



**COLLECTED
PAPERS OF THE MEMBERS
OF THE
INTERNATIONAL COLLEGE OF APPLIED KINESIOLOGY**

COPYRIGHT ICAK 1986

PRESENTED JUNE 11th THROUGH JUNE 13th, 1986

**SHELDON C. DEAL, N.D., D.C.
PAST CHAIRMAN I.C.A.K.**

INTRODUCTION

by

Sheldon C. Deal, D.C.

Past Chairman

This twenty-first collection of papers of the members of the International College of Applied Kinesiology represents 41 papers written by 34 authors.

These papers will be presented by their authors to the general membership at the Summer meeting to be held in St. Louis, Missouri on June 11, 12, 13, 1986. The authors welcome comments and further ideas on their findings either in St. Louis or you may write them directly as their addresses are included in the Table of Contents.

These manuscripts appearing in this collection of the International College of Applied Kinesiology papers have been initially screened. However, neither the International College of Applied Kinesiology nor the Executive Board nor the Examining Board necessarily endorses or approves or vouches for the originality or authenticity of any statements of fact or opinion. The opinions and positions stated in these papers are those of the authors and not by fact of publication necessarily those of the International College of Applied Kinesiology or the Executive Board or the Examining Board.

The papers are being mailed out to the members well in advance of the St. Louis meeting. This will allow the membership at large to read the papers in advance which will save time at the Summer meeting and hopefully stimulate more questions from the members and more demonstrations from the individual author.

We the members of I.C.A.K. can be proud of the amount of research being conducted and feel fortunate to have it at our fingertips in the form of these Collected Papers. It cannot help but be an asset to our health and also to the health of our patients.

****TABLE OF CONTENTS****

*Diplomates	PAGE
CORRELATIONS BETWEEN APPLIED KINESIOLOGY AND GERMAN ELECTRO- ACUPUNCTURE, A SERIES I. DETERMINING QUANTITATIVE AMOUNTS IN NUTRITIONAL TESTING	Mary Anderson, D.C. 503 N. Hwy. 101 Solana Beach, CA 92075 1
CORRELATIONS BETWEEN APPLIED KINESIOLOGY AND GERMAN ELECTRO- ACUPUNCTURE, A SERIES II. TESTING FOR TOLERANCE AND COMPATIBILITY OF NUTRITIONAL SUPPLEMENTS	Mary Anderson, D.C. 13
DIET PLANNING AND META- BOLIC INDIVIDUALITY A BODY-TYPING APPROACH	John Bandy, D.C.* P.O. Box 467 Blowing Rock, N.C. 28605 19
APPLIED MECHANICS, MUSCULO- SKELETAL FORCES AND THE KINESI-ARC SYSTEM	Charles A. Bender, D.C. 484 Union Ave. Middlesex, N.J. 08846 37
STRUCTURAL LESIONS WITH SPECIFIC GAIT PATTERNS	Richard J. Caskey, D.C.* 1153 W. Main St. Waterbury, CT 06708 45
THE THERAPEUTIC USE OF MAGNETS	Earl L. Colum, D.C.* 1249 Shermer Northbrook, IL 60062 49
FIVE ELEMENT MASTER CHART PART II: SHENG CYCLE, SOURCE AND LUO POINTS	Salvatore V. Cordaro, D.C.* 4730 Richardson Ave. Bronx, N.Y. 10470 57
LEARNING DIFFICULTIES VIEWED IN THE LIGHT OF APPLIED KINESIOLOGY, SPECIFICALLY, THE FERRERI NEURAL ORGANIZATION METHOD	Mitchell R. Corwin, D.C. 3101 Clayton Rd. Concord, CA 94519 61
THE EMOTIONAL ASPECTS OF MERIDIAN SPINAL ADJUSTING	E.J. Cousineau, D.C. 312 E. Pioneer Ave. Puyallup, WA 98372 69
THE SEVEN CONDITIONS OF MUSCLE BALANCE	Sheldon C. Deal, D.C.* Richard D. Utt 1001 N. Swan Tucson, AZ 85711 75

		PAGE
THERAPY LOCALIZATION OF ACUPUNCTURE POINTS	Gerald Deutsch, D.C.* 448 E. Southern Tempe, AZ 85281	93
A SCREEN TEST FOR CERVICAL INJURIES TO DE- TERMINE MALINGERING	Gerald Deutsch, D.C.*	103
TECHNIQUE VARIATIONS	David P. Engel, D.C.* 3873 Monroe St. Toledo, OH 43606	109
STRESS AND DISEASE	Burt Espy, D.C. 17125 Boones Ferry Rd. Lake Oswego, OR 97034	115
UNIVERSAL SACRAL FAULT	Edward E. Evans, D.C.* 9424 W. Raintree Dr. S. Columbus, IN 47201	125
THE UTILIZATION OF LIPS APART AND LIPS TOGETHER IN FOOD ALLERGY MUSCLE TESTING	Kenneth S. Feder, D.C.* 775 Douglas Atlanta, GA 30342	129
THE CURE FOR DYSLEXIA AND LEARNING DISABILITIES: UPDATE	Carl A. Ferreri, D.C. 3850 Flatlands Ave. Brooklyn, N.Y. 11234	133
PROTOCOL TO EFFECT THE BEST RESULTS FOR DYSLEXIA AND L.D. TECHNIQUE	Carl A. Ferreri, D.C.	151
PARASITES	Terry L. Franks, D.C.* 1975 Cliff Rd. Burnsville, MN 55337	157
PREPELVIC TAP	Richard Guidry, D.C. 4416 Johnston St. Lafayette, LA 70503	161
OBSERVATIONS ON TONSILLITIS AND THE SORE THROAT	Richard Guidry, D.C.	163
ENDO NASAL INSUFFLATION	Christopher L. Harrison, D.C.* 299 California Ave. Palo Alto, CA 94306	165
APPLIED KINESIOLOGY TESTING IN THE DIAGNOSIS OF CANDIDA ALBICANS	Darrel W. Hestdalen, D.C. 664 W. 12th St. Dickinson, N.D. 58601	171
CLAVICLE SUBLUXATION IN RECTUS FEMORIS DYSFUNCTION	Darrel W. Hestdalen, D.C.	177

GALL BLADDER MERIDIAN IMBALANCE IN RECURRENT HYDROCHLORIC ACID DEFICIENCY	James D. Hogg, D.C. 1810 Second Ave. Rock Island, IL 61201	181
STATISTICAL BEFORE AND AFTER EXAMINATION RESULTS	Alex P. Karpowicz, D.C.* 1201 Wheeler Ave. Dunmore, PA 18510	183
NON-KINETIC PHYSIOLOGICAL INDICATORS IN EXAMINATION OF THE NEW PATIENT	Gary N. Klepper, D.C.* 1440 28th St., Suite 1 Boulder, CO 80303	187
PATIENT THERAPY LOCALIZA- TION VERSUS DOCTOR THERAPY LOCALIZATION	Gary N. Klepper, D.C.*	195
PATIENT ORIENTATION	George Koffeman, D.C.* 203 S. West Ave. Jackson, MI 49201	201
PROFESSION OUTLINE OF THE "HEILPRAKTIKER"	Matthias Lesch, D.C. Hauptstr. 272 Weil am Rhein 7858 GERMANY	205
	Alfred Schatz, D.C. Johanniterstr. 11 7800 Freiburg W. GERMANY	
APPLIED KINESIOLOGY AND REIKI	Nancy L. McBride, D.C.* 1249 W. Gardena Blvd. #101 Gardena, CA 90247	209
LOW BACK PAIN REPORT	Richard Meldener, D.C.* 49 Rue des Mathurines Paris, 75008 FRANCE	213
HAIR SAMPLES AND STRESS FRACTURES IN RUNNERS	Gordon D. Mendenhall, D.C. 6204 8th Ave., N.W. Seattle, WA 98107	217
PROPRIOCEPTORS: NEW METHODS OF ANALYSIS AND CORRECTION	James L. Otis, D.C. 2920 Domingo Ave. Berkeley, CA 94705	245
TONIC LABYRINTHINE REFLEXES IN THE WEIGHT BEARING POSITION	Walther H. Schmitt, Jr., D.C.* 87 S. Elliott Rd. #110 Chapel Hill, N.C. 27514	259
MENINGEAL SUBLUXATION OVERVIEW	Sheldon Sinett, D.C.* 133 E. 58th St. New York, N.Y. 10022	273
LOW BACK PAIN AND DEPRESSION A RETROSPECTIVE STUDY OF 129 CASES	John F. Thie, D.C. * 1192 N. Lake Ave. Pasadena, CA 91104	277

THE GRADING OF INTER-
VERTEBRAL DISC LESIONS

B.E. Vickery, D.C.
P.O. Box 623, Rt. 53
W. Redding, CT 06896

279

A SPECIFIC NUTRITIONAL
GUIDE AND SOME APPLIED
KINESIOLOGY SUGGESTIONS
FOR PATIENTS' SIGNS AND
SYMPTOMS

C. Lance West, D.C.*
5755 Uplander Way
Culver City, CA 90230

283

INDUCTION OF NEUROVASCULAR
RESPONSE

A.J. Woodson, D.C.
772 Sciota St.
Urbana, OH 43078

401

THE LEG-PUSH TEST

A.J. Woodson, D.C.

407

INDEX

413

CORRELATIONS BETWEEN APPLIED KINESIOLOGY AND GERMAN
ELECTROACUPUNCTURE, A SERIES.

I. DETERMINING QUANTITATIVE AMOUNTS IN NUTRITIONAL TESTING

MARY B. ANDERSON, D.C.
Solana Beach, CA
February 1986

Abstract:

Among the significant findings in our study of applied kinesiology is muscle testing for nutritional supplements and establishing a need for them. Another significant study is "medication testing", a facet of German Electroacupuncture, as presented by Dr. Reinhold Voll, M.D. of Germany.

This paper presents how muscle testing for nutritional supplements also correlates to similar testing using Electroacupuncture According to Voll (EAV) and the EAV Dermatron as a monitor of accuracy. The foundation for "medication testing" is briefly explained and how three years of my research involving the EAV Dermatron and applied kinesiology muscle testing produces the same results in establishing the quantity of therapeutic nutrients to be taken by the patient.

* * * * *

CORRELATIONS BETWEEN APPLIED KINESIOLOGY AND GERMAN
ELECTROACUPUNCTURE, A SERIES.

I. DETERMINING QUANTITATIVE AMOUNTS IN NUTRITIONAL TESTING

PAGE 2 - Mary B. Anderson, D.C.

February 1986

Electroacupuncture According to Voll (EAV) involves locating acupuncture points and their measurements. These point locations measure the resistance of the individual point within the acupuncture meridian. Because of the unique method of calibration of this system, etiological diagnosis and medication testing for non-toxic treatment can be established. The EAV system is a complex discipline in itself and I am using only a few facets of its laws in this paper.

To ascertain a basis for determining nutritional testing by applied kinesiology methods, I compared approximately 300 case histories with the EAV system since 1982.

The individual German acupuncture measurement points bear a direct relationship with an anatomical structure or physiological function in the body. E.G. an abnormal measurement point on the Liver Meridian would correspond in AK to Pectoralis Major muscle. The muscle, however, would only be weak if the Liver was not the direct cause of the problem, but only a secondary cause (hypotonic). Abnormal point measurement readings reflect primary and secondary imbalances. Secondary imbalances (hypotonic) would produce weak indicator meridian muscles, but the primary imbalance (hypertonic) shows no weak indicator meridian muscles.

CORRELATIONS BETWEEN APPLIED KINESIOLOGY AND GERMAN
ELECTROACUPUNCTURE, A SERIES.

I. DETERMINING QUANTITATIVE AMOUNTS IN NUTRITIONAL TESTING

PAGE 3 - Mary B. Anderson, D.C.

February 1986

Measurement readings on the EAV system involves challenging a point with a probe after the application of a requisite contact pressure with an electrical voltage of approximately 1.5 volts DC. To facilitate the measurement, the patient holds in one hand the negative electrode and the physician applies the current to the point to be measured via a brass probe stylus. The physics and details of point measurement are well described in the Voll literature. These points have been found to be reliable and reproducible by qualified and experienced physicians.

The measurement scale is calibrated from 0 to 100, which represents 0-20 microamperes. A reading showing a value of 50 scale units with no movements of the indicator needle on the meter permits the inference that the structure or function under study is in good health. The most important phenomenon to observe in making readings is that of the indicator drop. This is seen when the needle rises to a maximum labile value and then begins to fall off, eventually reaching a minimum stable value.

Point measurement and their values have many different meanings. However, since this paper is correlating AK nutritional testing

CORRELATIONS BETWEEN APPLIED KINESIOLOGY AND GERMAN
ELECTROACUPUNCTURE, A SERIES.

I. DETERMINING QUANTITATIVE AMOUNTS IN NUTRITIONAL TESTING

PAGE 4 - Mary B. Anderson, D.C.

February 1986

with the EAV indicator drop, it will not discuss the details of other criteria in measuring points. For the sake of simplicity the EAV indicator drop means a dysfunction in that meridian.

Another insight by Dr. Reinhold Voll was that a substance introduced into the electrical circuit when the point measurements are being made, will, if the substance is correctly chosen, change the reading values made at the acupuncture point to a more normal value. First the introduction into the circuit is done qualitatively to see if the indicator drop has become stable and balanced to a normal value as close to 50 scale units as possible. After determining a substance is beneficial an exact quantitative amount would be introduced into the circuit to also balance the meridian value to 50 scale units. The closer the scale units to 50 that can be established, the more ideal the substance would be to stimulate the body to homeostasis.

It has already been determined that in AK muscle testing for nutritional supplements, the substance to be tested is placed in the mouth and a weak indicator muscle will strengthen. The clinical judgment of the physician would then establish a dosage.

CORRELATIONS BETWEEN APPLIED KINESIOLOGY AND GERMAN
ELECTROACUPUNCTURE, A SERIES.

I. DETERMINING QUANTITATIVE AMOUNTS IN NUTRITIONAL TESTING

PAGE 5 - Mary B. Anderson, D.C.

February 1986

I have found that:

1. A nutritional substance placed in the mouth, if needed, will strengthen a weak indicator muscle.
2. By continuing to muscle test with larger quantities of substance a point will be reached when the indicator muscle will again retest weak.
3. The highest substance amount that will continue to keep an indicator muscle strong is the correct dosage.
4. The substance dosage determined by muscle testing is the same, without exception, as that determined by EAV in-circuit substance testing. Both methods balance the meridian.

E.G.

Dermatron Liver Meridian Testing

1. Scale units measured 68 with an indicator drop to 64 on a specific liver meridian measurement point.

CORRELATIONS BETWEEN APPLIED KINESIOLOGY AND GERMAN
ELECTROACUPUNCTURE, A SERIES.

1. DETERMINING QUANTITATIVE AMOUNTS IN NUTRITIONAL TESTING

PAGE 6 - Mary B. Anderson, D.C.

February 1986

2. Livatrophic (Nutridyn) introduced into electrical circuit abolished the indicator drop.
3. Quantitatively, e.g. 4 Livatrophic glandulars balanced the scale units to 50.

Applied Kinesiology Liver Meridian Testing

1. Weak Pectoralis Major indicator muscle to start.
2. Strengthened by placing a Livatrophic in mouth.
3. Continue to add Livatrophic in mouth one at a time until muscle retests weak.
 - e.g. A. 4 Livatrophics in mouth, Pectoralis Major muscle will still test strong.
 - B. 5 Livatrophics in mouth, Pectoralis Major will reweaken.
4. This indicates strong at 4, weak at 5. Four tablets would be the end point.

CORRELATIONS BETWEEN APPLIED KINESIOLOGY AND GERMAN
ELECTROACUPUNCTURE, A SERIES.

I. DETERMINING QUANTITATIVE AMOUNTS IN NUTRITIONAL TESTING

PAGE 7 - Mary B. Anderson, D.C.

February 1986

This is a very simplistic analysis of what happens to the energy household in that meridian.

The weak indicator meridian muscle, you must bear in mind, is only a secondary imbalance (hypotonic). A primary imbalance will not present itself with a weak meridian muscle (hypertonic).

Even though the EAV system will demonstrate indicator drops in both primary and secondary imbalances, the physician must understand which meridian needs the therapeutic support. Understanding the Law of Five Elements is of utmost importance.

Now that the need for a therapeutic substance has been established, the next question that presents itself is how often is the dosage administered.

I have found through case studies that after approximately 6-8 hours the meridian readings on the instrument begin to fluctuate from their normal values. The initial dosage tested to be taken three times per day (t.i.d.) will keep the meridian in balance.

CORRELATIONS BETWEEN APPLIED KINESIOLOGY AND GERMAN
ELECTROACUPUNCTURE, A SERIES.

I. DETERMINING QUANTITATIVE AMOUNTS IN NUTRITIONAL TESTING

PAGE 8 - Mary B. Anderson, D.C.

February 1986

The patient may only need to stay on that dosage for a few days to a week before retesting for reduction in dosage requirements. The dosages will start to reduce and be a monitor of the progress of the patient.

After the muscle no longer tests weak in the clear and it is necessary to do temporal tapping, EID, humming or counting to bring out the weak muscle, then this indicates the patient's therapeutic dosage turns into a maintenance dosage. Usually this happens after the patient has been taking the reduced dosage of 1 t.i.d. The dosage is then again reduced to 1 two times per day (b.i.d.) for approximately 1 month. After 1 month at 1 b.i.d., then reduced to 1 per day for approximately 1 month.

Depending on how stressed the organ has been, they may either continue on 1 per day for many weeks or if muscle no longer tests weak on temporal tapping, EID, humming or counting, the nutrition is then discontinued.

I have reached this end point on multiple patients monitoring their progress on the EAV Dermatron for an objective view of optimal meridian values on the meter.

CORRELATIONS BETWEEN APPLIED KINESIOLOGY AND GERMAN
ELECTROACUPUNCTURE, A SERIES.

I. DETERMINING QUANTITATIVE AMOUNTS IN NUTRITIONAL TESTING

PAGE 9 - Mary B. Anderson, D.C.

February 1986

The following is an example only of how the dosage may show a pattern in muscle testing.

Week 1	4 Livatrophic t.i.d.	Total 12 per day
Week 2	3 Livatrophic t.i.d.	Total 9 per day
Week 3	2 Livatrophic t.i.d.	Total 6 per day
Week 4	1 Livatrophic t.i.d.	Total 3 per day

After muscle no longer tests weak in clear:

Week 5	1 Livatrophic b.i.d.	Total 2 per day
Week 9	1 Livatrophic 1 per day	Total 1 per day
Week 13	Discontinued.	

Note: The above is only an example. Each patient is different. Some patient's therapy only lasts one month. Some can last 1 year. It depends on the stressed organ. It must be tailored made for the patient. The above is only an example.

Also the physician may have several choices of nutrition to have the patient take. Each individual has their own specific requirements. The glandular, Livatrophic, was used only as an example.

CORRELATIONS BETWEEN APPLIED KINESIOLOGY AND GERMAN
ELECTROACUPUNCTURE, A SERIES.

I. DETERMINING QUANTITATIVE AMOUNTS IN NUTRITIONAL TESTING

PAGE 10 - Mary B. Anderson, D.C.

February 1986

Author's Comments:

The patients, I have found using this method, become very aware of their own health needs. It helps them monitor their own progress and become more involved with their own health. I have found also that the patients have been less likely to take supplements without discretion. This helps also in case management. There is a certain amount of enthusiasm to both the doctor and the patient when they can see themselves getting better. Even though the dosages may be high to start, if the doctor explains that it's only temporary in order to stimulate the body to cooperate, there has been no problem with the high dosages in the early weeks of treatment. Patients have told me they look forward to their office visits to see their improvements.

THIS IS A VERY SIMPLISTIC APPROACH. THE IDEAL TREATMENT IS TO TREAT THE HYPERTONIC MERIDIAN FOR BEST RESULTS. FINDING THE WEAK LINK IN THE CHAIN IS MOST IMPORTANT.

My knowledge in the Voll system is that I have completed and passed all necessary requirements through the Occidental Institute Research Foundation for Bioenergetic Medicine to be qualified as an EAV physician.

CORRELATIONS BETWEEN APPLIED KINESIOLOGY AND GERMAN
ELECTROACUPUNCTURE, A SERIES.

I. DETERMINING QUANTITATIVE AMOUNTS IN NUTRITIONAL TESTING

PAGE 11 - Mary B. Anderson, D.C.

February 1986

REFERENCES

1. Voll, R. "Twenty Years of Electroacupuncture Diagnosis in Germany. A Progress Report." American Journal of Acupuncture, Vol. 3, No. 1, (March 1975), pp. 7-17.
2. Madill, Peter, M.D. "Electroacupuncture: A True and Legitimate Preventive Medicine. An Appreciation of the Work and Discoveries of Dr. Reinhold Voll, M.D." American Journal of Acupuncture, Vol. 7, No. 4, (October-December, 1979), p. 283.
3. Leonhardt, H. Fundamentals of Electroacupuncture According to Voll. Translated from German by Helga Sarkisyanz, M.D. Uelzen: Medizinisch Literarische Verlagsgesellschaft mbH., 1980.

