If the moment is right you'll get a physical release of the articular surfaces. If not, you may get an energetic release.

Set it all up, let the body relax, let your mind relax and allow your hands to work… you'll learn from the process.

The power and the potency of Intention

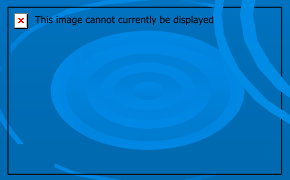
…Prone Cervical Adjustment

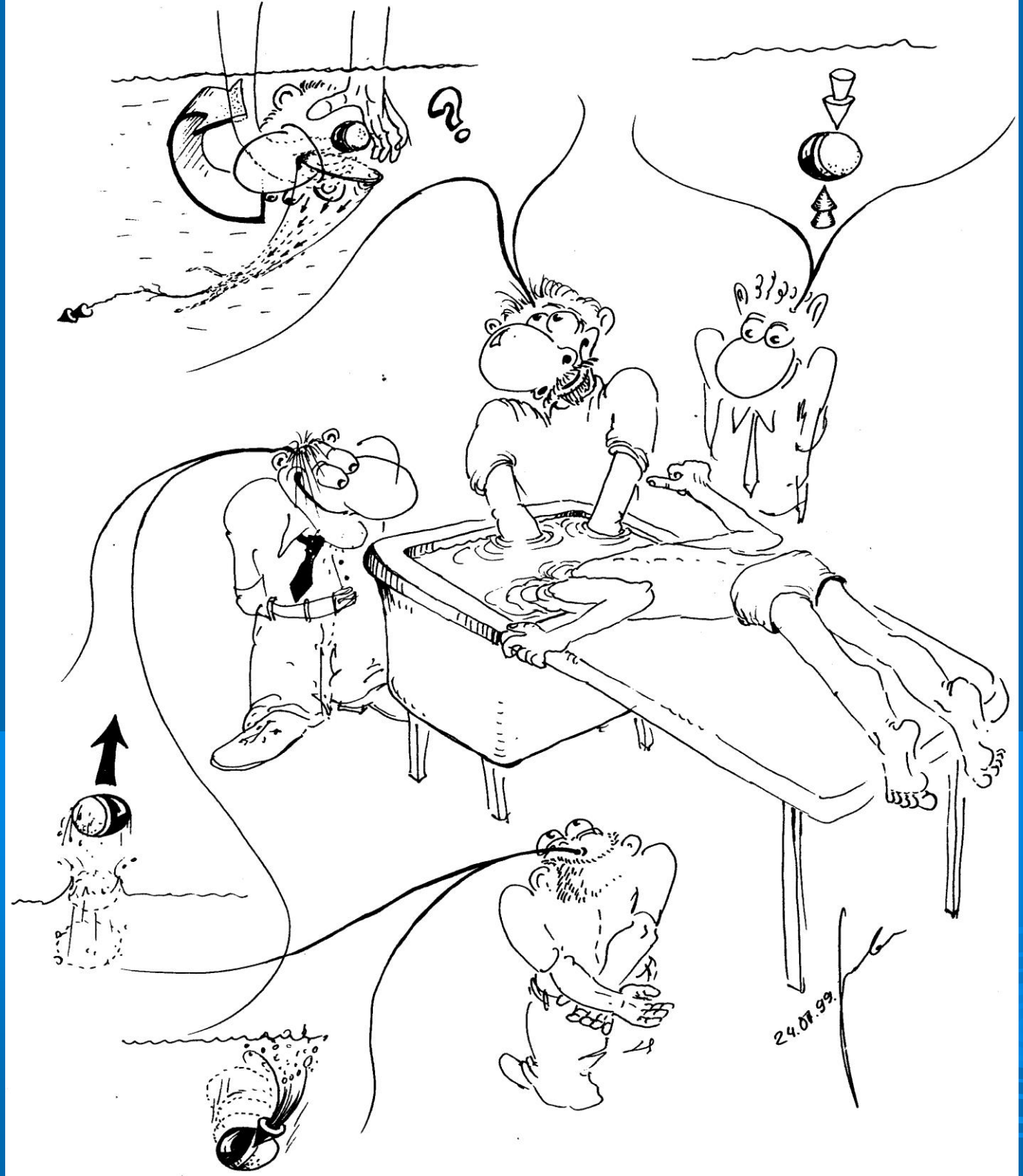
Find a lesion

Set up to the point of physiological locking

Practise ‘floating’

Mobilise under supervision

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The Sacral Toggle

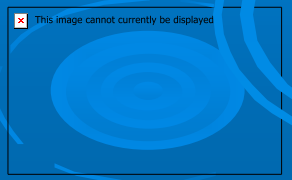
- Toggle means a swiveling, spinning or a turning movement.
- It is essentially an L5/S1 adjustment.
- It is also a whole correction of the pelvis.
- It is only used when all findings conform in all positions (standing, sitting and lying).
- The specific intention is to show the sacrum the way back to neutral.