CORRELATIONS BETWEEN APPLIED KINESIOLOGY AND GERMAN
ELECTROACUPUNCTURE, A SERIES.

II. TESTING FOR TOLERANCE AND COMPATIBILITY OF
NUTRITIONAL SUPPLEMENTS

MARY B. ANDERSON, D.C.
Solana Beach, CA
February 1986

Abstract:

Muscle testing for the correct nutritional supplements is not always sufficient. Intolerance to the desired substance is often overlooked. Even though product labels are similar, nutrient processing may lead to toxicity which contributes to allergic reactions.

This paper presents a screening for this reaction by muscle testing a specific acupuncture point which can be reliably demonstrated when performing EAV in-circuit substance testing.

* * * * *

As applied kinesiologists we have relied on muscle testing to ascertain whether a nutritional supplement is needed for various muscle weaknesses.

CORRELATIONS BETWEEN APPLIED KINESIOLOGY AND GERMAN
ELECTROACUPUNCTURE, A SERIES.

II. TESTING FOR TOLERANCE AND COMPATIBILITY OF NUTRITIONAL
SUPPLEMENTS

PAGE 2 - Mary B. Anderson, D.C.

February 1986

In a previous paper by this author, I presented a correlation between applied kinesiology and German Electroacupuncture as a mutual method for determining quantitative amounts of nutrition to be taken.

Electroacupuncture According to Voll (EAV) involves locating acupuncture points and their measurements. These point locations measure the resistance of the individual point within the acupuncture meridian.

Traditional Chinese Acupuncture clearly describes twelve paired meridians and two unpaired meridians. Dr. Reinhold Voll, M.D. of Germany has objectively demonstrated in his system of analysis these common meridians in addition to several uncommon vessels, one of which is an Allergy Vessel.

After determining the need for a substance and a muscle tests strong as a result of this substance, I have proceeded to find out if the body is able to tolerate the nutrition by EAV in-circuit substance testing. This is done by challenging a point with a probe after the application of a requisite contact pressure.

CORRELATIONS BETWEEN APPLIED KINESIOLOGY AND GERMAN
ELECTROACUPUNCTURE, A SERIES.

II. TESTING FOR TOLERANCE AND COMPATIBILITY OF NUTRITIONAL
SUPPLEMENTS

PAGE 3 - Mary B. Anderson, D.C.

February 1986

If the point measured cannot maintain a maximum liable value and begins to fall off, then the substance will not be tolerated well by the patient. This is known in EAV as an indicator drop. This substance, if not tolerated, is incompatible with the patient's energy household. The specific anatomical and/or physiological functions can then be cross-checked to find out where the incompatibility lies.

Some areas of the body that will correspond to this incompatibility are sinus, lungs, large intestine, small intestine, ileocecal valve, duodenum, liver, pancreas, stomach, gallbladder, urinary bladder, kidney, circulation, endocrine system, muscles and ligaments. There are also others.

The body, for example, may only have incompatibility in the small intestine and adrenals. If muscle testing for the correct nutrition is done with muscles unassociated with the small intestine or adrenals, the intolerance can be missed.

The Allergy Vessel point that has been discovered by Dr. Voll is located on the index finger above the fingernail on the ulnar side. See Figure 1.

CORRELATIONS BETWEEN APPLIED KINESIOLOGY AND GERMAN
ELECTROACUPUNCTURE, A SERIES.

II. TESTING FOR TOLERANCE AND COMPATIBILITY OF NUTRITIONAL
SUPPLEMENTS

PAGE 4 - Mary B. Anderson, D.C.

February 1986

This point can be muscle tested and is a reliable screening to determine if the patient can tolerate the substance. The point can be therapy localized by either the patient or the doctor, as well as all other acupuncture points. Test both right and left acupuncture points since this is a bilateral vessel. Right will indicate interference on the right side of the body; left, on left side. Cross therapy localizing can aid in searching for compensated areas.

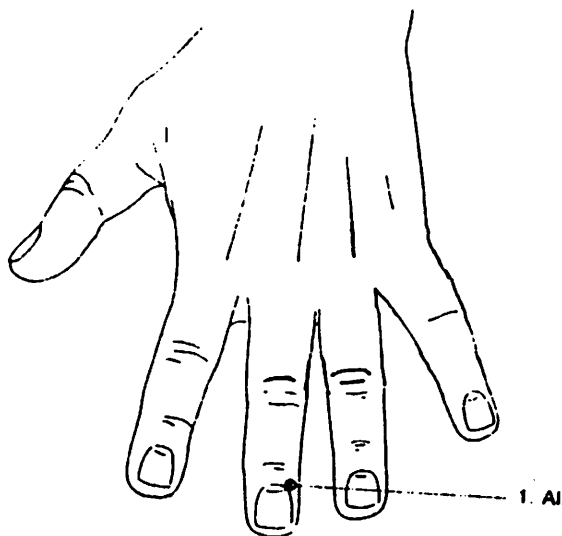


Figure 1.

CORRELATIONS BETWEEN APPLIED KINESIOLOGY AND GERMAN
ELECTROACUPUNCTURE, A SERIES.

II. TESTING FOR TOLERANCE AND COMPATIBILITY OF NUTRITIONAL
SUPPLEMENTS

PAGE 5 - Mary B. Anderson, D.C.

February 1986

If the doctors will screen for tolerance and compatibility with each patient before consumption, they will find many difficult cases respond more quickly. Avoiding a compensated or hidden toxicity can make the difference. If necessary, use temporal tapping, EID, humming or counting when testing.

Author's Comment:

This testing came to my attention when patients would bring in nutrition purchased from various health food stores and other sources. The ingredients as stated on the labels looked comparable to nutrients I carried in my office, but they did not muscle test the same. EAV in-circuit testing proved many of them to cause toxicity.

In the past three years of comparing nutritional supplements, I found a few reliable manufacturers that consistently had products that were tolerated well by patients. The processing involved appears to play a very important part.

Additionally, Allergy Vessel Point 1 is an excellent screen for food allergy testing.

CORRELATIONS BETWEEN APPLIED KINESIOLOGY AND GERMAN
ELECTROACUPUNCTURE, A SERIES.

II. TESTING FOR TOLERANCE AND COMPATIBILITY OF NUTRITIONAL
SUPPLEMENTS

PAGE 6 - Mary B. Anderson, D.C.

February 1986

REFERENCES

1. Leonhardt, H. Fundamentals of Electroacupuncture According to Voll. Translated from German by Helga Sarkisyanz, M.D. Uelzen: Medizinisch Literarische Verlagsfgesellschaft mbH., 1980.

2. Anderson, Mary B., D.C. "Correlations Between Applied Kinesiology and German Electroacupuncture, A Series. Determining Quantitative Amounts in Nutritional Testing." Collected Papers of the Members of the I.C.A.K. Summer 1986.

DIET PLANNING AND METABOLIC INDIVIDUALITY
A Body-Typing Approach

John V. N. Bandy, D.C.

ABSTRACT: Body typing is a concept based on the idea that metabolic individuality exists and is not a random occurrence but rather is orderly and understandable and can be determined by observation and simple examination procedures. Specific dietary recommendations to achieve metabolic balance in individuals is also discussed.

INTRODUCTION

D. D. Palmer set out for chiropractic a truly holistic philosophy. His structural, chemical, and psychological triad of health categorizing environmental irritants (stresses) is a more functional representation of holistic health care than the presently accepted triangle of body, mind and spirit. As chiropractors, we are in the unique position of being the only natural health care licensed in all 50 states and have the opportunity to help our patients achieve that state where they are using a minimum of energy to maintain bodily functions and have plenty of reserve energy to enjoy a full and challenging life. In short, by applying chiropractic principles, we can help our patients towards wellness. The purpose of this article is to discuss the lowering of chemical stress by the preparation of individualized diets based primarily on the concept of body typing.

In practice, along with structural correction, diet is one of the first issues I address for patients with visceral complaints. This is not because diet is more important than other stresses, such as job stress, marital stress,

or air pollution, but because it is much easier to change. In planning a diet for a patient, there are a number of considerations:

(1) Removal or reduction of foods you consider to be universally stressful. My list includes sugar, refined carbohydrates, alcohol, drugs (recreational), coffee, fried foods, hydrogenated and/or rancid oils, pork, chemical preservatives and additives.

(2) Development of a diet that will promote endocrine balance.

(3) Removal of foods to which the patient is allergic.

(4) Modification of the diet to obtain proper ph balance.

GLANDULAR DOMINANCE (Figure 1)

The basic structure of the diets I recommend is built around the concept of body typing. Doctors and philosophers have been classifying people by size and shape for centuries. The authors I have found the most helpful in developing the system that I use are Nicola Pende, M.D.,^{1,2,3} Melvin Paige, D.D.S.,⁴ Henry Beiler, M.D.,⁵ Elliot D. Abravanel, M.D.,⁶ and William H. Wakeman.⁷ The system is based on the concept that all people are conceived with a particular balance in their endocrine system and that this balance affects their physical development, metabolic patterns, emotional tendencies and food preferences. By observing the size and shape of the torso, rib angles, extremities (especially the hands), bony prominences, etc., determination can be made as to a person's endocrine balance, most importantly his/her dominance. The dominant gland is the gland that is hereditarily the strongest in a particular individual. It is the gland that dominates his/her physiology. Although all the glands are important in our metabolism, it is my opinion that people can be divided by dominance into four major categories: Anterior

pituitary, thyroid, adrenal cortex, and gonadal. [There are also a few people whose systems seem very balanced (no dominance) that Pende called Eumorphic.] Each of these glands produces distinctive traits, and each person has a different balance of these traits depending on his/her individual metabolic balance during development. The gland that has had the most effect on the person's development is the dominant gland. Although most people have a dominance, the degree of dominance can vary greatly, making some people much easier to body type than others. As an aid in those close calls I find the hands, height and food cravings to be the most helpful clues.

ANTERIOR PITUITARY

The anterior pituitary has been called the master gland due to its production of trophic hormones, but for dominance purposes the most important function of the anterior pituitary is the production of growth hormones. The most obvious morphological characteristic of pituitary dominance is increased bone growth. P-types tend to be taller than other body types, but even more characteristic is an increase in the span of the bones and an enlargement of the bony prominences. Especially common are an enlarged supraorbital area, broad shoulders, and long and large extremities. Their hands are big with long tapered fingers, long palms and a distinctive lateral angle at the metatarsal/phalangeal joint. P-type women generally are larger below the waist than above.

The prolactin in milk is a pituitary stimulant and causes strong cravings in P-types. They also tend to tolerate simple carbohydrates poorly and function best on a high protein diet (including red meat) with little or no dairy products. The pituitary and gonads function on opposite ends of the

metabolic seesaw, and P-type women often have low estrogen and/or progesterone PMS symptoms.

THYROID DOMINANCE

The chief trait of thyroid morphology is leanness. The thyroid obviously elevates metabolism, and T-types tend towards high metabolism. Their hands are long and thin with straight rather than tapered fingers, often with pronounced joints. Nails are hard and moons pronounced. T-types usually have prolific eyebrows often meeting above the nose. Their hair is fine and teeth are white and small. Their bones are long and thin. Women often have hypogonadal weight gain with no other body fat. The thyroid is stimulated by anything that raises the blood sugar. Therefore T-types tend to crave sweets, coffee, chocolate, juices, alcohol, etc. They tend to be the classic hypoglycemics and do best on a diet that is high in protein and high quality fats and low in simple carbohydrates. Breakfast is the most important meal. T-types tend towards nag-type illnesses but tend to live long lives. Arthritis and skin problems are common, as are headaches. T-types tend toward depression. If they are in the habit of starting their day with coffee or soft drinks, they tend to have sharp hills and valleys in energy and temperament. The thyroid and adrenals are on opposite ends of the metabolic seesaw, and adrenal support is often needed along with high quality cholesterol as a steroid precursor. T-types do best on an early-to-bed-early-to-rise schedule.

ADRENAL DOMINANCE

The key morphological characteristic of A-types is muscular development and intramuscular water retention. This type tends to be of medium height

and to be strongly built. Their hands are square with tubular fingers about as long as the palms. The face tends to be triangular.

A-types tend to have good resistance to disease and get well quickly. They tend to work and play hard. Thymus and thyroid tend to be their weakest glands, and they often are the victims of asthma and allergies. The adrenals are stimulated by sodium and cholesterol, and A-types usually crave salt, salty foods and grease. Chips, red meat, french fries and fried shrimp are prime examples. The adrenals tend to get stronger and stronger as the day progresses, and A-types who stimulate their adrenals in the morning often drink in the evening to calm down (hence beer bellies). They tend towards high blood pressure and heart attacks, and the diet they should follow is similar to Pritikin's diet, being high in complex carbohydrates and low in fats. Late to bed and late to rise is the norm.

GONADAL DOMINANCE

Gonadal hormones are responsible for the closing of the growth plates, therefore, the chief traits in G-type morphology are shortness and, of course, a high degree of sexual development. Dolly Parton is the extreme example of the G-type woman. The male tends to be short and strong (the muscle is softer and not so well defined as the A-type male) with ample body hair (often on the back). They have fine bones and small hands with tapered fingers. The fingers usually are shorter than the palm. Their hair usually is thick and coarse. Males usually are under 5'9" and women under 5'3".

Pituitary stimulation is a good balancer for G-types, which makes dairy foods a good choice for them. Red meat, hot spices and rich creamy sauces are not on the G-diet, because these are stimulants to gonadal metabolism.

G-women have less PMS than the average woman, and their only consistent physical fight is with weight gain after menopause. G-types tend to age well. Probably due to high estrogen levels, their skin tends to be very smooth and elastic.

WEIGHT GAIN PATTERNS (Figure 2)

Once dominance has been established and a basic diet has been chosen, modification can be made, based on metabolic breakdown in the patient, allergies, and ph considerations. There are a number of useful tools in determining metabolic breakdown or dysfunction of specific glands. The most useful examination procedures in day-to-day practice are those that are done in the office and are fast and inexpensive, including history, observation, physical examination, urinalysis and applied kinesiology. Blood work and more extensive diagnostic tests generally should be run to confirm what is already suspected from the in-office examination. Dr. Walter Schmitt⁸ has written a concise, easy-to-read text on in-office urinalysis and physical examination entitled Common Glandular Dysfunction in Chiropractic Practice. Those interested in further information about in-office diagnostic procedures should consult his text. What I would like to cover in this article is the use of body typing as an indicator of glandular dysfunction. This falls under observation. After determining dominance, the next step in body typing is analyzing weight gain patterns.

The accepted theory of weight gain and loss is basically that weight gain is a function of more calories being consumed than are utilized and that weight loss is a function of more calories utilized than consumed. If this theory of "calories in versus calories out" is correct, then there are

obviously some major differences from person to person on the calories outside of the equation.^{9,10,11}

Most of us have observed patients who can eat copious amounts of food without putting on a pound and others who gain weight on 800 calories per day. These differences are attributable to differences in metabolic rate and are a function of dominance and metabolic breakdown. Certainly we also have observed that patients do not all put weight on in the same areas. The theory here is that specific weight gain patterns are caused by specific glandular changes. These patterns are relatively easy to detect, and the most common are illustrated below.

Hypo anterior pituitary weight gain is from head to toe and is soft, fleshy, and often in folds. This is most common in short G-types. Hyper anterior pituitary weight gain, by contrast, is from the hips to the ankles, not affecting the upper body, and is fairly firm. Hyper thyroidism obviously does not cause weight gain, but hypo thyroid weight gain is soft weight from the elbows to the knees. It is most pronounced in the abdomen and hips and does not affect the face and neck, forearms and hands, or calves and feet. Hyper adrenal weight gain is round, firm, belly weight, while hypo adrenal is not associated with weight gain. Hyper gonadism is trimming in its effect (with the exception of the breasts and hips of women), whereas hypo gonadal weight gain in men is manifested as softness in the tissues with some breast enlargement, and in women as the dreaded "saddle bags" (dimpled weight gain on the lateral hips and thighs). There are other patterns, but these are the major ones.

The basic philosophy I use in modifying the diet for glandular dysfunction is to remove the foods that stimulate the gland (hypo or hyper) from

the diet, then treatment is applied to normalize its function. For example, an adrenal dominant individual with low thyroid function would be given an adrenal diet with no simple carbohydrates. The adrenal diet is designed to remove adrenal stimulation, since the adrenals of this patient tend to push too hard already, and the simple carbohydrates are removed in order to allow the thyroid greater opportunity to rest and recuperate during treatment. Another common example is a thyroid dominant female with "saddle bag" weight gain. She would follow a T-type diet low in spicy foods and red meat while treatment was concentrated on improving her ovarian function.

It is important to note that weight loss is best achieved slowly. In most cases by following the body type diet and not snacking, the patient will lose approximately one pound per week. This rate of weight loss appears to be optimum for maintaining a good energy level and metabolic function. When calorie consumption gets too low, the patient will adapt by slowing his/her metabolism, and the desired effect will be compromised. Although patients sometimes get discouraged by gradual weight loss, it should be pointed out that one pound per week equals 52 pounds per year.

ALLERGIES

Space does not allow a lengthy discussion of allergies, but it is an important consideration. Diet modification is the elimination of the offending foods. There are numerous testing procedures to determine which foods are a problem: RAST, patch, cytotoxic, pulse and applied kinesiology (A.K.) being the most common. A.K. is by far the easiest and least expensive and probably is 80-85% accurate, which is comparable to the others.

A person can be allergic to anything, but the most likely foods to

check are the foods the patient eats more than three times/week, the foods they crave and the foods they feel as though they may have reacted to in the past. To test foods with applied kinesiology I have the patient bring foods that fall into the three categories mentioned above. I like this better than a test kit, because you are testing the same foods (brands, etc.) that the patient ordinarily eats. Select a strong indicator muscle and have the patient smell or taste a food and repeat the test. A weakening of the indicator muscle suggests that the patient reacts negatively to the food, and it should be eliminated from the diet. After a period of treatment and abstinence the offending foods can be reevaluated, and those foods that no longer weaken the patient can be reintroduced. The holiday from offending foods and good holistic chiropractic care will alleviate most allergies, and approximately 90% of the foods can be reintroduced at least on a rotation basis. The remaining 10% of allergies appear to be permanent.

PH (Figure 3)

Following the dietary change and good chiropractic care, including manipulation, reflex work, supplementation, etc., most patients' ph will fall into line. Those that do not may be on the wrong diet or may not be following the diet. It should be pointed out that the chief reason I find for patients not following the diet is that their willpower is overcome by their cravings. My experience is that people crave foods for three reasons: they crave foods that stimulate their dominant gland, that stimulate a gland that is hypo- or hyper functioning, and they crave foods to which they are allergic. As strange as it may seem, people do not seem to crave foods that they need. The only good answer I have found for stopping the cravings is

to avoid the food totally and correct the metabolic imbalances. If they are following the proper diet, then they usually can be ph balanced by concentrating on foods that are of the proper ash. A partial list of alkaline and acid ash foods is included. Authorities disagree on the exact ph that is best, and I have changed my mind several times over the years, but currently the authors I respect most--Bland, Goodheart and Beardall--agree on 7.4. If a patient follows the diet well and is metabolically fairly well balanced and is not having allergic reactions and still has a ph of 6, then it may be that there is an attraction to acid ash foods and there is a need to round out the diet by lowering the acid ash food consumption and by increasing the alkaline ash food consumption.

Once the patient's metabolic imbalances are corrected and the ph regulated, the body type diet should be the basic diet that the patient follows for life. With wellness achieved the patient should be able to handle dietary indiscretions on special occasions with no ill effects. The patient should be advised that stress is cumulative and the very human tendency to let the diet "go to pot" when under emotional stress should be avoided.

Footnote. The author notes that this subject is too vast to be thoroughly covered in a journal format. Therefore, the article is intended as an introduction to the concept of body typing.

Bibliography

1. Pende, N., Constitutional Inadequacies
Lea & Febiger, Philadelphia, 1927
2. Pende, N., Human Biotypology
Malvine, Paris, 1925
3. Pende, N., Human Biotypology and Orthogenesis
Genoa, Tipografia Sociale, 1927
4. Paige, M.E., Body Chemistry in Health and Disease
St. Petersburg, Fla., Nutritional Development
5. Beiler, H., Food is Your Best Medicine
New York, Ballantine, Third Edition 1892
6. Abravanel, E.D., Dr. Abravanel's Body Type Diet and Lifetime Nutrition Plan
New York, Bantam Books, 1983
7. Wakeman, W.H., Vita Centering
Maitland, Fla., Vita Communications, Inc., 1983
8. Schmitt, W.H., Common Glandular Dysfunctions in the General Practice
A.K.S.P., 1926 Overland Drive, Chapel Hill, N.C.
9. Durnin, J.V.G.A., Energy Balance in Man With Particular Reference to
Low Intakes
Bibltha Nutr. Dieta, Vol. 27, pp. 1-10 (Karger, Basel 1979)
10. Apfelbaum, M., Bostsarron, J., Lacatis, D., Effect of Caloric Restriction
and Excessive Caloric Intake on Energy Expenditure
Amer. Journal fo Clinical Nutr., Dec. 1971, pp. 1405-1409, U.S.A.
11. Miller, D.S., Parsonage, S., Resistance to Slimming Adaptation or Illusion
The Lancet, April 15, 1975, pp. 773-775

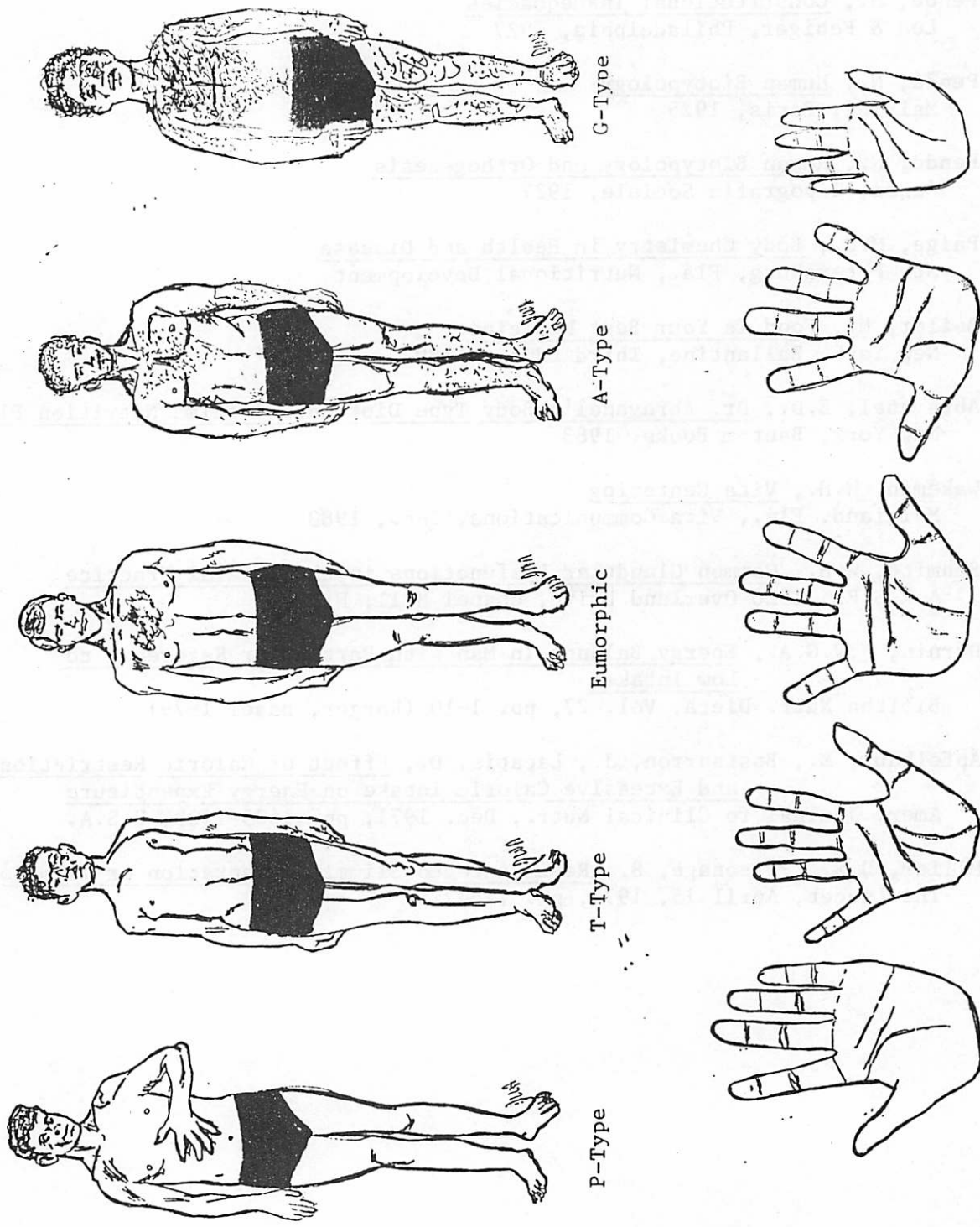


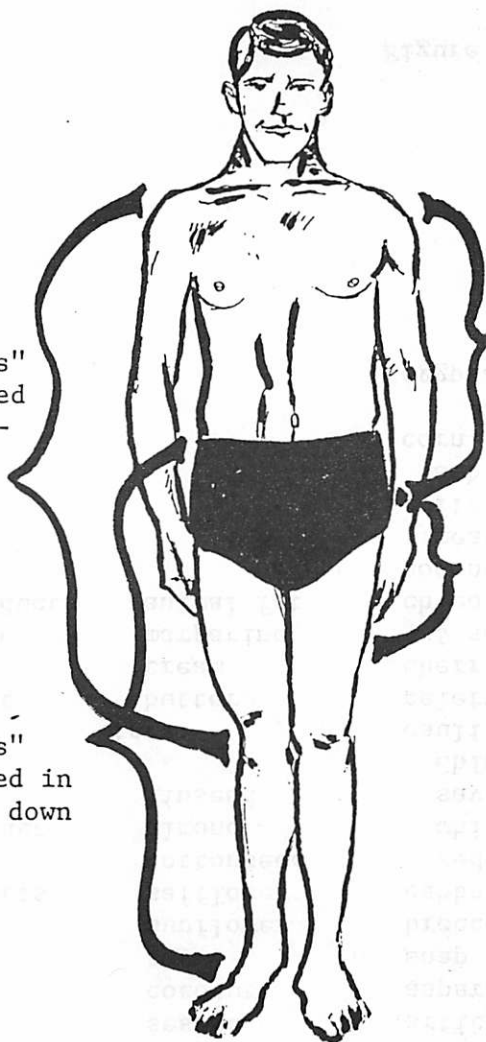
Figure 1

HYPO-THYROID

"from elbows to knees"
Weight is concentrated
in the hips and abdo-
men.
-excludes forearms,
calves and neck
-soft and fleshy in
nature

HYPER-ANT. PITUITARY

"from hips to ankles"
Weight is concentrated in
the hips and spreads down
to the ankles.
-firm in nature



HYPER-ADRENAL

"pot-belly"
Weight is concen-
trated in the abdo-
men.
-firm
-spreads to
the chest

HYPO-GONADAL

"saddle bags"
-"cellulite"
-in men breast
development and
general softness

HYPER-ANT. PITUITARY

"head-to-toe"

Weight is evenly distrib-
uted and is often concisus.
-causes all glands to be-
come hypo-active
-the hardest weight to lose

Figure 2

<u>HIGHLY ACID</u>	<u>ACID</u>	<u>NEUTRAL</u>	<u>ALKALINE</u>	<u>HIGHLY ALKALINE</u>	<u>VERY HIGHLY ALKALINE</u>
alcohol	beans,	oils:	apple	garlic	almond
barley	kidney	avocado oil	fresh	gooseberry	avocado
bread	navy	olive	apricot	grapefruit	ripe banana
buckwheat	white	sesame	artichokes	grapes	bean, fresh
caffeine	garbanzo	coconut	asparagus	kelp	lima
honey	beef	soy	snap beans	leek	blackberries
lentil	Brussels	sunflower	broccoli	lemon & peel	carrot
millet	sprouts	safflower	cabbage,	lettuce	chives
oatmeal	cashews	cottonseed	red	melons	endive
pasta	dried coconut	almond	white	raw milk	dried peach
peanuts	egg yolk	linseed	savoy	yogurt	persimmon
sweet	fish		Chinese	onion	pomegranate
potatoes	fowl	fats:	cauliflower	orange	plum
rice	dried fruit	butter	celery	fresh peach	raspberries
rye grain	game	cream	cherries, sweet	fresh pear	spinach
sugar	pasteurized	margarine	& sour	peppers, green	
tobacco	milk products	animal fat	chicory	& red	
walnuts	mushrooms		coconut, fresh	potato	
wheat	mutton		meat & milk	radishes	
	pork		coffee	rhubarb	
	poultry		substitutes	tomato	
			corn, fresh	turnip	
			sweet	watercress	
			eggplant	yeast	
					beans, dried
					lima
					string
					bean sprouts
					dandelion
					greens
					dates
					figs, esp.
					black
					prune
					raisin
					Swiss chard
					tubers

Figure 3

PITUITARY DIET

- Plenty of: Red meat (not pork)
Organ meats
Seafood
Poultry
Vegetables (90% cooked, 10% raw)
Water and herb teas
- Moderate amounts of: Fresh fruits
Whole grains
Butter
Cold pressed oils
- Avoid: All dairy products (except for a small amount of butter)
Sugar
Coffee, tea, etc.
Fried foods
Margarine or Crisco
Refined carbohydrates
Fruit juices
- Schedule: High protein breakfast
Moderate lunch
Lighter dinner
- Diet outline: Breakfast
Eggs
Steak or organ meats
Poultry or fish
with no more than a small whole grain serving
with herbal tea
- Lunch
Poultry or fish
Red meat
with cooked veggies
with a small salad
with a whole grain serving
with a piece of fresh fruit
with water or herbal tea
- Dinner
Poultry or fish
Red meat
with cooked veggies
with fresh fruit
with water and herbal tea
- For weight loss: No snacking between meals.
Take five hours between breakfast and lunch.
Take six hours between lunch and dinner.

THYROID DIETPlenty of:

Eggs
 Poultry
 Fresh vegetables (90% cooked)
 Raw nuts and seeds
 Water and herbal teas

Moderate amounts of:

Red meats and organ meats
 Dairy products
 Whole grains
 Butter
 Cold pressed oils

Avoid:

Coffee and tea
 Refined carbohydrates
 Desserts
 Fried foods
 Margarine and Crisco
 Fruit and fruit juices

Schedule:

Breakfast - heaviest meal - very little carbohydrates
 Lunch and dinner divided evenly

Diet outline:

Breakfast

Eggs and/or
 Breakfast steak or chicken breast
with whole grain serving
with herbal tea

Lunch

Cheese or yogurt
 Red meat, chicken or fish
with vegetables (as much as desired)
with water, milk or herbal tea

Dinner

The same basic meal as lunch
 About the same size

For weight loss:

No snacking between meals.
 Take five hours between breakfast and lunch.
 Take six hours between lunch and dinner.
 May late night snack on a half dozen raw almonds.

ADRENAL DIET

- Plenty of: Whole grains
Vegetables and fruit
Cheese and yogurt
Water and herbal teas
- Moderate amounts of: Fish (not shellfish and not fried)
Poultry (without skin)
Natural desserts
Cold pressed oils
Butter
Milk
Eggs (no more than 3/week)
- Avoid: Salt and salty foods
Red meat
Shellfish
Fried foods
Margarine or Crisco
Sugar and refined carbohydrates
- Schedule: Light breakfast
Medium lunch
Larger dinner
- Diet outline: Breakfast
Whole grains
Yogurt
Fruit
- Lunch
Vegetables
Fish or poultry
Whole grain
Fresh fruit
Water, milk or herbal tea
- Dinner
Poultry or fish
Eggs or omelet (no more than 3 eggs/week)
Beans
Vegetables
Fruit
Water, milk or herbal tea
A good time for a vegetarian meal.
- For weight loss: No snacking between meals.
Take five hours between breakfast and lunch.
Take six hours between lunch and dinner.

GONADAL DIET

- Plenty of: Vegetables (90% cooked)
Fruit
Dairy products (milk, not cream)
Whole grains
- Moderate amounts of: Fish
Poultry
Eggs (no more than 3/week)
- Avoid: Red meat
Spices (Mexican, Italian, Indian, etc.)
Cream (especially ice cream)
Sugar
Coffee and tea
Fried and oily foods
Butter, margarine, Crisco
Refined carbohydrates
- Schedule: Light breakfast
Light lunch
Larger dinner
- Diet outline: Breakfast
Fresh fruit or soaked dried fruit
Yogurt or Keifer
Whole grains
Water, milk or herbal tea
- Lunch
Vegetables (as much as desired)
Whole grains
Fish or poultry
Water, milk or herbal tea
- Dinner
Fish or poultry
Whole grain
Vegetables
Cheese
Fresh fruit
Water, milk or herbal tea
- For weight loss: No snacking between meals.
Take five hours between breakfast and lunch.
Take six hours between lunch and dinner.

APPLIED MECHANICS, MUSCULO-SKELETAL FORCES AND THE KINESIO-ARC
SYSTEM

Charles A. Bender, D.C.

Abstract: The evolution of machine designs that integrate kinesiological knowledge with pragmatic experiential advances of elite weight trainers.

HISTORY

It is rather universally agreed that progressive resistance training, prudently applied, will enhance certain phases of any athlete's performance. The spillover of this knowledge has resulted in a marked increase in the number and character of fitness clubs in this country.

Until the seventies, progressive resistance training took the form of barbell workouts. Participants, for the most part, were weight lifters and bodybuilders. Each had a different goal and each evolved a different procedure to arrive at his goal. Trial and error played a significant role in the evolution of both sports. Over the years the Eastern bloc nations scientifically evaluated and made the most significant progress in what we call Olympic weight lifting. In this country body building leaped ahead in great part due to the observations and effective communications of Joseph Weider.

Weider began observing body building techniques in the nineteen thirties. Even to the present date he is engaged in establishing practical principles of weight training that take the guesswork out of how to train. Having trained the elite bodybuilders of the past five decades, he quite simply knows which exercises accomplish what goals for the body.

BACKGROUND PRINCIPLES

Weider has classified all resistance exercises into two major groups; Basic and Isolation.

Basic exercises work the major muscle groups in conjunction with smaller muscle groups. Isolation exercises work single muscle groups.

Basic exercises are far more effective at building muscle

mass, in part because much heavier resistance can be used. Isolation exercises will help shape, define, and separate individual muscles.

THE CAM REVOLUTION

During the seventies, a man with a new idea and a great marketing strategy took the fitness world by storm. Claiming that championship physiques would soon emerge from short one-set-to-failure-per-bodypart workouts on his cam equipment that resisted along the optimum strength curve, he created a dynasty that is still in evidence. However, the championship physique has yet to emerge. Bodybuilders, who flock to new ideas like crows to a cornfield, went back to the free weights as their mainstay.

THE PROBLEM WITH CAMS

The problem with cam machines isn't the cams, the problem is with unrealistic expectation based upon over-estimated result projection. Despite initial projections, no known championship physiques have emerged from exclusive use of cam machines. Potential results appear limited by several factors.

From birth we begin to grow in strength by working our bodies against resistance. But we do not work our muscles in isolation according to strength curves that have questionable relevance in light of the empirical realities known to virtually every strength coach. It is unnatural to isolate a muscle, thereby depriving it of the opportunity for maximal stimulation that would be afforded by recruitment of synergistic muscles to complete the exercise.

Each joint is the fulcrum, or pivot point, for a lever system that has its own most efficient way of working. To lock the fulcrum's position and refuse to vary the resistance reduces the total work ability of the prime movers. To put it simply, the muscle you are exercising tires out prematurely (failure). But just because the stretched muscle cannot contract against the resistance doesn't mean that the rest of the muscle is in failure. Free weight training solves

the problem by allowing a person to shift the lever position or recruit other muscles to assist the weakening prime mover.

THE A.K.-FITNESS TIE-IN

In 1978, I began studying the movements of athletes from both a kinesiological and applied kinesiological perspective. The findings of one of those studies was published in the Collected Papers in 1980 and in the Selected Papers in 1982.

Following a severe accident in 1983 which resulted in significant soft tissue injuries and an avulsion fracture of the pons, the direction of my study turned toward effecting an optimal rehabilitation program.

Since I was unable to do any exercises using my own body as resistance, such as push-ups, sit-ups, etc., it became necessary to use resistance equipment because the weight is controllable. The bench press simulates the push-up and the lat pull-down simulates the pull-up, for example. The bench press is a free weight exercise and the pull-down a machine movement.

Having a patient who was involved in making gym equipment, I consulted with him relative to making a multi-type unit that would meet my requirements. I discussed my needs predicated upon my prior motion studies and he became interested in having me study and develop my concepts as they related to weight training.

BACK TO BASICS

Every new resistance system attempts to justify its existence relative to free weight exercises. Why is this so?

Quite simply, free weight training is nothing more than an exaggeration of otherwise normal muscular actions. Therefore, the body is genetically and experientially prepared to bench press, overhead press, curl, and so on. As exotic looking, flashy, chrome resistance equipment hit the market, the least impressed were the elite bodybuilders. That is not to say that they ignored its existence, but after

a brief fling they returned to the basic free weight movements as the foundation of their progress. We chose the bodybuilder as our model because he or she has passed through all the levels that anyone embarking upon a progressive resistance exercise program will attain. The bodybuilders traditionally began as fat or skinny and weak, gradually evolving to Herculean proportions. The point is that the free weight concept is the only concept that is capable of actualizing a person's genetic potential for body shaping.

THE DILEMMA

Without question, there is no concept more effective than free weights to optimize either strength or body shape. However, free weights are messy, inconvenient, and potentially unsafe.

The fulcrum locking, prime mover isolating systems are very neat and reasonably safe but they are not particularly effective for building strength or size in muscle.

Other circuit units have haphazardly selected a routine that fits around a single unit. Again, gains are possible but the potential is limited as compared with free weights.

HOW KINESI-ARC SOLVES THE PROBLEM

Kinesi-Arc is the name of a line of circuit training machines developed under my supervision and under the auspices of Pro-Gym Systems, Inc. of Belle Mead, New Jersey, who began to manufacture and market the product in the early fall of 1985.

We believe that we are the first company to approach the problem by studying accomplished bodybuilders training with free weights as our model. Every movement was filmed and studied specifically to determine the action of each muscle and joint. We worked each athlete through all phases of each exercise: strict, cheat, loose, etc. Each new exercise was begun with the athletes properly rested.

Failure on a strict isolation movement is just a sticking point if a trainer can cheat out those last few

repetitions that yield growth. We wanted to develop equipment that would allow anyone to optimize genetic potential, if desired, in a safe, convenient way.

We studied the films carefully and determined that the arc concept specifically applied by varying the length of the lever arm and placing the pivot point or fulcrum at the optimal position relative to the stabilizing joint of the prime mover would maximize the free weight-like effect of the machine movement. In addition, by positioning the chains (chains and sealed bearingsprockets are used) proximal to where barbell plates would be, the natural feel is enhanced.

Simply, every exercise requires its own distinctive arc because when a muscle contracts it pulls the insertion closer to the origin by drawing the bone of insertion through an arc around the mediating joint. We had to define the parameters of those arcs relative to effective exercises and the variety of limb lengths performing them.

Briefly, consider the following two examples:

1. Watch a good bench presser. The weight in the deep position is across the chest and in the extended position is almost over the face. Kinesi-Arc has placed the pivot point and determined a lever arm such that the movement will move through a normal arc. And just as with a normal bench press recruitment is possible. (See Comprison Chart).

2. Observe a free weight shoulder press. As the weight is pressed, the back tends to arch for balance and power. Kinesi-Arc simulates this by supporting the back and establishing the arc that the free weight arching was trying to accomplish.

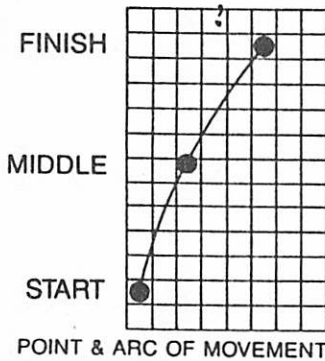
One other unique feature that has been incorporated for very practical reasons is dual selection. All exercises can be done bilaterally, alternately, or unilaterally. The first two methods offer the variety that makes for increased exercise effectiveness. The

unilateral feature allows the injured athlete to work around his injury. The potential for Kinesi-Arc to function as a rehabilitative tool must not be overlooked.