General considerations for SAT

SAT is not appropriate for all patients:

- A unique segment is not available
- A group lesion, viscera, fascias, posture, etc.

It is ideal for the functional patient with a spine that is easy to adjust.

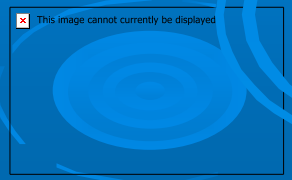


General considerations for SAT

Primary lesions are found most commonly in the upper C's or Pelvis (atypical)

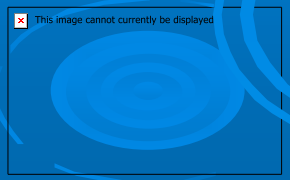
-Should you treat the primary first ? Ask the body

Positional lesions are best corrected at the start of a treatment regime if possible



TREATMENT SCENARIOS

A Work through the pivotal segments from above down.



Typical Treatment Scenarios

A

UC 1st

LC 2nd

UT 3rd

MT 4th

S 5th

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TREATMENT SCENARIOS

A Work through the pivotal segments from above down.

B Often in working from above down the base goes into lesion after correcting T3.

If so then correct the base and re-check C5/6 before moving on

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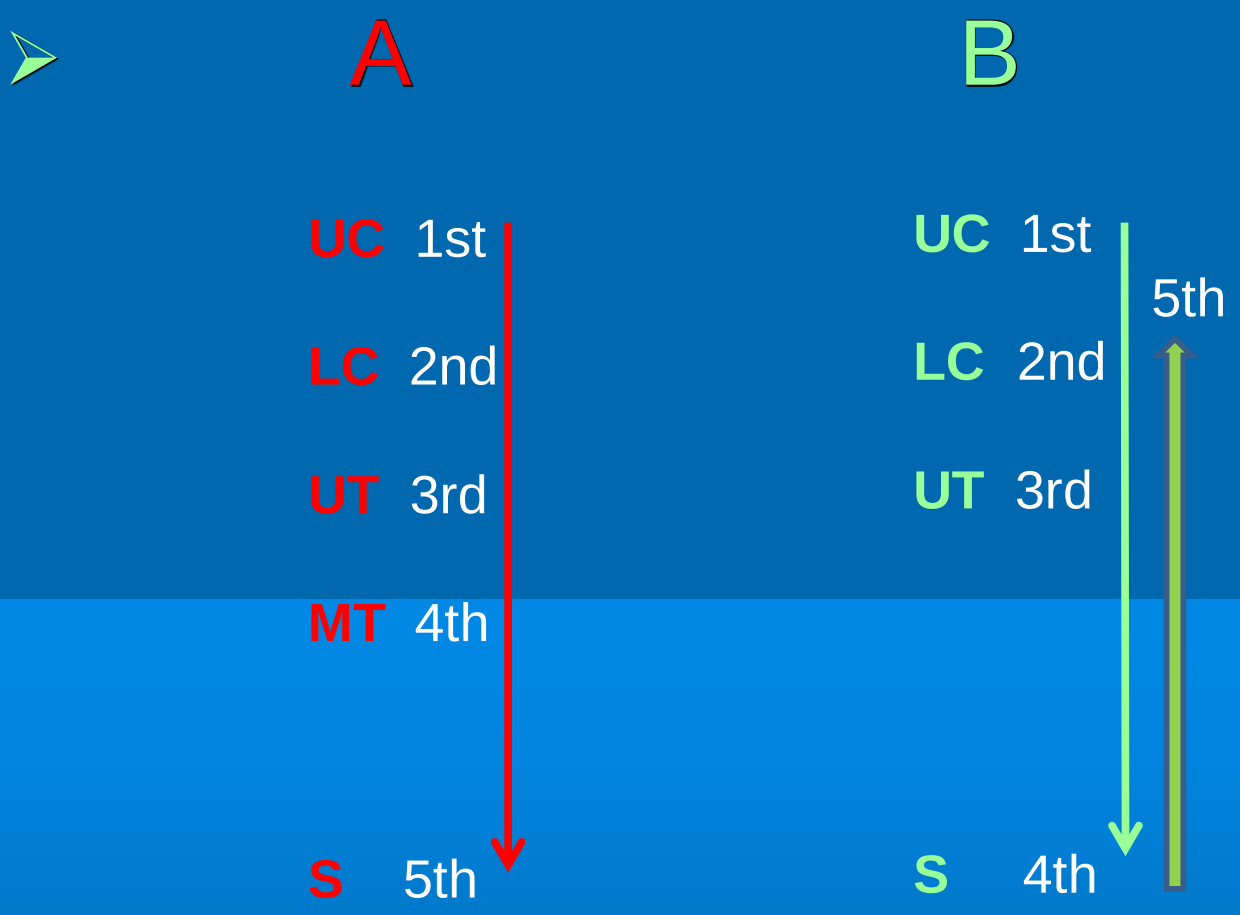
Typical Treatment Scenarios



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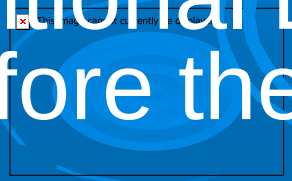
TREATMENT SCENARIOS

A Work through the pivotal segments from above down.