Currently Kinesi-Arc circuit equipment is impacting favorably upon client oriented health clubs from New England to Texas. At this summer's meeting of I.C.A.K., I expect to review some of the studies we are conducting on optimizing training goals

COMPARISON CHART

KINESI-ARC CONCEPT (ARC/PIVOT)

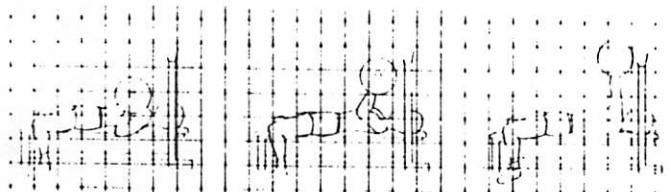
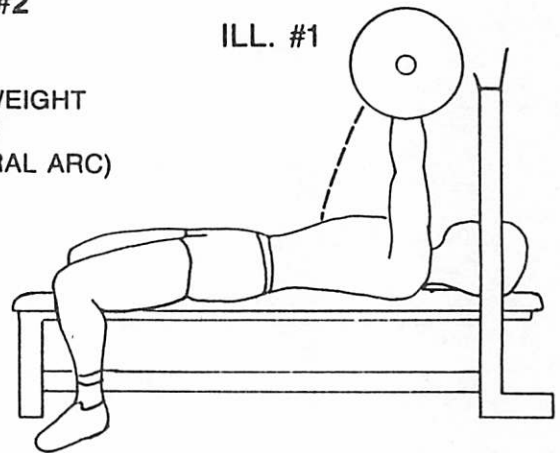


EXERCISE COMPARISONS (ARC AND PIVOT) PECTORAL PRESS

ILLUSTRATIONS #1 & #2

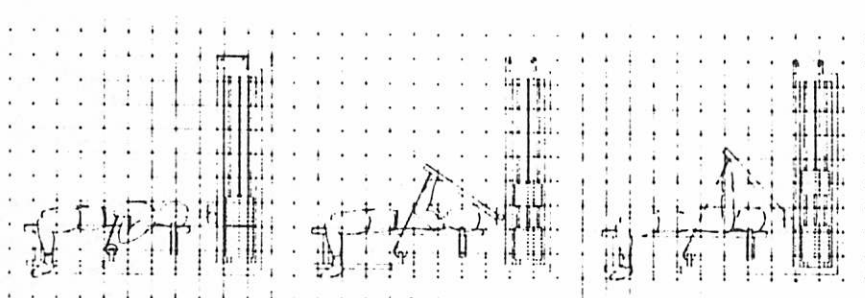
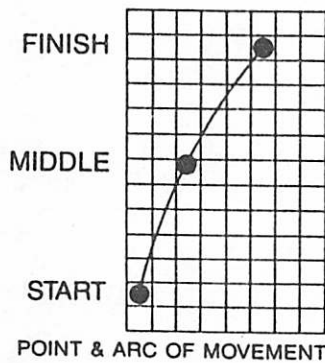
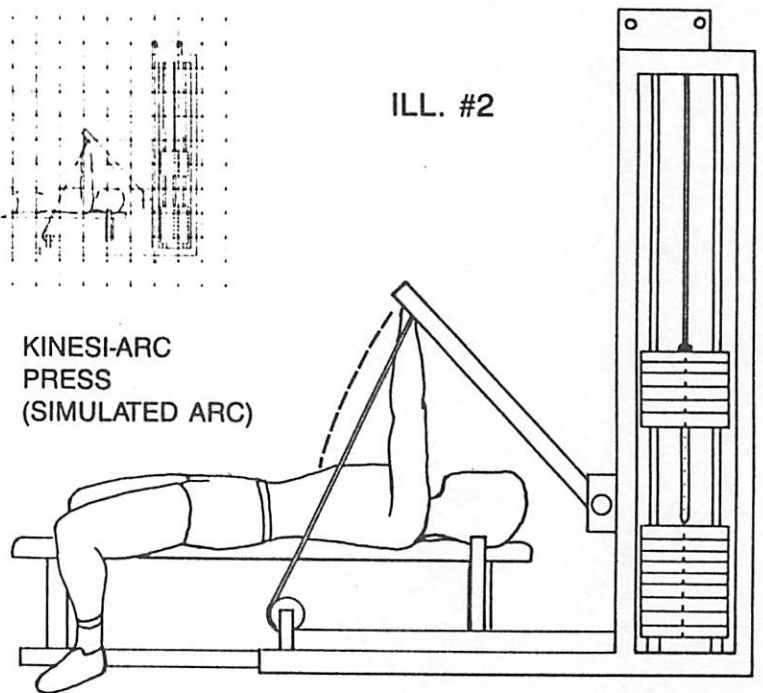
FREEWEIGHT
PRESS
(NATURAL ARC)

ILL. #1



ILL. #2

KINESI-ARC
PRESS
(SIMULATED ARC)



Dr. Richard J. Caskey, D.C.

Abstract: This paper is a report of personal finding related with the correlation of certain bilateral (gait) muscle testing procedures and the incidence of certain specific structural lesions or adaptations. Correlations between those procedures and recognized manifestations of the dural torque concepts will be presented. Investigation would indicate that these findings are often not secondary to or correctable by already established dural torque procedures.

This paper like so many other new ideas was prompted by a calculated "accident". Approximately two years ago I was faced with a patient presenting with left gluteal pain for which I could not expose an underlying cause. After exhausting virtually all of our diagnostic "arrows" I decided to test for classic gait testing which likewise was unfruitful. At that point I reasoned that if we could display gait mechanisms of opposite legs and arms, why could we not find a gait mechanism of flexion of one leg and extension of the other. Therefore, I proceeded to test both lower extremities for simultaneous flexion on one side vs. extension on the opposite. In this original case I found extreme marked weakness only when simultaneously testing for right hip flexion and left hip extension. Needless to say, I checked myself for accuracy by evaluating individual motion or poor patient stability which was negative. Logically, I expected to find corresponding acupuncture points similar to classic gait patterns, but after long investigation could find no apparent acupuncture involvement. The only therapy localization I could find to abolish this positive finding was to the symphysis pubis. At first I thought it was again acupuncture, but I eventually discovered that the underlying problem involved challenging one pubic bone against the other. The most frequent finding is to challenge one pubic bone cephalad and the other simultaneously caudad. Correction was simple and classic: adjust in the direction of weakness the phase of respiration causing strength. My initial observation was that the weakness was quite marked and that the post treatment change was quite dramatic. Since that time it has been my experience that the weakness associated with

these testing procedures is not at all subtle in nature, but quite grossly demonstrable in nature.

Following the same train of thought I reasoned that if there was a problem with flexion and extension of opposite legs, what about simultaneous contralateral leg abduction and leg adduction. Naturally enough, that caused me to search for the same phenomena in reference to the arms. As it turned out, each of these modes of testing showed a particular incidence of occurrence and a specific correction was correlated with each which I will concisely outline.

CONTRALATERAL FORWARD AND BACKWARD LEG - PUBIC SHIFT

Testing procedure:

Patient lying supine tries to resist examiner by simultaneously pushing one leg toward the ceiling and the other toward the floor. Both knees are kept straight and the examiner uses the shortest lever arm possible. If present weakness will show in one direction and is abolished by TL to the symphysis pubis. * In all tests must rule out individual weakness.

Correction:

Challenge one pubic bone on the other by pushing in opposing directions. (Usually cephalad vs. caudad). Correct by adjusting in direction of weakness on phase of respiration of strength.

CONTRALATERAL LEG ADDUCTION AND ABDUCTION - SUPERIOR TO INFERIOR PELVIC TORQUE

Testing procedure:

Patient lying supine (may hold table for stabilization) tries to resist examiner by pushing both legs in the same lateral direction simultaneously while examiner is testing adduction of one leg and abduction of the opposite leg simultaneously. * In this case weakness of the quadratus lumborum must be ruled out due to similarities in testing procedures.

Correction:

The patient's pelvis is challenged by simultaneously pushing one asis cephalad and the other asis caudad. Correct by adjusting both iliac bones in the direction of weakness on the phase of respiration of strength.

CONTRALATERAL FORWARD AND BACKWARD ARM - STERNO-CLAVICULAR DISRELATIONSHIP

Testing procedure:

Patient lying supine brings one arm forward in flexion and the other backward into extension and tries to simultaneously push the forward arm further into flexion (toward ceiling) and the backward arm further into extension (toward the floor). If present will cause weakness in one direction and will be abolished by TL to one sterno-clavicular joint (SCJ).

Correction:

The SCJ which showed positive TL should be challenged for proper vector of correction and various lines of drive should be checked by challenging the manubrium away from the clavicle, and corrected in direction of weakness with phase of respiration causing strength. * A quick double thumb contact appears to yield the most favorable results.

CONTRALATERAL ARM ABDUCTION AND ADDUCTION - SUPERIOR TO INFERIOR SHOULDER GIRDLE TORQUE

Testing procedure:

Supine patient tries to resist examiner's contact on each arm by simultaneously pushing one arm into abduction and the other into adduction.

Correction:

Examiner simultaneously challenges both shoulder girdle mechanisms by pushing one shoulder joint cephalad and the other caudad. Again, correct by multiple thrusts in the direction of weakness on the phase of respiration causing strength.

OBSERVATIONS

At this point, it is becoming evident that these aforementioned lesions are part of the dural torque complex, but are unique and independent of the therapeutic options currently utilized. Recently, Dr. Goodheart enlightened us all to the original research of Dr. Fred Illi indicating a marked redominance of longer right stride excursion and increased right sacro-illiac mobility. I, like Dr. Goodheart, had noticed for a long time that patients far more commonly demonstrated diagnostic indicators for the need of an elongated left stride, but I also noticed that the pattern of weakness shown by testing right leg forward and left leg backward was also vastly more common. With the advent of the illio-lumbar ligament technique, I was curious to see if this advance would abolish these indicators. In spite of the many positive changes I have witnessed with the illio-lumbar ligament technique it has not once altered these diagnostic indicators. This has led me to believe that these findings are unique components of the dural torque mechanism, and incidently correcting the indicated lesion very commonly eliminates the sign of unequal foot turn in when other factors are unsuccessful.

I have witnessed a variety of clinical changes with the administration of these corrections. In my practice I deal with a large number of athletes, and owing to the specific locomotive needs of various sports, it's not surprising that I have seen some of the outstanding responses with athletes. Because of it's effect on foot plant, the pubic shift has been of tremendous benefit to fanners; particularly in regards to shin splints. An observation that I have noted for a long while is that arm stride inequalities are often as important to a runner as leg stride inequalities. Many top flite runners

realize that a strong and balanced arm stride is essential, especially with sprinting or hill climbing. The sterno-clavicular correction has been instrumental in that regard. Many runners who show this pattern will comment about chronic shoulder "clicking" with their running.

Lateral motion is a vital component of tennis, and the pattern of contralateral abduction-adduction has been of benefit in a variety of cases. Also, it is quite evident that several sports including golf, tennis, baseball batting, cause a homolateral rotation through the shoulders. The arm patterns can be of benefit in conditions relating to these mechanisms.

CONCLUSIONS

At this point I am currently gathering data on the incidence of these findings with new patients, and I will report these statistics at a later date. I have found these procedures of great benefit in my own practice, and I would appreciate any feedback on your ability to reproduce these responses.

THE THERAPEUTIC USE OF MAGNETS
Earl L. Colum, D.C.

Abstract: The use of magnetic fields not only as a diagnostic tool but therapeutic as well. Applying two basic principles of Applied Kinesiology namely therapy localization and challenging with magnetic fields has demonstrated that there is a consistent basic pattern. Using the north or south magnetic poles individually or north and south poles together for therapy localization, followed by challenging for direction of treatment and the associated respiratory phase, has shown to be an effective means of correcting the following conditions.

1. Osseous lesions - cranial faults, TMJ, subluxations, fixations, and joint disorders of the extremities.
2. Muscle involvement - weakness, hypertonicity, fascial flush, strain counterstrain, golgireceptors, spindle cell, combined muscle weakness, and reactive muscles.
3. Visceral - allergies, iliocecal and valves of Houston.

There are only a few areas, that when therapy localized, will show a respiratory phase without challenge. First is the diaphragm, at its origin, at the anterior rib cage. Second is the TMJ. The TMJ will not always have a response, depending on the type of involvement. Frequently each TMJ will have a respiratory phase that is different than the opposite side. So each must be therapy localized individually on different phases of respiration. Therapy localizing to both TMJs in this case will have a negative response as the body cannot say breath in and breath out at the same time.

Thirdly, the cranial sutures, when involved, will always show a respiratory response. At times, the suture will have a common fault along its entire length and will readily show a respiratory phase. However, it is often seen that opposite ends of the suture will have a different respiratory phase. The sagittal suture most always shows an inspiration assist at least on the anterior two thirds. Frequently the posterior third will have an expiration assist. If the patient therapy localizes over the two areas at the same time, an intact muscle will weaken without showing any breathing pattern. So, when therapy localization is positive and no respiration assist is evident, each end of the suture must be done individually.

The cranial-sacral respiratory assist pattern, usually inspiration, is found in more than 95% of the patients on their first visit. If your findings are much lower, I would encourage testing patients in seated position. For the manual correction of the cranial part of the inspiration lesion, moving the mastoid forward with inspiration several times as taught in AK, always proves effective for treatment. Correction of the sacral part is best done manually by adjusting the base of the sacrum, anterior and footward in a scooping motion. The adjustment is light in force, with one to three moves being sufficient.

I have always maintained that the inspiration sacral lesion was an involvement of the top half of the sacral articulation, and the expiration lesion was an involvement of the lower half of sacroiliac joint. The correction of the inspiration assisted cranio-sacral lesion with magnets will support this idea.

In September '85, a patient therapy localized the lateral portion of the mastoid, below the ear, which showed positive but had no respiratory assist. Challenging the mastoid from P to A was positive with an inspiration assist. However, when challenged from A to P, an expiration assist was also found. Before any correction, the hamstrings were tested and were intact. The mastoids were then corrected by pushing forward with inspiration and backward with expiration several times. The forward and backward correction abolished the therapy localization to the mastoid. When the patient laid down, the hamstrings were checked and found to be weak in both legs without any respiratory assist. Testing the medial hamstring with the foot rolled lateral toward the floor and tested in a footward direction, was also weak but assisted by expiration. The lateral hamstring was tested with the foot rolled medial to the opposite side and pushed footward. This also showed weakness and was strengthened by inspiration. Correction was made on both sides by adjusting the base of the sacrum with inspiration and lifting upward on the lower portion of the sacrum. This corrected the hamstrings on both legs in all positions. From then on, all patients were routinely checked for this problem, and it was frequently found.

The correction of the mastoid(s) by pushing forward and backwards with respiration always worked, but did not make sense. How can you have two opposite situations with the same bone?

In October '85, I mentally reviewed my treatment of cranial problems. I had used the magnets mostly as an indicator, to tell me the direction and phase of respiration in treating cranial faults, using my fingers as the treating tool. If other sutures of the skull could have two respiratory phases, couldn't the TS line follow the same pattern?

Correction of Inspiration Cranial Sacral Fault

Therapy localize or challenge with the south magnetic pole from the mid point of the top of the ear above the external acoustic meatus backward along the squamosal, past the asterion, to the end of the suture between the mastoid and the occiput, proved to be positive. The north magnetic pole TL and challenge was positive from the mid point above the ear anteriorward along the suture to the pterion. The dividing point between north and south pole, above the ear, can be easily therapy localized by using the magnet over the area.

The procedure would be as follows: The patient, seated, shows no general respiratory assist pattern. When the outer edge of the tip of the mastoid is therapy localized, an intact muscle weakens with no respiratory assist. While the patient maintains contact, the suture is therapy localized with a magnet; usually south pole posterior and the north pole anterior, both of which strengthen the weakened muscle. This is the normal pattern found. Occasionally, one side of the head will have a reversed pattern in that the north pole will respond on the posterior side and the south pole anteriorly. Frequently these patients will admit to having some mental quirks.

Correction is done bilaterally at the same time. With a magnetic south pole in each hand the doctor contacts the area over the center of the ear on the suture. On the right side of the patient, the direction is circular clockwise movement along the suture to it's most posterior portion. The left side of the patient's head is treated in a counter clockwise circular movement, posteriorly along the suture. The hands will be moving simultaneously in a mirrored fashion while the patient holds a breath in. The north end of the magnets are then used during expiration from the point above the ear anterior. With each phase of respiration the area along the suture is transversed several times back and forth. This is repeated for at least three respiratory cycles.

As with the manual correction, once the mastoid portion has been corrected the area will no longer therapy localize and weakness of the hamstring muscles occurs.

With the patient prone, test the hamstrings in the usual fashion. They will be weak with no respiratory help. Testing the lateral hamstring will show weakness with an inspiration assist. The medial hamstring will also be weak with an expiration assist. With the patient's breath in neutral, the south magnetic pole placed over the top half of the sacro-iliac joint, which strengthens the lateral hamstring on the same side, the north pole placed over the lower half of the sacro-iliac joint will strengthen the medial hamstring.

Correction is done with respiration. The south poles of the magnets are used on the top half of the articulation and the north pole over the lower half. The south or inspiration direction is again circular, up the middle, out, down, and in. Both sides are treated at the same time. On inspiration the south pole of the magnets are used over the top half of the articulations; the right side circular movement is clockwise and the left side, counterclockwise.

As the patient lets the air out, the magnets are reversed and the north poles are placed over the lower half of the SI joint. Move them in a circular direction opposite that of the south pole. This is clockwise on the left and counterclockwise on the right. Both ends of the articulation are treated through at least three cycles of respiration. Retesting the hamstrings will show the strength has returned.

The patient who comes in with total weakness without respiratory assist can also show the need for cranial-sacral magnetic therapy. Therapy localization with magnets increases strength. There is usually another major factor involved contributing to the total weakness; the iliocecal valve, stomach alarm point, diaphragm or atlas.

When the patient comes in with an in the clear respiratory assist problem, therapy localizing with a north or south pole over the suture will have a strengthening effect. The area so therapy localized is then treated with the magnetic pole indicated with direction and respiration. The other half of the suture can then be challenged and treated as indicated. In most cases both ends of the suture will need treatment but the body only shows the most involved part or the greater of the two lesions. Always test and treat hamstrings following cranial corrections.

If only the major, in the clear, cranial respiratory fault is treated, only part of the hamstring will show weakness; medial and lateral together or individually.

The pattern described above, north involvement anteriorly, and south posteriorly, is the most common. The problem could be unilateral, reversed having the south pole anterior and the north posterior or only one magnetic pole effecting the whole suture.

The correction of the cranial-sacral fault with the use of magnets has proven to be the most effective and long lasting method used. Other cranial faults are corrected in the same manner, by therapy localizing and challenging. Double therapy localizing is necessary in many cases and is essential for total correction.

THE MOST IMPORTANT FUNCTION IN THE USE OF MAGNETIC FIELDS IS THE ABILITY TO UNCOVER AREAS OF INVOLVEMENT THAT HAVE BEEN TREATED BY MANIPULATION SUCCESSFULLY BUT ARE NOT TOTALLY CORRECTED.

The following experiment has been done repeatedly as a demonstration for patients and observers. A muscle, weak in the clear such as the subscapularis, is found. The patient therapy localizes to the second dorsal which strengthens the muscle. The second dorsal is challenged to determine the direction of correction and the phase of respiratory assist is noted. Adjusting the vertebrae with direction and respiration abolishes the weakness to the subscapularis. Challenging the second dorsal level with a magnetic pole, usually south, causes the weakness of the subscapularis to return. Treating with the south pole according to findings again strengthens the subscapularis.

Finding a similar situation in which the patient can therapy localize a vertebrae to strengthen a weak muscle is done. A positive challenge and respiratory phase is then noted. No treatment is given. The same vertebral level is then challenged with a magnet to determine direction and respiration. Treatment is given with the magnets. The original muscle weakness is now strong. Manual or magnetic therapy localization and challenge are now negative.

The vertebral level in need of treatment can be determined in several ways: using a weak muscle to find the vertebral level that strengthens; therapy localizing alarm points or neurolymphatics that weaken an intact muscle while the doctor therapy localizes spinal levels, repeating the muscle test until a level is found that strengthens the weakened muscle; bilateral muscle weakness indicating levels of fixation; patient symptomatology; palpation; ingestion of allergic substances producing muscle weakness that is negated by therapy localizing a specific spinal level; reevaluating previously treated areas; challenging with north, south, or north and south poles together, above, below, and to the side of each spinous process.

Once the level of involvement is determined, challenging then proceeds. If the patient had therapy localized with the palmar surface of their hand, the south pole is used first to check. If their contact was volar, north and south poles together must be used. In this situation the spinal level has to be treated at the same time with the area that was volar therapy localized. This will change the volar contact to a palmar contact.

If challenging the vertebrae manually does not show the direction of treatment, the magnets must be used. The respiratory assist is then determined. Inspiration assist determines the need for south pole therapy and expiration assist would be north pole.

The area can also be challenged with the magnet by tapping the interspinous spaces and over the area of the intervertebral foramina. Where tapping has produced weakness of an intact muscle the area is then challenged for direction. In a subluxation the prime area is the side to which the spinous was challenged. If the challenge force was from left to right, the prime area would be on the right side. The right side is challenged with the south pole in a clockwise direction producing weakness in an intact muscle. Touching the left side with the magnet will cause the muscle to regain its strength. The left side is now challenged for direction. In a subluxation the direction will be the same as on the right. A fixation will show a counterclockwise direction needed. The secondary or left side of this subluxation may not show until the right side is challenged first.

In a subluxation that is expiration assisted, the primary side will be on the side of challenge, responding to the north magnetic pole.

After the correction is made at the sides of the vertebrae, the interspinous spaces must be treated. The same magnetic pole will be used. Tapping to challenge is important to find the exact spaces involved. Due to the difference in length of the spinous processes, the spaces involved will not always be medial to the laterally treated areas. The direction on the lower space is always towards the primary side of involvement. The upper space will be opposite.

For clarification, see the diagrams on page 8, or contact me.

The magnets used are pencil magnets, an inch and a quarter long and a quarter of an inch in diameter. With a larger magnet it is difficult to find the exact area for treatment and to manipulate them in close interspinous spaces like the cervical region.

The Iliocecal valve and valves of Houston

The importance of a respiratory phase while any correction is being made is of extreme importance and should not be dismissed. A prime example is seen in the treatment of the open iliocecal valve. When the valve is therapy localized, respiration has no effect on the weakened intact muscle. When the area is challenged down, back, and out, the intact muscle weakens. Inspiration at this point will strengthen the weak muscle. If the area is challenged upward toward the left shoulder, the weakened muscle will regain its strength. Those using A.K. have treated the open valve in this upward direction for years and blamed the patient's indiscretions when the problem reoccurs. All corrections should have a direction and respiratory phase. The manual correction for the open iliocecal valve should then be down and out with the patient holding a breath in.

The valves of Houston are treated manually by pushing down, back, and out over their location with inspiration. In cases of diarrhea, the area over the valves of Houston should be challenged. Most often seen is the need to treat upward with inspiration.

The iliocecal valve and the valves of Houston are treated as a fixation at the level of the fourth lumbar, a south pole inspiration assisted lesion. The muscles involved with the ICV are the pectoralis major (clavicular) tested together and the rectus femoris bilaterally, both tested in the seated position. The valves of Houston go with the tensor fascia lata which can be tested either seated or supine. The magnetic correction at the fourth lumbar strengthens all the above muscles.

The iliacus muscle on the right side is directly associated with the ICV and is treated as a south pole subluxation at the first lumbar with the right side being primary.

Either patients who have the ICV in the clear or those who show no muscle weakness due to previous therapy will respond to magnetic therapy localization and challenge to the fourth lumbar. The patient who has had ICV in the past will have all muscle weakness reoccur when the treatment points are tapped and an intact muscle tested. This will also cause the positive TL over the valve area to return. Magnetic correction of the fourth lumbar removes the positive TL and challenge, to the iliocecal valve, valves of Houston, and strengthens the weak muscles.

When a patient returns and has the pectoralis and rectus femoris weakness again, the valve will have no response. Therapy localizing at the stomach alarm point is positive. Double TL will show the first lumbar involvement. Fix the first lumbar as a southpole fixation.

Conclusion

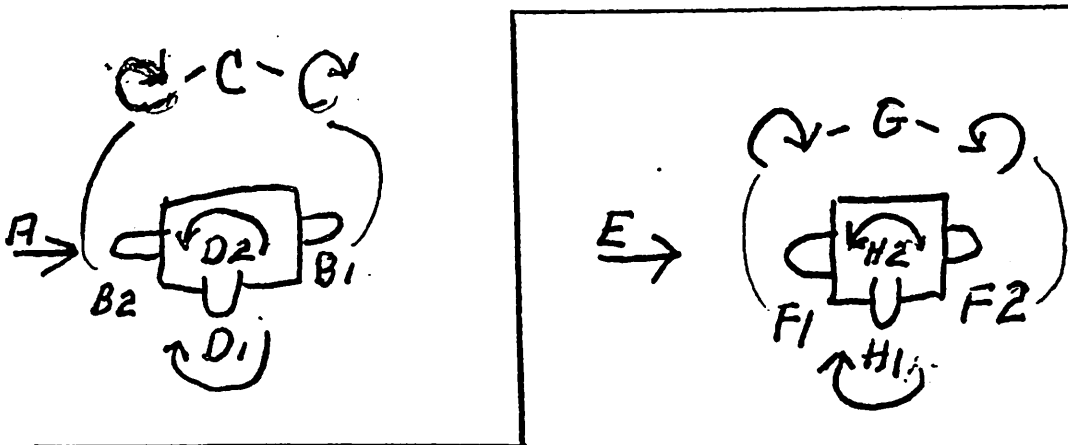
The use of magnets has proven to be a safe, effective and non-traumatic method of treating patients. The need can be easily determined by therapy localization, followed by challenging and treatment. Their ability to uncover areas needing further help is of great significance.

Simple problems have simple solutions. Chronic or severe conditions differ in their need for magnetic therapy. The use of north pole or north on one side of a vertebrae and south on the other side or north and south poles together, indicates a greater involvement. Finding and correcting these variables will help you help your patients even more.

The wide scope of the use of magnets will be presented in future papers and in workshops.

Subluxation - Inspiration Assisted South Pole

- A. Direction of manual challenge
- B1. Prime area for TL and challenge
- B2. Will not always show till B1 is TL.
- C. Direction of treatment with S pole and insp. B1 & B2 together.
- D1. Below spinous B1 direction
- D2. Above Spinous dir. opposite B1) S pole & insp. together.

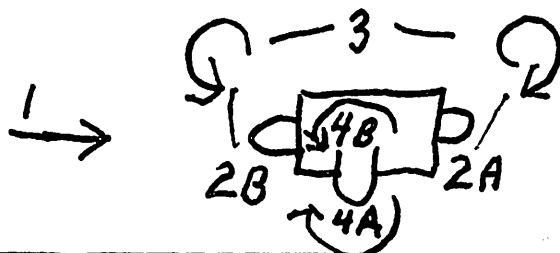


Subluxation - Expiration Assisted North Pole

- E. Direction of manual challenge.
- F1. Prime area TL and challenge.
- F2. Secondary area.
- G. Direction of treatment together - N poles with expiration.
- H1. Same direction as F1
- H2. Opposite direction as H1) N pole and expiration.

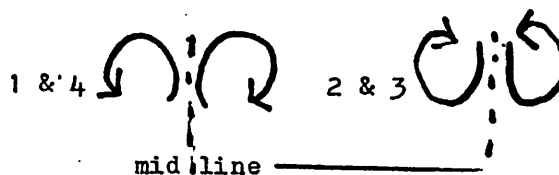
Fixation - Inspiration Assisted South Pole

- 1. Direction of manual challenge. Center vertebrae of the three.
- 2a. Clockwise. Primary area.
- 2b. Counterclockwise.
- 3. Direction for treating 2a & 2b together. S pole and Inspiration.
- 4a. Below spinous - primary dir. of 2a) S pole and inspiration.
- 4b. Above spinous - opposite dir. of 4a



The Expiration Fixation is rare but would be treated opposite to the inspiration fixation.

- 1. S pole front & back of body.
 - 2. N pole Front & back.
 - 3. N&S together insp. A&P.
 - 4. N&S " " expir. A&P.
- The whole head treated as ant.



FIVE ELEMENT MASTER CHART

PART II: SHENG CYCLE, SOURCE AND LUO POINTS

by

SALVATORE V. CORDARO D.C.

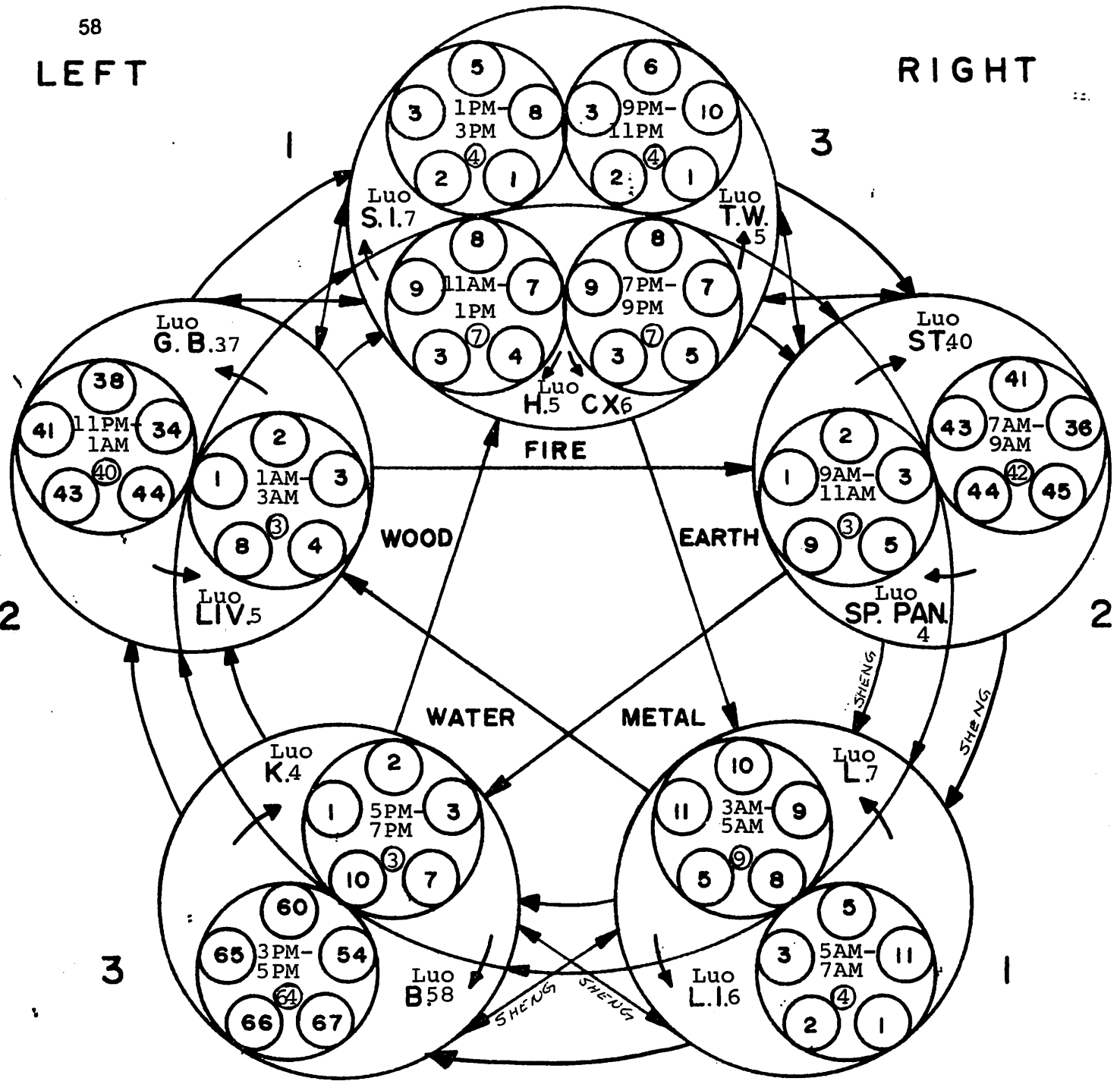
ABSTRACT: An explanation of the above points using the Five Element Master Chart which was circulated at the Super 20 Seminar and elsewhere in the profession.

INTRODUCTION: In the Winter Book 1985, page 31, I presented Part I: Rules for Tonification and Sedation using a combination of acupuncture laws, mainly a transfer of usable points from Mother to Child and from Child to Mother, plus the Ko Cycle Theory. Here is a good point to remember in applying acupuncture techniques. First fix vertebral, respiratory cranial faults and cranial bones¹ distortion plus neutralize scars across meridian paths with skin technique (challenge scar for direction, fix with fluori-methane spray).² It may be all you need to balance system. Remember, constantly returning subluxations may have acupuncture cause.

SHENG CYCLE: A transfer of excess energy of Mother to deficient Son in clockwise direction. Example: Outer circle Stomach is Mother (excess). Large Intestine is Son (deficient). Go to deficient Large Intestine circle (Son). Use the Mother's earth position on Large Intestine circle which is LI-11. This will draw

LEFT

RIGHT



MASTER CHART

Part I: Stimulation and Sedation

Part II: Sheng Cycle, Source Points and Luo Points

Original Chart drawn by Sheldon C. Deal, D.C.C

LAW OF THE FIVE ELEMENTS

energy from excess Mother Stomach to Son Large Intestine. The same applies to the inner circle. Example: Inner circle Spleen is Mother (excess). Lung is Son (deficient). Spleen point in Lung circle is L-9. This same law will draw energy from inner to outer circle as well.^{3,4}

SOURCE POINTS: On the Master Chart this is found in the center of each small, coupled element circle. Example: Kidney - K-3, Lung - L-9, Bladder - B-64 and so on. Things to remember: Source points are twice as sensitive to stimulation, sedation and anesthesia and pass through these cycles quickly. Use caution. Source points have a special rapport with the organ involved and its function.^{3,4}

LUO POINTS: This is a connecting point when stimulated, transfers the energy from a meridian to its coupled meridian. Example: In the metal position the Lung Luo point is L-7. The energy transfer is from Large Intestine to Lung which balances these coupled meridians. Likewise, the transfer from Lung to Large Intestine is affected by stimulation of LI-6. Remember, the Luo point will transfer energy from its opposite in the midday-midnight cycle. (See the 24 Hour Circulation of Energy Chart)¹ The Luo point will transfer energy across its bilateral counterpart, right side of body to left side of body or left to right. Remember that Spleen-21 is the Great Luo Point connecting with all other Luo points.^{3,4}

FOOTNOTES

- 1 Dr. Robert Perolman, Special Seminar
- 2 Dr. George Goodheart, Special Seminar
- 3 Dr. David Walther, Applied Kinesiology
- 4 Dr. Rolla J. Pennell and Dr. Gordon D. Heuser, "The How
To Seminar of Acupuncture for Physicians"

LEARNING DIFFICULTIES VIEWED IN
THE LIGHT OF APPLIED KINESIOLOGY,
SPECIFICALLY, THE FERRERI NEURAL
ORGANIZATION METHOD

by

Mitchell R. Corwin, D.C.

ABSTRACT

This is a preliminary study of twenty-three patients treated for the condition of "learning disability," utilizing the protocol outlined by Dr. Carl A. Ferreri in research papers and the book, Breakthrough for Dyslexia and Learning Disabilities.¹

INTRODUCTION

It has been my recent effort to learn, apply, and document the advances in applied kinesiology specifically relating to Dr. Ferreri's work in correcting neurological disorganization or "learning disabilities." The following documentation has been gathered over the past six months in a satellite office² which specializes in learning problems in children and adults.

It is my purpose, in this and future papers, to document that the Ferreri Neural Organization Technique is reproducible, demonstrable, and effective in relieving and/or curing "learning disabilities," given our current understanding and definition.

This paper will review a statistical evaluation of twenty-three patients and four case histories. All the patients were treated utilizing the Ferreri method. It will not be my purpose to describe that method here.

METHODOLOGY

Twenty three patients were selected for this study. They represent 60 percent of all patients seen at the Neural Organization Center in Concord, California² between September and February of 1985-86. The remaining 40 percent were disqualified, either because they were not "learning disabled" or because they had not received a minimum of three treatments at the time of the evaluation.

The selection criteria used were demonstrable neural disorganization as defined by Dr. Ferreri,¹ and imbalances in standing gait muscle testing as outlined in Dr. Robert Blaich's "Human Performance" seminars.⁴ Standard patient history forms were utilized, and in addition a one-page questionnaire⁵ was mailed to all participants. Forty eight percent of the questionnaires were completed and returned in time to be incorporated in the following data.

STATISTICAL DATA

1. Sex Male: 18 (78%). Female: 5 (22%).
2. Age Range: 8 months to 52 years. Average age: 18. Mean: 14.
3. Total Treatments Average: 5.5. Mean: 5.
4. Significant Emotional Overlay Number: 11 (48%).
5. Prior Chiropractic Care Number: 11 (48%).
6. Handedness Right: 60%. Left: 35%. Ambidextrous: 5%.
7. First Born Number: 15 (65%).
8. Birth Natural: 70%. Cesarean: 17%.
Complications at Birth: 13%.
9. Forceps Delivery Yes: 5%. No: 22%. Don't know: 73%.
10. Childhood Vaccinations Number: 88%.
11. Exam Findings of Anterior Atlas Number: 6 (26%).
12. Crossed K-27 Pattern (Homo-Lateral Gait) Number: 9 (38%).
13. Prominent Allergies Number: 10 (43%).
14. Familial Learning Difficulties Number: 13 (57%).

CASE HISTORIES

The following case histories are a cross-section of the twenty-three patients studied.

Case Study #1 An eleven-year-old male child was referred to me by a local learning center, which he attends two hours a week for private tutoring and testing. He is the only child of a family in which both parents believe themselves to be "learning disabled."

An evaluation of the child by the local public school system prior to his treatment, utilizing the standard testing parameters of eligibility from the California Educational Code, Section 3030(J), Title 5,³ revealed the following:

A ten-year, ten-month-old fourth grader, who was retained in second grade.

Reading skills tested at mid-third grade level.

Written language skills fell in a third grade range.

Berry Development Test (for visual motor integration)

showed an accelerated grade level of approximately one year.

His classroom teacher reported minimal progress made during the school year.

The child's total grade score for fourth grade was three Ds and three Fs. His I.Q. tested at verbal 113, performance 100, and total I.Q. 107.

This child was my first referral to the office, with his treatment beginning in September of 1985. He has been seen eleven times to date, with the last three as followup visits in which he did not require corrective treatment.

During the course of his treatment, the child made rapid progress in both academic and developmental skills. His mother wrote as follows:

"There has been such a change in every area of his life that I can't believe he is the same boy!"

His first quarter fifth grade scores were two Bs and five Cs, and in the second quarter he earned three Bs and four Cs.

Evaluation by the local learning center which he had been attending showed an improvement in his Wide Range Achievement tests from a 3.6 grade level prior to treatment to a 6.0 grade level only seven months later. His tutor stated that the boy "has developed a much happier attitude towards academic pursuits."

Case Study #2 A thirteen-year-old male child in the seventh grade averaged scores of two Bs and three Cs. He was seen ten times for treatment of learning problems, with the last three visits as followup not requiring corrective treatment.

His mother reported that following treatment, his eighth grade scores were five Bs, with a note from school describing "conscientious effort."

Case Study #3 A fifteen-year-old male child with learning difficulties was referred for evaluation of his academic potential. He is an only child. His father has learning difficulties and is currently under my care for this. His mother was screened and found not to have a learning difficulty.

The child attends public school at the ninth grade level, but was not classified as "learning disabled" according to the California Educational Code.³ The father reported that the child never crawled and walked at eighteen months. Onset of puberty was at age thirteen.

The child was seen five times over a six-week period, and reported a feeling of increased well-being, improved coordination, and comparative ease in doing his school work. His father stated that there was a marked change in his social-personal skills and level of maturity.

Case Study #4 A twenty-one-year-old adult male had been seen by me for routine chiropractic care and was found to have the cranial distortion consistent with "learning disabilities" as defined by Dr. Ferreri.¹ Upon questioning, the patient stated that he was identified as dyslexic throughout high school, and now works as a driver in a low-skilled job. He has had significant difficulty in reading; for example, he had never been able to read more than a few paragraphs at a time in a newspaper.

The patient was seen thirteen times. He also was treated for multiple musculo-skeletal complaints due to lifting injuries on his job.

Throughout the treatment, the patient experienced continued improvements in his general feeling of well-being. Academically, he now enjoys reading newspapers from front to back, with reading speed and memory retention that continue to improve.

SUMMARY

During the six month period presented here, the Ferreri Neural Organization Technique has been shown to be an effective method of treatment for learning difficulties. On the questionnaire,⁵ patients or their parents were asked to evaluate the treatments. Of those who responded, 89 percent rated the treatment successful. Of those patients whose questionnaires have not been returned, additional followup will be necessary to evaluate their progress.

A more comprehensive test to measure the effectiveness of the Ferreri method would be a study utilizing a control group and a significant number of participants in an external environment. Such a study currently is being developed in cooperation with a public school system in Northern California. Children from seven to nine years of age (second and fourth graders) will be evaluated and treated beginning in September of 1986. Their academic progress will be documented and followed throughout the course of the school year.

REFERENCES

1. Ferreri, Carl A., D.C., Ph.C., Breakthrough for Dyslexia and Learning Disabilities, Exposition Press, Fla., 1984.
2. Neural Organization Center, 3101 Clayton Road, Concord, California 94519, (415) 682-1236 - or 2920 Domingo Avenue, Berkeley, California 94705, (415) 845-3246.
3. Educational Code of the State of California, Section 3030(J), Title 5:
"Eligibility criteria: The assessment of a pupil suspected of having a specific learning disability requires the determination of a significant discrepancy between intellectual ability and achievement in one or more of the following academic areas: oral expression, listening comprehension, written expression, basic reading skills, reading comprehension, mathematics calculation, or mathematical reasoning. Further, the discrepancy must be determined to be directly related to a disorder in one of the basic psychological processes, which include: attention, visual, auditory processing, sensory motor skills, and cognitive abilities, including association, conceptualization, and expression."
4. Blaich, Robert, D.C., Lecture presentation, Human Performance, San Francisco, California, 1985.
5. Corwin, Mitchell R., D.C., Patient Questionnaire, MC Form S #4, rev. 8/85.