B Often in working from above down the base goes into lesion after correcting T3.

If so then correct the base and re-check C5/6 before moving on

C If starting in the base (positional L5/S1) address the (?) and (?) before the UC's



Typical Treatment Scenarios

A

UC 1st

LC 2nd

UT 3rd

MT 4th

S 5th

B

UC 1st

LC 2nd

UT 3rd

S 4th

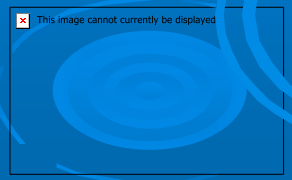
5th

C

LC 2nd

UT **3rd**

S 1st



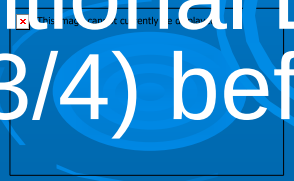
TREATMENT SCENARIOS

A Work through the pivotal segments from above down.

B Often in working from above down the base goes into lesion after correcting T3.

If so then correct the base and re-check C5/6 before moving on

C If starting in the base (positional L5/S1) address the (C5/6) and (T3/4) before the UC's



TREATMENT SCENARIOS

- If the dorsal curve is primary, then work on it as a curve first, before the pivots.

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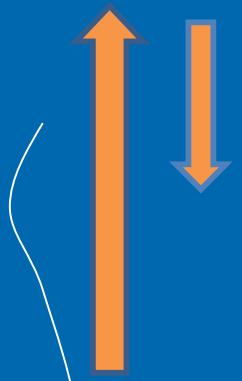
Typical Treatment Scenarios

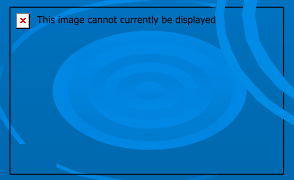
D

LC 2nd

UD **3rd**

D's 1st





Final Consideration…

Where there is recent shock or a revived history of shock, this must be released before specifically adjusting the pivots

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Treatment of Shock

Par: Gerald Lamb D.O. (U.K.) et Alain Dubreuil D.O. (QC.)

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What is Shock

Shock is an every day occurrence

Reflexes caught off guard lead to shock

A momentary surge of adrenaline or longer if more traumatic

Shock may be emotional….relationship upset or bereavement

A physical shock is like a ‘buzz’ in the system (bee-hive)

Emotional shock is like bubbles in sparkling water

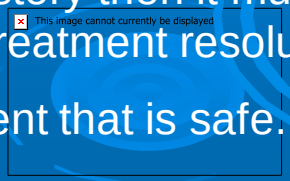
All the signs are of hyperadrenal activity..sweating, palor, trembling, high blood pressure

It should resolve naturally within hours…but I have found that it seems to sit in the background never fully resolving

It may then be readily reactivated even by a minor shock

If shock is evident or can be inferred from the history then it must be treated. Otherwise it tends to interfere with treatment resolutions

The steps that follow are an approach to treatment that is safe.



Technique

A/P hold over the diaphragm or coeliac plexus….just for the purpose of this exercise. It can be treated from anywhere in the body

Make sure the hands are relaxed with arms resting on the couch or patient's thigh

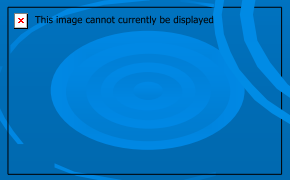
Settle into yourself and become aware of just observing

Throughout the procedure attend to your hands as if 'out the corner of your eye'. This will ensure your hands are light and your awareness is heightened

Begin by imagining that the space between your hands is growing larger and continue to increase the sense of space until shock is present between your hands and is continuously active

The only effort is to create enough space to ensure that shock is present and if it ebbs a little then create more space untl no further shock arises

Try to hold the shock as a steady presence until it ebbs away into relative calmness



Technique (continued)

If the shock does not fully die away or if after 15 minutes no further change is taking place then check with the body when to remove your hands.

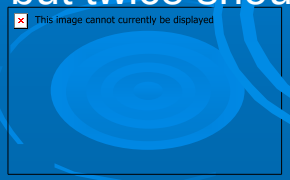
Most resolutions occur within 10 to 15 minutes

Should there be a sense of too much shock or the patient becomes a little agitated then you can readily control the rate of release by closing your hands together in order to compress the space a little

If the patient starts to shake uncontrollably then place a finger on the bridge of the nose (thinking Lamina Terminalis) and a finger on the coccyx. Holding the space between your contacts will settle the system within 10 minutes.

Treating the shock is a treatment in itself and should be all you do in the session.

It may need to be repeated on another occasion but twice should be enough




JAB