PATIENT QUESTIONNAIRE

Name _____ Age ____ Birthday _____ Phone No _____

Address _____

Referred by _____ Address _____

Prior Chiropractic Care Yes / No When _____ Recent Dental Work Yes / No Work Phone _____

Marital Status S / M / D / Sep Ethnicity _____ Handedness Right / Left / Both Ht. ____ Wt. ____

Number of Brothers ____ Sisters ____ Birth Order _____ Eye Color _____ Hair Color _____

Significant Past Injuries _____

L. D. Deficits (circle appropriate ones) Hearing / Reading (silently or out loud) / Hesitant Speech

Visual / Memory - Comprehension / Attention Span / Depth - Time Perception / Phobias

Writing Skills Cursive / Script / Both Friends Many / Few Present Grade Level ____ I.Q. (if known) ____

Special Education Public / Private Tutors Yes / No Describe _____

Present Medications (if any) List: _____ Present or Past Medical Care Yes / No

Physician's Name _____ Address _____

Treatment Course _____ Outcome or Comments _____

Present or Past History of Bedwetting Yes / No Allergies None / Foods / Grasses / Chemicals

Do you (child) have scoliosis Yes / No Other family members Yes / No Who _____

Has previous testing been performed to evaluate the disability Yes / No Are Results Available Yes / No

Do other Family Members have Learning Difficulties Yes / No Who _____

Birth History Natural / Cesarean / Premature Labor Easy / Difficult / Longer than 6 Hours

Was Forceps Used Yes / No Apgar Score (if known) 1-2-3-4-5-6-7-8-9-10 Home Delivery Yes / No

Birth Size Small / Large / Avg Congenital Anomalies Yes / No Infant Development Norm / Slow

Age Crawled _____ Age Talked _____ Vaccinations Yes / No Age Walked _____

Child Development Slow / Avg / Precocious Age of Puberty _____ Menstrual Cycle Reg / Irreg / Absent

Severe Head Trauma Yes / No Severe Illness Yes / No Describe _____

Do you (child) plan to be reevaluated in the near future, following my care Yes / No

Would you agree to follow-up correspondence at 6 months / 12 months / 24 months

to assist me in gathering and publishing research data Yes / No

How would you rate the results of the treatment to date Successful / Satisfactory / Unsatisfactory

Additional comments _____

Would you like additional information about learning difficulties and / or my approach Yes / No

Do you feel the explanation provided about the method of treatment was adequate Yes / No

Would you like to purchase a copy of the book, Breakthrough For Dyslexia and Learning Difficulties,

by Dr. Carl A. Ferreri (founder of the Neural Organization Technique Centers) Yes / No

Would you like me to speak to a special interest group or to your friends Yes / No

Would you refer friends or family to me for this treatment Yes / No

Thank You

Signature _____

Date _____

THE EMOTIONAL ASPECTS OF MERIDIAN SPINAL ADJUSTING

By Dr. E.J.Cousineau, D.C.

ABSTRACT: Listing and discussing the particular phrases that can challenge the emotional aspects of several of the spinal meridians, much the same as a joint or a muscle can be challenged.

INTRODUCTION:

This paper is the thirteenth paper written by your author on the use of the Associated Vertebrae of the Meridians of Acupuncture as the means of balancing those meridians by spinal adjusting alone.

The human emotions can become stressors to the body's General Adaptative System as it seeks to handle the input of life itself and its environment. Sometimes this can be in opposition to the person's goals and ambitions, but the goal-seeking mechanism of the body attempts to carry out its function, even to the point of overloading and unbalancing one or more of the acupuncture meridians.

When a meridian becomes overloaded or unbalanced, then every muscle associated with that meridian will test weak on one side of the body compared to its corresponding muscle on the opposite side.(1) Also, the meridian's Beginning and End Points will cause weakness in any previously-tested strong indicator muscle, when it is Therapy-Localized by the testing-doctor, or by the patient themselves.(2) Further, any other person, other than the patient or the testor, can T.L. the

Introduction (Contd)

meridian End Point and produce the same weakening effect upon the patient's strong, previously-tested muscle.(3)

There is one caution that must be observed; If the End Point used is T.L.d by a finger having the same unbalanced meridian, then there will be no weakness, but strength ensue, since the test will be reversed. The finger containing an unbalanced meridian EndPoint will cause weakness when touched to any muscle belonging to a balanced meridian, but will cause no weakness in a strong test muscle, when touched to a muscle belonging to an unbalanced meridian.(4)

When an unbalanced meridian is challenged by repeating certain phrases in the hearing of the patient, it can produce an emotional overload on that meridian and cause weakness in the previously-tested strong indicator muscle.

When the associated vertebra for the unbalanced meridian is adjusted chiropractically , those phrases will no longer cause weakness in the previously-tested strong indicator muscle.

This fact is the subject of this paper.

Emotional Aspects of Spinal Meridians (Cousineau) Cont'd. p. 3

Phrases that Stress unbalanced Spinal Meridians:

Stomach Meridian - Associated Vertebra is Lumbar One

" Things are bad all over. "

Such negative expressions weaken the strong indicator muscle, if the Stomach Meridian is already unbalanced. Such expressions as "Things are good" will NOT weaken the strong indicator muscle.

Gall Bladder Meridian - Associated Vertebra Thoracic 11

" It's not my fault, it's their fault."

The attempt to escape responsibility for the consequences of one's own acts result in the feeling of "Blame", or "Something's the matter with me.". When one can accept the fact that they make mistakes, and the consequences are acceptable to them, or they will change them, than this phrase will cease to be a stressor.

Pancreas Meridian - Associated Vertebra - Thoracic Nine

" It's not fair,"

The patient is in a "no-win" situation, where they try repeatedly and unsuccessfully to change a situation. The adrenals get the sugar out of the storage depots in the liver and muscles and into the blood stream causing a high blood sugar level, preparatory to the "Fight or Flight" mechanism. This produces several muscle weaknesses.

Pancreas Meridian (Cont'd.)

The Lower Trapezius muscles when tested bilaterally and simultaneously, will be weak when the Pancreas Meridian is unbalanced. Adjusting Thoracic Nine corrects this.(6)

The Right Groin will Therapy-Localize weakness in a test-muscle. Adjusting Thoracic Nine corrects this.(7)

The Victor Frank Test for high blood sugar levels will be present, and this is weakness in the right leg-raise test when the left leg is flexed at the knee with the foot flat upon the table when the patient is in the supine posture.(8)

Adjustment of Thoracic Nine corrects this weakness

The Adrenal Meridian (Triple-Warmer)- Lumbar Two

" I don't want to, but I got to, because I ought to."

The exhaustion of the adrenals from overstressing, due to continual attempts to adapt to "no-win" situations, causes weakness in those muscles associated with this meridian.

These are the soleus-gastrocnemius and sartorius-gracilis muscle groups. Adjustment of Lumbar Two restores the strength immediately.to all of them.

CONCLUSIONS:

The patient's perception of their environment as unacceptable to their goals and ambitions causes their goal-seeking mechanism to strive to the point of exhaustion to produce changes. Thus emotions become stressors overloading the meridians and causing muscle weaknesses.

Emotional Aspects of Spinal Meridians (Cousineau) Cont'd. p 5

CONCLUSIONS (Cont'd.)

Every muscle on an unbalanced or overloaded meridian will test weak on one side of the body or on the other. The Beginning or End Point of that overloaded meridian will T.L. to make a strong indicator muscle go weak.

Repeating certain phrases in the hearing of the patient will cause weakness in a strong previously tested muscle if that phrase pertains to an emotion expressed by the organ associated with the unbalanced meridian.

Stomach Meridian - "Things are bad all over."

Gall Bladder Meridian - " It's not my fault, it's their fault."

Pancreas Meridian - " It's not fair."

Adrenal Meridian - " I don't want to, but I got to,
because I ought to."

When the associated vertebra for the unbalanced meridian is adjusted chiropractically, those phrases will no longer cause weakness in any previously-tested strong muscle indicator.

Emotional Aspects of the Spinal Meridians (Cousineau) p. 6

BIBLIOGRAPHY:

- (1) Dr. E.J.Cousineau, D.C., COLLECTED PAPERS OF ICAK, Summer 1982,
"Surrogate Testing by the Doctor, etc." page 63
- (2) Dr. Wallace Gunn, D.C., COLLECTED PAPERS OF ICAK, Summer 1979
" How to Treat a Magnetically Imbalanced Body." page 122
- (3) Dr. E.J.Cousineau, D.C., COLLECTED PAPERS OF ICAK, Summer 1982
" Multiple Point Therapy Localization/Challenge " page 53
- (4) Dr. E.J.Cousineau, D.C., COLLECTED PAPERS OF ICAK, Summer 1982
" The Summation of Stimuli." page 53
- (6) Dr. E.J.Cousineau, D.C., COLLECTED PAPERS OF ICAK, Winter 1983
- (7) "The Pancreas Meridian and Ninth Thoracic Vertebra." page 73
- (8) Dr. E.J.Cousineau, D.C., OFFICE RECORDS, 1981-1985
312 East Pioneer Avenue, Puyallup, Washington 98172

The Seven Conditions of Muscle Balance

by

RICHARD D. UTT

and

SHELDON C. DEAL, D.C., N.D.

Abstract. Several new concepts in muscle testing are introduced. First is the idea of testing an isolated muscle from extension towards contraction as well as from contraction towards extension. The concepts of frozen and flaccid imbalance conditions are explained, leading to six distinct conditions of muscle imbalance. Examples of correction techniques, including the new Proprioception Integration Technique, and examples of typical physiological implications of these imbalance states are given.

One of the earlier discoveries made several years ago was that each muscle can be tested not only in contraction to extension, as is normally done in Applied Kinesiology, but also in extension to contraction. This innovation was introduced because of the discovery that the proprioception associated with a specific isolated muscle can affect the ability of the isolated muscle to test locked or unlocked in both contraction to extension and extension to contraction. This phenomenon is due to the interplay between the proprioceptors of the primary muscle and its synergist antagonists, which are constantly monitoring each other. We call an imbalance condition a **HYP0** condition when the imbalance affects the ability of the isolated muscle to properly lock when tested in **CONTRACTION**. We call the imbalance condition a **HYPBR** condition when the imbalance affects the ability of the isolated muscle to properly lock when tested in **EXTENSION**.

Hypo and Hyper Muscle Testing.

Whenever we muscle test, we activate not only the Golgi tendon organs and the

spindle cells in the belly of the muscle, but also other proprioceptors are brought into play. These include the Pacinian corpuscles, the Ruffini end organs, and the Golgi organs in the ligaments of the joint. These proprioceptors send signals to the spinal column and the central nervous system and then on to the brain from each muscle and corresponding joint structures. The brain's response is sent to the central nervous system and then back to the muscle and also to all the corresponding antagonist muscles to make a change. The details can get quite complicated, but basically what is happening is that all structural movements are the results of two opposing sets of muscles working in balance. When one set pulls, the other set must release correspondingly. Thus the proprioception for a muscle refers control signals to the antagonists muscles as well as to the primary muscle and its synergists to enable this action to happen smoothly and efficiently.

To go further into the basic process of testing a particular muscle, we put the muscle into such a position that the muscle is fully CONTRACTED and not twisted so that the fibers are as even as they possibly can be. Then we ask the person being tested to hold the muscle in that position while we put a light pressure on the moving limb in such a direction as to move the isolated muscle TOWARDS EXTENSION. When the muscle does not hold or look in its fully contracted position, it is said to be HYPO, "weak", "underenergy", or "unlocked". This concept is basic to ICAK muscle testing.

The first of the new concepts is that we also test the muscle from extension towards contraction with the muscle now EXTENDED to near its fullest with all its fibers as close to alignment as possible without many of the fibers being twisted. This is the opposite condition to conventional muscle testing. In the usual muscle testing theory we understand that we are not testing the muscle that has been extended because we can only test the muscle in its contracted state. This is true as far as the original concept goes, but the muscle in its extended state is in a sense still isolated. It is the proprioception of the isolated muscle that sends signals to the central nervous system, to the brain, and back from the brain to the central nervous system and to the antagonist

muscles. Now testing the extended muscle from extension back TOWARDS CONTRACTION is in reality testing the antagonist muscles as a group. In a normal or homeostatic condition, the antagonist muscles individually or as a group should lock, i.e. test "strong". If they do not lock and test "weak", then we say that the isolated muscle being tested in extension towards contraction is HYPER. This can be verified by going to the primary muscle and showing that therapy localization of the alarm point of the meridian on which the muscle is located will weaken or unlock the muscle. Another way to verify that the muscle is hyper is to show that the primary sedation points for the corresponding meridian will not unlock the muscle, as taught in the 100-hour basic ICAK course.

In some instances there is a direct antagonist, such as adductors to gluteus medius, hamstrings to quadriceps, and biceps to triceps. But in many other instances we are bringing on line groups of muscles. For example when we test the pectoralis major clavicular (PMC) in extension back towards contraction, the antagonist muscle group includes the middle trapezius, supraspinatus, subscapularis, and all other muscles attached to the opposite side of the humerus from where the PMC muscle inserts onto the humerus.

For example, let's test a muscle, say the biceps, that has a single direct antagonist, in this case the triceps. We extend the biceps so that the arm is at approximately a 160-degree angle (we don't want to lock the joint because we would not get a true indication from the triceps muscle). Now we test the biceps from extension towards contraction, which is the same as testing the triceps from contraction towards extension. If the test indicates an unlocked or "weak" triceps, we then say that the triceps appears as hypo, but we can also say that the biceps are hyper.

To understand this concept more fully, we are going to bring into play Dr. Goodheart's Golgi tendon technique.⁴ For example, if you sedate the biceps by pushing on the tendons in a direction away from the belly of the muscle to create a hypo

condition, you will notice now that when you test the biceps in its contracted state towards extension, the muscle will now unlock (i.e., test "weak"). Now let's put the biceps back to its homeostatic condition by tonifying it by pushing on the tendons in the opposite direction towards the belly of the muscle. Now the biceps will again appear to be "strong" to manual muscle testing from contraction towards extension. At this point go to the extended position and test the antagonist, which is the triceps. The triceps should hold. We now have a muscle combination that tests locked from contraction towards extension and from extension towards contraction; this is a homeostatic condition, not hypo, not hyper.

Understanding this principle is very important because the next example is to go back to the Golgi tendon organs and push them together, tonifying the isolated muscle and creating a hyper condition. When you test the isolated muscle from contraction towards extension, the biceps in this particular case, it will test "strong" or locked. But if you put the biceps into an extended state and now test from extension towards contraction, you will find that the triceps will be unlocked, and of course the biceps from extension towards contraction is now unlocked. This is the opposite condition to the previous example; it can be corrected by the opposite procedure, sedating the isolated muscle, the biceps, or tonifying the antagonist, the triceps.

It gets a bit more complicated when testing a muscle that has a group of antagonist muscles, such as the PMC, in its extended state. As we said before, all the muscles that attach to the opposite side of the humerus are antagonists as we test the PMC from extension back towards contraction. Now when the isolated muscle, in this case the PMC, is hyper, the antagonist muscles are unlocked, "weak", or hypo as a group, even though each muscle in the group may be in a homeostatic (i.e., "balanced") state as an individual isolated muscle.

What is this telling us? This is telling us that the proprioceptors in the isolated

musculature and the joint that we are working with are sending the signals to the antagonists to lock and unlock. We do not have a muscle that is merely "on" or "off". Rather we have a muscle and its antagonist that can be tested for a hypo condition, a homeostatic condition, or a hyper condition.

What is the benefit of checking muscles for hyper as well as hypo condition? The reason is that unless the entire circuit is in balanced homeostatic condition, we cannot get accurate readings from the muscle when it is used as an indicator in muscle testing. For example, when checking for Ileocecal Valve Syndrome, if the indicator muscle is in an unbalanced hyper state, it will not unlock (i.e., go "weak") when therapy localizing for the Ileocecal Valve.

Frozen Muscle Conditions.

Many times when we check a muscle to use as an indicator, we find that it tests locked in contraction, and perhaps we also test it in extension and find it locked in that mode too. In our minds we may think that we have a good indicator muscle and that everything is working properly in the circuitry for that muscle. We are now using that muscle to test other circuits in the body through various therapy localization or challenge techniques. What we have overlooked is the possibility that the muscle might be stuck in a locked condition or frozen. **THEN ALL FURTHER TESTING YOU DO WITH SUCH A MUSCLE WILL BE A TOTAL WASTE OF TIME IF YOU DO NOT ELIMINATE THE FROZEN CONDITION FIRST.**

There are two types of frozen condition. **HYPO FROZEN** occurs when we go to **SBDATB** a muscle using any one of our sedation techniques and the **MUSCLE FAILS TO UNLOCK FROM CONTRACTION TO EXTENSION**. We have a **HYPER FROZEN** condition whenever we use any of the **TONIFYING** techniques, and the **MUSCLE FAILS TO UNLOCK FROM EXTENSION BACK TOWARDS CONTRACTION**.

We want to emphasize that, when we are testing a muscle that is extended, the resistance is not actually coming from the isolated muscle, rather it is the antagonists of the isolated muscle that are locking. However this is a test of the isolated muscle because the antagonists are responding to proprioception signals from the isolated muscle.

To check for a HYPO FROZEN muscle we first test the muscle in CONTRACTION TOWARDS EXTENSION. If we find that the muscle locks, we know that it is not hypo, but it could be hypo frozen. To check for the possible frozen condition, we next attempt to SEDATE it. We can do this by any of the usual sedation techniques, such as pulling apart at the origin and insertion to activate the Golgi tendon organs. Now we test the muscle again from contraction towards extension. If the muscle is balanced, it will respond to the sedation stimulus and unlock. IF THE MUSCLE DOES NOT RESPOND TO THE SEDATION WHEN TESTED FROM CONTRACTION TO EXTENSION AND REMAINS LOCKED, IT IS HYPO FROZEN.

We could have used any other technique for sedating the muscle just as well, pushing the spindle cells in the belly of the muscle together, etc. A new technique for sedating a muscle using a magnet is particularly quick and convenient when testing for frozen muscles. The sedation is provided by placing the north pole of a magnet over the belly of the muscle. The isolated muscle is tested from contraction to extension while the magnet is being held in place. If the muscle does not unlock, it is hypo frozen. We can also sedate the muscle by placing the south poles of two magnets on the origin and insertion points of the isolated muscle.

We test for a HYPER FROZEN in much the same fashion, except that now we test the muscle from EXTENSION TO CONTRACTION and then TONIFY it to make the frozen muscle test. We could tonify the muscle by pushing together at the origin and insertion points or pulling apart at the belly of the muscle, etc. Or we could use a magnet as described

above except that the poles are reversed to tonify. (The south pole is placed over the belly of the muscle.) We then test to see if the initially locked muscle unlocks when tested from extension towards contraction. IF THE MUSCLE DOES NOT RESPOND TO THE TONIFICATION WHEN TESTED FROM EXTENSION TO CONTRACTION AND REMAINS LOCKED, IT IS HYPER FROZEN.

What is happening in the hypo frozen condition is this. We attempt to sedate an isolated muscle by using the origin and insertion golgi tendon technique, for example. Then we test the muscle from contraction to extension, and the muscle fails to unlock. This shows that the necessary signals from the proprioceptors which will cause the muscle to unlock are failing to complete the trip from the proprioceptor cells through the central nervous system back to the muscle, and the muscle does not unlock as it normally would. The signals could be blocked anywhere along the pathway from the proprioceptor to the motor neuron. Similarly in the hyper frozen condition the signals from the proprioceptors activated by tonifying the isolated muscle fail to reach the antagonist muscle group to cause the muscles to unlock.

Flaccid Muscle Conditions.

When a muscle is flaccid, it is said to be lacking any response to the proprioception circuitry. In other words, when we put the muscle into isolation, it has absolutely no strength what so ever in contraction, extension, or both. The muscle is also found to be unfixable in a direct manner. In other words, no matter what technique we use, nothing we can find will correct the muscle. It is basically in a state of paralysis. The muscle operating circuitry is inoperative. This is quite different from the usual hypo or hyper condition where the muscle and its circuitry is operational, but are just not receiving the necessary signals to lock.

The hypo flaccid condition is any muscle that will not lock and is totally flaccid

with muscle testing from contraction to extension. A hyper flaccid condition is any muscle that will not lock from extension back toward contraction. In other words all the antagonists as a group are totally flaccid.

Working with these concepts led to the conclusion that there are six different states of muscle imbalance:

Hypo	Hyper
Hypo Frozen	Hyper Frozen
Hypo Flaccid	Hyper Flaccid

as well as the seventh balanced state:

Homeostasis

Correction Techniques.

There are a number of different methods for correcting the six out-of-balance muscle conditions. The basic Proprioception Integration Techniques (or PIT) will now be discussed briefly.

When you find an out of balance muscle that you cannot correct with PIT or a previously out of balance muscle that will not hold a correction, you need to look for the physiological imbalance that is causing the muscle to remain imbalanced. The out of balance condition will be permanently cleared only after you clear the underlying causative factor. This is particularly important with frozen muscles. Some frozen muscles may have been frozen for many years. Very likely these muscles will require more elaborate treatment than PIT to unfreeze.

There are other methods that we can use to correct frozen muscles. Some of these would be to use neurolymphatic, neurovascular, structural, nutritional, emotional, Bach flowers, and simple acupuncture correction techniques.

Flaccid or paralyzed muscles are very difficult to correct. The trick is that you don't work on the muscle itself. You go instead to circuitry that is operating and work with it. Such as the antagonist, ligament interlink, or the spinal level above that is working.

Proprioception Integration Technique.

When an isolated muscle is not in homeostasis, this is an indication that the circuits from the proprioception through the central nervous system to all the muscle fibers involved are not operating properly. The basic concept in the Proprioception Integration Techniques is to reactivate the inactive proprioception circuits. Since each of the muscles out of homeostasis conditions represents a different circuit failure mode, we have a different Proprioception Integration Technique or PIT for each type of muscle condition.

From CONTRACTION to extension

<u>Name</u>	<u>Finding</u>	<u>Correction</u>
Hypo flaccid	Unlocked	Will not lock with PIT.
Hypo	Unlocked	PIT #2
Hypo frozen	Locked. Will not unlock when sedated.	PIT #1
Homeostasis	Locked. Unlocks when sedated.	

From EXTENSION to contraction

<u>Name</u>	<u>Finding</u>	<u>Correction</u>
Homeostasis	Locked. Unlocks when tonified.	
Hyper frozen	Locked. Will not unlock when tonified.	PIT #3
Hyper	Unlocked	PIT #4
Hyper flaccid	Unlocked	Will not lock with PIT.

PIT #1 is used to balance a HYPO FROZEN muscle condition.

There are three steps:

- 1) Put isolated muscle into maximum CONTRACTION.
- 2) Tense isolated muscle.
- 3) Push isolated muscle towards further CONTRACTION with isometric pressure.

Note that the muscle is already in a fully contracted position; so the limb to which the muscle inserts or attaches does not move during the correction. The pressure used is proportional to the physical condition of the person being balanced. Be cautious about using excess pressure, particularly on an older person whose bones may be brittle. You can instruct the patient to say, "Stop", anytime there is excessive pain.

The idea behind the procedure is this: By placing the muscle into contraction and tensing the isolated muscle, we activate the spindle cells, Golgi tendon organs, Golgi organs, and Ruffini end organs. By placing the muscle under isometric pressure as well, the additional movement activates the Pacinian corpuscles. Thus we are activating all five types of proprioceptors while the isolated muscle is in maximum contraction. The body recognizes that position and resets all the proprioception to that position as a group.

This is a little like resetting the brake alignment on your automobile. You drive the car in reverse at about 10 miles per hour and then slam on the brakes. That resets all the brakes to the proper alignment. You are resetting all of the proprioceptor circuitry serving the muscle in the same fashion.

PIT #2, used to balance a HYPO muscle condition, is similar to PIT #1.

There are three steps:

- 1) Put isolated muscle into maximum EXTENSION.
- 2) Tense isolated muscle.
- 3) Push isolated muscle towards CONTRACTION with isometric pressure.

We use isometric pressure in the same direction as before, but this time we work at the

fully extended position.

PIT #3 is used to balance a HYPER FROZEN muscle condition.

As before there are three steps:

- 1) Put isolated muscle into maximum EXTENSION.
- 2) Tense isolated muscle.
- 3) Push isolated muscle towards further EXTENSION with isometric pressure.

Now in PIT #3 and #4 for the hyper muscle conditions we use the isometric pressure in the opposite direction. As with PIT #1 we go to the end of the range of motion of the isolated muscle in the direction that we are going to apply pressure and then apply the isometric pressure.

PIT #4 is used to balance a HYPER muscle condition.

Again there are three steps:

- 1) Put isolated muscle into maximum CONTRACTION.
- 2) Tense isolated muscle.
- 3) Push isolated muscle towards further EXTENSION with isometric pressure.

We go to the opposite end of the range of motion of the isolated muscle than that used in PIT #3 and apply isometric pressure in the same direction.

As we see the whole picture, we see that there is a consistent pattern:

<u>Correction</u>	<u>Condition</u>	<u>Position</u>	<u>Pressure Direction</u>
PIT #1	Hypo frozen	Max. contraction	Towards contraction
PIT #2	Hypo	Max. extension	Towards contraction
PIT #3	Hyper frozen	Max. extension	Towards extension
PIT #4	Hyper	Max. contraction	Towards extension

Note that the direction of the isometric pressure used to correct the imbalance

condition is always opposite to the direction of the pressure used to test for the muscle condition, just like the example of running a car backwards to reset the brakes.

Remember that all the proprioceptors associated with an out of balance muscle must be activated to reset the muscle with the PIT techniques. Proprioceptors will not respond when they are saturated beyond their capacity to function. The body draws a circle around the overly stressed proprioceptors and pretends that they are not there. This can be a continuous thing or it can happen at just certain times of the day when the body is under a higher level of stress. Allergens can provide sufficient stress to do this at times. In such cases the direct application of PIT may not work. The stress on the proprioception needs to be reduced first by finding other ways to reduce the stress in the body. Oftentimes while doing the PIT technique, the vector of force being applied isometrically needs to be varied or changed.

Examples of Typical Frozen Muscle Situations.

Why is correcting frozen muscle conditions important? We have just learned that we must be sure a muscle is not frozen as well as not hypo or hyper before using it as an indicator. Now we shall see how many hard to deal with symptoms can be associated with frozen muscles. Many times we have hypo or hyper frozen conditions without being aware of it, since the patient apparently tests out normally. All muscles are strong and locked, but the patient still has a problem. Our investigations have shown that many physiological imbalance conditions exist because of frozen muscles that are not corrected in these routine balancing techniques. The following examples will describe some typical interesting situations that we have dealt with successfully by correcting frozen muscles.

Women with premenstrual syndrome (PMS) often have a gluteus medius frozen hyper or hypo or both bilaterally. Many times they are found to also have a frozen gluteus maximus muscles and adductors, depending on the severity of the PMS. These

muscles will tend to be frozen only during the time preceding menstruation. At other times of the month when the PMS is not active because of the normal flow of hormones through the body, the frozen muscle conditions are not present. These muscles tend to unfreeze again as the hormonal balance starts to reappear with ovulation. Then going back into the premenstrual period, these muscles will have a tendency to freeze up again. When the patient has pains in the abdomen or in the ovaries area, once we release these frozen conditions, many times the PMS will disappear.

This is also true of pelvic inflammatory disease (PID) and is specifically true with all symptoms of hot flashes. This is an indication of imbalances related to the pericardium meridian, which reflexes to circulation and the sexual organs. Balancing frozen muscles associated with the pericardium meridian may relieve the condition.

Many times we work with people with urinary incontinence problems. Invariably a muscle on the kidney or bladder meridian will tend to be frozen, but balancing these meridians alone is not going to solve the problem. Testing the muscles that Dr. Alan Beardall¹ found to be associated with this problem, the pubococcygeus, the ileococcygeus, and the coccygeus, both sacral and coccyx divisions, we will find one or more to be frozen 90 percent of the time. After you unfreeze these conditions, the incontinence starts to improve.

Frozen muscles can cause other symptoms in the body. These include asthma, bronchitis, and inflammation of the lungs. Our research has shown that when we unfreeze the anterior deltoid and the anterior serratus, many times asthma will totally clear out. If not a total correction, at least a tremendous amount of improvement will appear. As in the case of a lady we worked on recently who had had severe asthma for the last three years. She was so excited with the result of the treatment that she invited her chiropractor to come with her on her next visit. He wanted to find out what happened to change a condition that had been chronic for so many years in such a short time. Also

in a seminar in Burbank, we demonstrated on Dr. Bruce Dewe, a medical doctor from New Zealand, a dramatic change in a chronic lung condition occurred when the frozen muscles were eliminated.

We have had several people who have had dramatic changes in their lung capacity after treatment of frozen muscles. One lady in particular experienced a major improvement. Her breathing problems went back as far as she could remember. No matter what she did, if she started to get up, she would be huffing and puffing. If she bent over to tie her shoe, she would be huffing and puffing. It took her an entire week to do a half a day's work around the house because her lungs did not have sufficient capacity to supply adequate oxygenation. We checked her with an spirometer before and after treatment. Before the treatment the best she could do was to blow 2500cc of air out of her lungs. We proceeded to unlock frozen conditions in the deltoid and anterior serratus muscle only. Both muscles were frozen hyper and hypo bilaterally. After unfreezing these muscles, she was able to blow 4300cc of air out of her lungs. Needless to say her endurance and ability to perform physical tasks improved remarkably.

We have had instances where people have come in with acute colitis. On a recent referral from a doctor of osteopathy, the client had a severe case of colitis in addition to a number of other conditions which the doctor was treating her for. We only worked with her colitis condition. Her tensor fascia lata and hamstring muscles were frozen. After balancing these muscles, her colitis condition was markedly improved.

When we work on people with angina and chest pain, we generally find the subscapularis, which relates to the heart meridian, and muscles associated with the pericardium meridian, such as the gluteus medius, are frozen. Many times the pains will disappear immediately when we correct these muscles. We are not in any way suggesting that this is a panacea for heart disease, but this will provide relief for physiological problems that so often mimic or accompany cardiovascular problems.

Another condition that may be related to frozen muscles is the reverse adrenal syndrome. People with this problem just can't seem to get their blood sugar under control. Everything seems to be setting them off. When we work on the triple heater meridian in particular, using the muscles associated with the adrenal glands, the sartorius, gracilis, gastrocnemius, and soleus, and unfreeze these muscles, the results can be phenomenal. Instead of taking the average of 8 months for the normal basket case hypoglycemic to get a handle on their low blood sugar problem, the process can be sped up to one half or one third the time.

We have seen literally hundreds of cases of people who have had scattered thoughts and could not center their thinking. By unfreezing the supraspinatus, which is associated with the central meridian and the brain, this whirlpool of rapid thought slows down. People seem to get more organized and more capable of getting maximum efficiency out of their time expenditure.

We worked on a gentleman who wanted to make it easier to drop a drug habit. He had been using marijuana for 5 years. He had never observed a high so nice as the high he experienced as we balanced out his frozen muscles. Drug users have a tendency to get a little high when you balance out their frozen muscles. What is happening is that energies are moving around circuitry where they haven't moved in such a long time that the body hasn't been accustomed to experiencing this. This general feeling of euphoria may wear off in several hours. Hopefully this relaxed state will continue for several days until they so choose to change back to a stress condition. If they can manage to make some life style changes, this stress need not return. It is a choice they make for themselves.

What we are telling you is that fixing the frozen muscle is more that just looking for a muscle and unlocking it so that it can be used as a good indicator. A frozen muscle is a monkey on the backs of most people that have any kind of acute or chronic

disease. As you start unfreezing the muscles, conditions are going to ease off immensely. There are very few disease processes that are not stress induced. In other words stress can induce just about any condition that you can possibly think of. Especially neurological conditions. Some people feel that they are totally relaxed, but you still find that 50 to 60 percent of their muscles are frozen. They don't even know what relaxation is anymore. They are as relaxed as they can be, and to them that feels completely relaxed. As you free their frozen muscles, they will walk out of your office feeling like a "wet noodle". Many times when we unlock these frozen conditions, the statement is, "I haven't been this relaxed in years."

A Note Of Thanks (by Sheldon C. Deal)

Approximately 3 years ago, certain concepts were visualized by Richard Utt. These concepts challenged the limitations of accepted norms. Application of these concepts dictated a theoretical set of procedures. Richard Utt, to whom I attribute a gift for lateral thinking, pursued the development of these procedures describing their significance to me on many occasions. In the meantime he developed a set of procedures to the point of time saving techniques and authored 3 manuals to define and explain them. Rich continued to attest to the accuracy of the concepts by procedure repetition and application.

After 2 years of speculation the results persuaded me to join him in verifying the new work. Twelve months, my usual initiation period for new material, has brought me to the conclusion that evidence proves Richard Utt's work to be worthy of further evaluation by the International College of Applied Kinesiology.

I wish to present Richard Utt, his concept, and resultant techniques as progress in the expansion of the understanding of Applied Kinesiology and in the efficiency of Applied Kinesiology techniques.

Source Bibliography:

1. Alan Beardall, "Clinical Kinesiology, Vol. 2, Pelvis and Thigh", pages 17 - 23, Clinical Kinesiology, Jan. 1981
2. Sheldon C. Deal, Gordon Stokes, and Mary Marks, "Basic AK Workshop Manual", Touch for Health Foundation, 1983
3. Sheldon C. Deal and Richard D. Utt, "Applied Physiology/Advanced Kinesiology Seminars I, II, and III", presented Tucson, Sacramento, and Kansas City, 1985 & 1986
4. George J. Goodheart, "1976 Research Manual", page 147, ICAK
5. Florence P. Kendall and Elizabeth K. McCreary, "Muscles, Testing and Function", Third Edition, 1983, Williams and Wilkins
6. Stoner, "The Eclectic Approach to Chiropractic", 2nd Edition, 1977, FLS Publishing Co.
7. John F. Thie, "Touch for Health", 2nd Edition, 1979, DeVorss & Co.
8. Richard D. Utt, Gordon Stokes, and Daniel Whiteside, "Applied Physiology Workbook I", Applied Physiology Publishing, 1984
9. Richard D. Utt, "Applied Physiology I", video tape, Gothenburg, Sweden, 1984
10. Richard D. Utt, "Applied Physiology Advanced Muscle Testing", video tape, Sacramento, California, 1985
11. Richard D. Utt, "Applied Physiology Advanced Muscle Testing Workshop Manual", Applied Physiology Publishing, 1986
12. Richard D. Utt, "Applied Physiology I Workshop Manual", Applied Physiology Publishing, 1986
13. Richard D. Utt, "Applied Physiology II Workshop Manual", Applied Physiology Publishing, 1986
14. D. S. Walther, "Applied Kinesiology, Vol. 1, Basic Procedures and Muscle Testing", published by Systems DC, 1981

Therapy Localization of Acupuncture Points
by Gerald Deutsch, D.C.

Abstract: Through the years there have been many diversified methods of how to therapy localize different points in the body, especially acupuncture points. The following treatise is my theory to explain the observations I have made and the experiences I have had in therapy localizing acupuncture points in various manners.

Those of us that were involved with, what we lovingly call A.K. (Applied Kinesiology) from the beginning, and observing its development from its basic inception through the genius of Dr. George Goodheart, can appreciate what the development of therapy localization did for us and chiropractic. It is both a diagnostic tool and a method to monitor the progress of a specific area of correction and rehabilitation. We certainly now could say we knew when to adjust, where to adjust and when to stop. I consider myself one of the lucky ones that sweated through the development and watched A.K. grow to its now world wide use. We, who saw the development of therapy localization¹, immediately realized its powerful potential. Think of the newcomer who takes the concept of therapy localization, naturally in stride, as if it were always there.

At this time, we are all using the patient to therapy localize the acupuncture points, neurolymphatic points, neurovascular points and/or vertebral segments. In the beginning, no doctor was therapy localizing the point themselves. I have checked and have not found any references in any of our literature that states that a doctor can

therapy localize anything with a specific result. With this in mind I thought I would just extend my thinking to our members and see if everyone else can utilize this concept.

Let us presume at this point that we all know that the patient can therapy localize a point. Many people still consider that only a patient can therapy localize a point. Many doctors have different concepts on therapy localizing with both doctor and patient and have been experimenting with varying results. However, since it wasn't in print I thought I would just clarify my ideas so as to create a specific concept as to what is happening. When Dr. Goodheart first discovered that an acupuncture point could be therapy localized he stated that therapy localizing indicates that an organ is full "or hyper". Dr. Loren Jackowski once presented a paper where he himself therapy localized a point. When asked why he does the therapy localizing himself he stated that he always did it. At first, the thought was that it couldn't be done. But upon working with it, we found that many points, including acupuncture points, therapy localize in that manner. After working with this concept I noticed that when I, the doctor, therapy localized a point, the patient did not or could not therapy localize at that point. This led me to believe that there must be a different energy that must be precipitated at this point.

DEUTSCH

3

It wasn't until I obtained a device called a Dermatron, an acupuncture measurement point finder developed by Dr. Voll² in Germany, that I was able to understand what was happening. With the use of this device or probably any device that could measure electrical skin resistance, I noticed that those points that the Dr. could therapy localize and get a weak muscle reaction read rather low on the meter. The higher readings were found when the patient therapy localized those spots. This proves that "full" points do therapy localize.

This opened a lot of possibilities in analyzing acupuncture energy manually rather than using any instrumentation of any type. What better instrument than the body to detect high energy and low energy, full meridians or deficient meridians. I also found that this concept would work with neurovascular and neurolymphatic points. I feel that this would be the same type of energy or electrical resistance to the point or part being therapy localized. For example, in my mind, if a neurolymphatic point was therapy localized by the doctor it would mean that the organ had a low energy pattern. Whereas if the patient therapy localized it was a high energy pattern.

In essence we would want to energize the organ based upon the way it therapy localizes. In many cases, I feel that working the neurolymphatic points by manual stimulation dissipates some of the high energy that could be present in the organ. When the doctor therapy localizes the neurolymphatic point we find that light

stimulation, nutrition and/or homeopathic remedies would be the answer to balance the particular neurolymphatic point. Basically, I found that this type of therapy localization was very useful in the acupuncture system.

Using the concept of Voll (see enclosed diagrams) you will notice that there are points circled on the meridians, whether on the hands or the feet, which are called the Control Measurement Points or CMP. According to Voll, these CMP's, when out of balance, indicate problems in that particular meridian. Dr. Voll classifies these imbalances, when these particular readings are high, as inflammation. When these readings are low he considers this degeneration. I can recall a specific patient with consistently low readings on the CMP of the colon with a specific area around LI4. Upon our insistence the patient requested a proctoscopy. It took a while to find a physician that was amenable to this suggestion from a chiropractor. It was finally done and much to the physicians surprise there were 2 polyps near the ileo-cecal area. Happily, they were not malignant. This only proves the efficacy of this type of diagnosis in the hands of a skilled practitioner. This, of course, is not the only case we have had where people were found to have other problems that were left undiagnosed.

DEUTSCH

5

I have found that this procedure has been helpful in predicting the use of a specific homeopathic remedy for that particular patient. The procedure is done in the following manner. When a high reading is found on a specific CMP with what is called a meter drop there is inflammation in that specific meridian or organ. It is noticed that when the highest reading is achieved there sometimes seems to be an energy drain, electrically, when the meter is read. When this energy drain is noted we can then take homeopathic remedies that would be classical or very specific to work with those particular meridians. Specific remedies are then placed on a holder that looks like a honeycomb which is then placed into the circuit of the instrument between the probe and the instrument. The intervention of a homeopathic or nutrient may balance the meter readings. Many remedies are placed on the honeycomb by trial and error, but when the proper remedy is discovered the particular reading balances at near 50 or at least at a point where the meter does not "drop". Likewise, when the needle is in the degeneration phase the remedies have been found to be able to raise the needle reading to a more normal level (see enclosed chart for the meridians and their CMP). You will notice that Dr. Voll has developed what he calls extra meridian points. He has never really revealed how he has developed these points but they are fairly accurate and I certainly would recommend their use. His assumption was that the body has no voids and each finger and each toe should have a specific meridian present, although classic acupuncture does not recognize these meridians. The unusual factor is that he has

DEUTSCH

6

isolated each acupuncture point to a specific organ part. This factor, along with doctor or patient therapy localization, can then determine what is happening to a specific organ part.

At this point you might ask, "What does this have to do with therapy localization?" We now go by the premise that therapy localization by the patient indicates a high energy pattern. I have taken this concept one step further with the results being confirmed by the Dermatron. When the doctor therapy localizes a point and gets a weak muscle reaction this indicates a low energy pattern. We found, through the use of the instrument, that when there was lower energy or deterioration of energy such as an indicator drop from the higher reading we can therapy localize it as a weak muscle. Low readings also indicate the need to treat the acupuncture point or at least the meridian or the organ system involved with such factors as vitamin therapy, homeopathics and/or indicating further diagnostic tests, i.e. laboratory testing to indicate further pathology. This should be done if you get consistently low readings. By using this method we have a way to indicate a problem with the organ using either the doctor or the patient therapy localization. The actual methodology that I use is very simple.

In order to speed up things, the doctor could therapy localize the patient. A patient therapy localizing can become rather clumsy when

DEUTSCH

7

they start to therapy localize different body parts and getting the fingers exactly in place would be a problem. In order to do this correctly, I act as a surrogate for the patient. When I test the particular parts I therapy localize the area I want to test. I simply place my thumb in the patients hand and have the patient close their hand around my thumb which completes the circuit. I have the ability to move more rapidly. Once the search is satisfied I take my thumb out of the patients hand and therapy localize, using my own hand and/or fingers. My other hand tests the muscle. I suspect this change in therapy localization has something to do with the polarity of the different parts or possibly some change in the polarity as skin resistance changes. This factor seems evident with neurolymphatic parts and neurovascular reflexes. Many times, acupuncture points which therapy localize on the body will actually indicate where to insert a needle and whether to sedate or tonify. The therapy localization also works quite effectively on the auriculo-points.

When these points are found one may conventionally test any food substance, homeopathic, vitamin, mineral and/or enzyme on the tongue and if the meridian or the CMP balances whether electrically or with muscular balance that would be the indicator that that would be the substance to help balance that CMP or that meridian. This procedure seems to work very nicely with all types of products especially homeopathics.

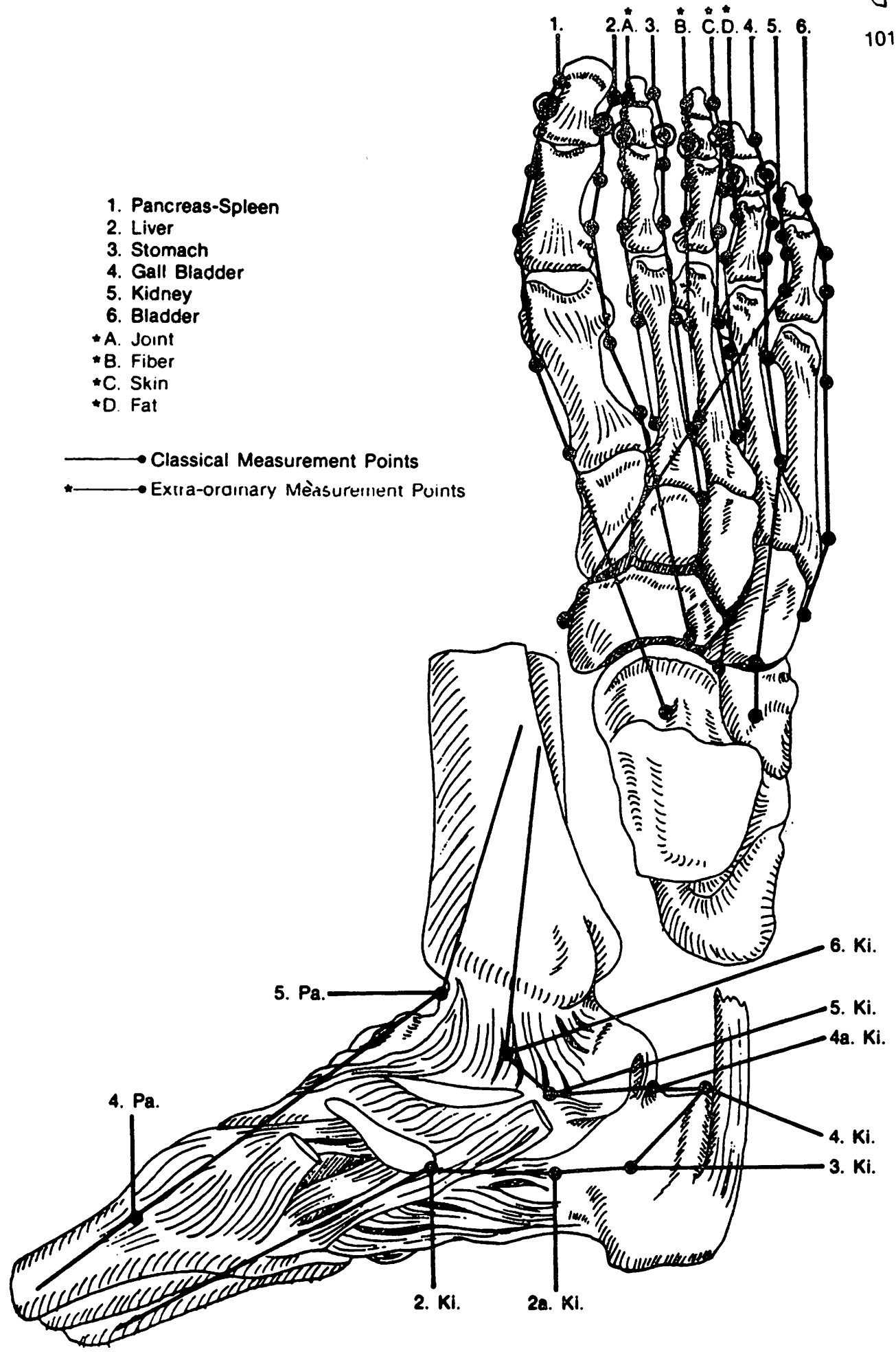
Homeopathic balancing presents a different problem over vitamin therapy. The properties of homeopathics cause them to test differently. Homeopathics are originally poisonous, diluted, then succussed which dynamizes them. Therefore, because of this property, the weak muscle, in the clear, doesn't react to the homeopathic product. The homeopathic product will weaken an intact muscle if that remedy is needed. Therapy localization, either by doctor or patient, eliciting a weak muscle may be a candidate for homeopathics if the homeopathic created a weak muscle in the clear. Double therapy localize using the therapy localized point and the homeopathic should strengthen the entire reflex if that homeopathic remedy is needed for that therapy localized point. We continually find that exposing the homeopathic substance to the ears or body is enough to initiate the weak muscle reaction if it is the proper homeopathic substance.

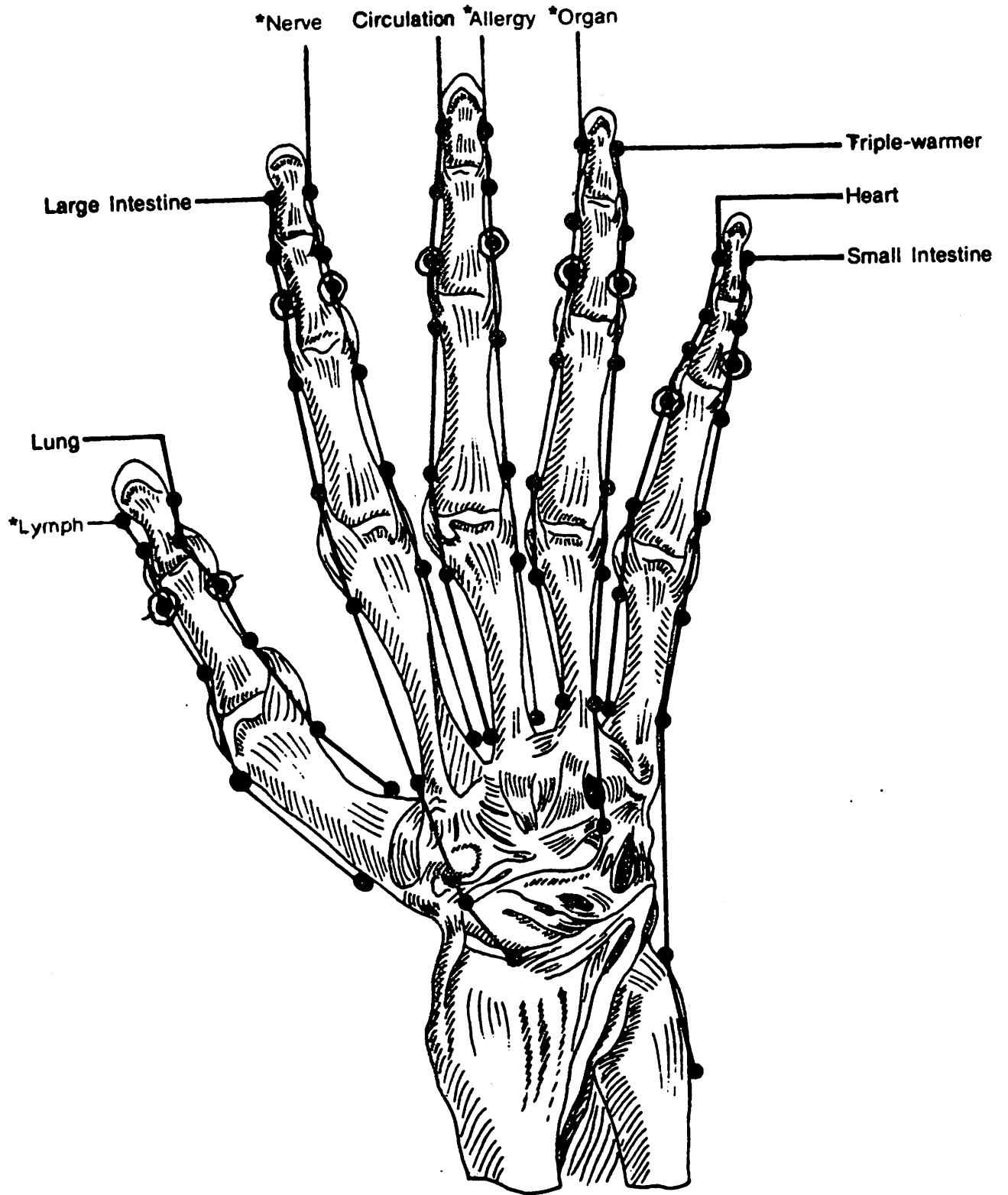
REFERENCES

1. Goodheart, George J., Applied Kinesiology 6th Edition, privately published, Detroit, Michigan, 1974.
2. Voll, Reinhold, Topographic Positions of the Measurement Points in Electroacupuncture, Beckers-Buchdrucker, Uelzan, 1976.

- 1. Pancreas-Spleen
- 2. Liver
- 3. Stomach
- 4. Gall Bladder
- 5. Kidney
- 6. Bladder
- *A. Joint
- *B. Fiber
- *C. Skin
- *D. Fat

—●— Classical Measurement Points
 *—●— Extra-ordinary Measurement Points





● Classical Measurement Points
 ◐ Extra-ordinary Measurement Points

A SCREEN TEST FOR CERVICAL INJURIES TO DETERMINE MALINGERING

by Gerald Deutsch, D.C.

Abstract: Many of us are doing independent medical examinations (IME) from many sources including insurance companies, Industrial Commissions or State Compensation Boards and for other doctors to confirm an injury to determine the need for treatment or the possibility of malingering.

This test, although simple, may help to determine whether one is testing a malingerer with cervical injury. After doing many IME's one may have built in intuition, so to speak, to determine malingering. Many times the patients seem very well informed as what to do and what may make an impression upon the examiner. Often, the patients will splint their own necks or feign pain in an effort to gain points with the examiner as to create the impression that there is serious injuries. Also, you will have a patient that has been injured but in an effort to create the impression of further injury or one that is far beyond what it appears to be they also feign improper motion. It becomes incumbent upon the examiner to determine when the patient is not cooperating. Observation of the patient is a very important part of the exam. In many cases, we instruct our staff to be "on the lookout" for our patients or examinees when getting from the parking

DEUTSCH

2

lot and walking up the walkway to the office. I instruct our assistants to see how the patients ambulate and whether they get in and out of the car easily. In many cases we notice that they do quite well getting out of the car and walking up to the door but as soon as they get into the office they seem to have a sudden "relapse". We have noticed this many times in our examinations. All patients should be screened very carefully. We do find many cases where there have been some injuries though the injuries are quite exaggerated by the time they get into the office. We have to separate the injured from the malingerer.

We, as Applied Kinesiologists, have a little more knowledge of the muscular system and its proper motion. During the examination we palpate the musculature that we are testing to see if there is a proper contraction in an effort to determine if the patient is really trying to do as we instruct. We have found that we can easily be fooled because of the so-called "patient's pain" and the inability to move in a certain direction because it "hurts". During one particular exam we observed that the patient looked very mobile getting out of the car and walking up the walkway but when she got into the office she assumed the "basketcase antalgic position" and proceeded to check in with the facial grimaces and everything that goes along with pure pain even though the accident was three months prior to this examination. Minor things were observed in the reception room. When no one paid attention to her, she seemed perfectly comfortable

DEUTSCH

3

sitting with her legs crossed. When called in for the exam she easily bent down from a seated position to the floor, to pick up her handbag, and then walked into the examining room in much "distress". This same patient, when asked to lean over in the examining room, could not bend more than 15 degrees certainly exhibiting an inconsistency in the examination. Simple things, such as posture, gait and rising from a chair should all be carefully noted. Many patients that are in pain would normally place their hands on their quadriceps to aid rising out of the chair, not so in the case of the malingerer. But noticing the way they help they themselves or compensate without any neurological knowledge is a definite indication to the doctor that they may be exaggerating their injury. When they are pretending injury the grimaces that accompany the so called pain would certainly be an academy award act.

Burn's Bench Test and Hoover's Sign are two very excellent test for malingerers. Burns Bench test is performed in 1 of 2 ways. A very low bench is provided for the patient to squat down on. The other version of the bench test is to have the patient on their hands and knees on an exam table and have them lean forward over the edge of the table thus giving traction to the lumbar spine. If there is nerve root and/or disc injury this would give relief. When the patient cannot or will not perform this test it is a definite sign of malingering. Hoover's Sign, a simple test, which asks the patient to straight leg raise one leg while the examining physician places his

DEUTSCH

4

hand below the ankle of the patient's opposite leg. If the patient does not try to lift the leg then there is no downward pressure on the opposite side indicating malingering. These tests are good low back tests and will aid in determining any malingering as far as the lumbar spine goes.

Many doctors find it difficult to determine if there is any malingering with cervical injury. In a simple test, which I named the Deutsch Cervical Malingering Test, the patient is placed in a comfortable seated position with the head facing forward in a neutral position, head neither flexed or extended. We ask the patient to slightly flex the head upon the chest about 7 to 10 degrees. We then ask them to rotate either right or left. Normally, the sternocleidomastoideus (SCM) muscle is activated on the opposite side with rotation. SCM motion is more active if there is very slight flexion upon the chest. In those instances when the patient cannot rotate but is adequately trying to rotate the cervical spine in the direction specified, the opposite SCM can be felt to contract. It may be a clonic, tonic type of contraction because of the effort of trying to rotate the cervical spine. Those patients that will pretend to have much exaggerated pain will contract the SCM on the same side, thereby splinting the neck and indicating the inability to turn.

The SCM pulls obliquely across from the opposite side to aid the rotatory motion of the cervical spine. Of course, the key is that the

DEUTSCH 5
opposite SCM is the one that aids the rotation. Neurologically, the SCM is controlled by the 11th cranial nerve while the rest of the cervical musculature receives its nerve supply from the cervical nerve trunks. In an acute sprain, where the nerve roots are affected, the SCM will still be functional because of its unique nerve supply. The SCM will splint because of the injury. However, because of its individual nerve supply, the SCM will be activated if you, as the examiner, will request motion. I hope that those of you who do Independent Medical Exams will find this useful. It certainly would be interested in knowing the results that you achieve with this test.

The additional use of the cervical challenge with a muscle test using a non-involved part, along with therapy localizing an individual vertebra or damaged muscle, is also one of the most powerful tools we have. Every test available should be utilized so the patient can have a fair evaluation of their injuries.

TECHNIQUE VARIATIONS

By David P. Engel, D.C.,D.I.C.A.K.

ABSTRACT

Alternative application methods of techniques commonly used in applied kinesiology are offered to reduce the physical stress encountered in their use.

INTRODUCTION

With the majority of I.C.A.K. membership holding a D.C. degree, most of us are aware of a thought which prevails in the daily operation of the chiropractic practice. We frequently find ourselves suggesting to patients the importance of preventative/maintenance care, especially when response of their chief complaint(s) begins. However, few D.C.'s heed their own advice. My chiropractor, Dr. Lance West, has probably treated more chiropractors (numerous times, not just one treatment) than anyone else whom I know. His recommendations to each battered body invariably include follow-up treatment to his own efforts by some competent kinesiologist in the doctor's area. And almost invariably, when he sees the same doctor with the same complaint at the same seminar the next year, they confess, after some questioning, that they haven't been treated since last Lance worked on them. My own experience in treating other doctors is quite similar.

Therefore, I feel it is of great value to reduce the amount of physical stress encountered by the seldom-treated D.C. Even a properly treated body is favored by minimizing an excessive workload. The following illustrated technique variations are offered to provide better access to the area being treated while reducing the effort necessary to obtain and maintain the necessary positions for treatment.

MATERIALS AND METHODS

It is not the purpose of this paper to elaborate on the Lawrence Jones, D.O.'s "Strain and Counterstrain" technique. Consult Jones' text or the numerous research tapes from Dr. Goodheart, further detailing its application in AK. However, I have found that holding various extremities and other body parts for the required 30 to 90 seconds can be very tiring, producing low back strain and other complaints in the doctor. These alternate applications produced the most relief from this stress.

1. Strain and Counterstrain of Pterygoideus/Anterior Neck Flexors

In Figure 1, the doctor is applying a technique requiring the patient's head to be held in flexion. Propping the doctor's foot on the hand rest or other part of the treatment table or on an exam stool provides a nice base (the elevated knee) which can bear the weight of the patient's head cradled by the doctor's non-treating hand.

2. Strain and Counterstrain of Psoas

Figures 2A & 2B show an excellent method of achieving substantial psoas relaxation. After determining the need for psoas Strain and Counterstrain, stand on the side of table ipsilateral to involvement side. Find most tense/painful fibers with superior hand. Flex patient's knees and hips as in Figure 2A. (Patient usually acknowledges a reduction in palpatory psoas tenderness). With inferior hand behind patient's hips, lift the hips and slide doctor's inferior thigh beneath patient's hips (Figure 2B). Wrapping inferior arm around patient's opposite hip or waist stabilizes the flexed trunk and helps reassure that the patient won't roll off the table.

Deep penetration of abdominal fibers is accomplished in this position and it is relatively easy to hold.

3. Strain and Counterstrain of Iliolumbar Ligament

Figure 3 shows a fairly simple way to take a load off the doctor's back while freeing the second hand for more effective application of Strain and Counterstrain to the iliolumbar ligament. Since many patients' femoral extension may be limited, placing the doctor's inferior foot on the table frame just superior to the ankle rest (Zenith HiLo) elevates the doctor's knee (on which the femur rests) less than if the doctor's foot were placed on the cushion of the table. This, of course, is effective for Strain and Counter-strain of Gluteus Maximus also. With the patient's femur so nicely stabilized into extension, femoral rotation can easily be incorporated if necessary for optimum response.

4. Coccygeal Lift Technique

I have found Dr. Goodheart's coccygeal lift to be of great value, applicable frequently, and under many circumstances. The only problem is my index finger often tires sooner than the required lift has been applied. I have found that by standing ipsilateral to the side of the coccyx lift, contacting the coccyx with the thumb (palmar surface, superior hand) and contouring it to the coccyx allows the lift to be accomplished by pushing superiorly on the thumb with the doctor's inferior hand (Figure 3A). The inferior hand pisiform is placed just distal to the distal interphalangeal articulation of the superior hand's thumb (Figure 3B). I have found this method to be effective and easy, especially if a prolonged coccygeal lift is necessary.

RESULTS

The results of using these technique modifications have greatly relieved the physical stress and strain I had encountered prior to their development.

I suspect they will offer similar relief to any who also applies them.

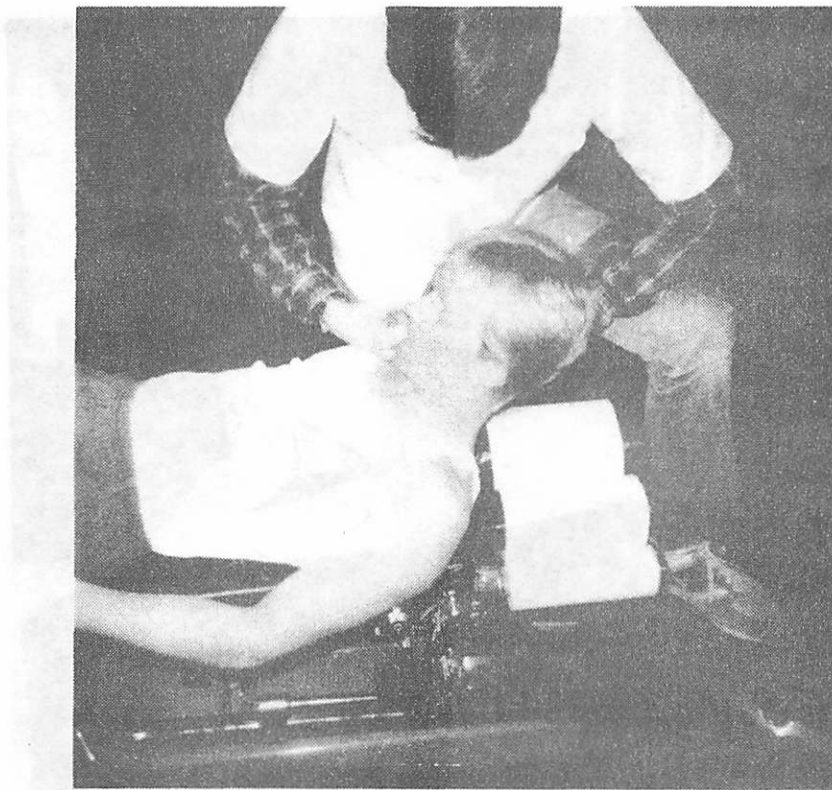


FIGURE 1

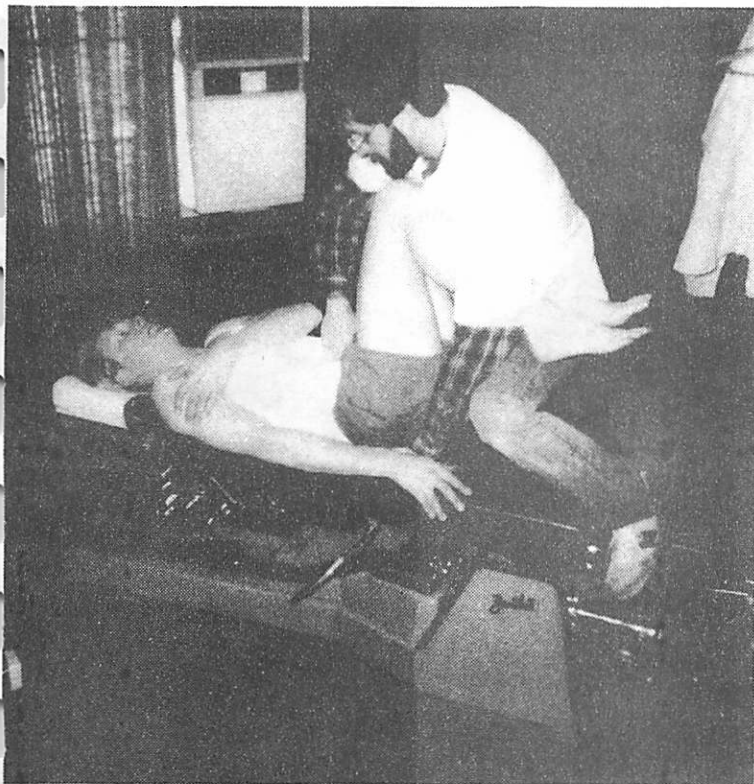


FIGURE 2 A

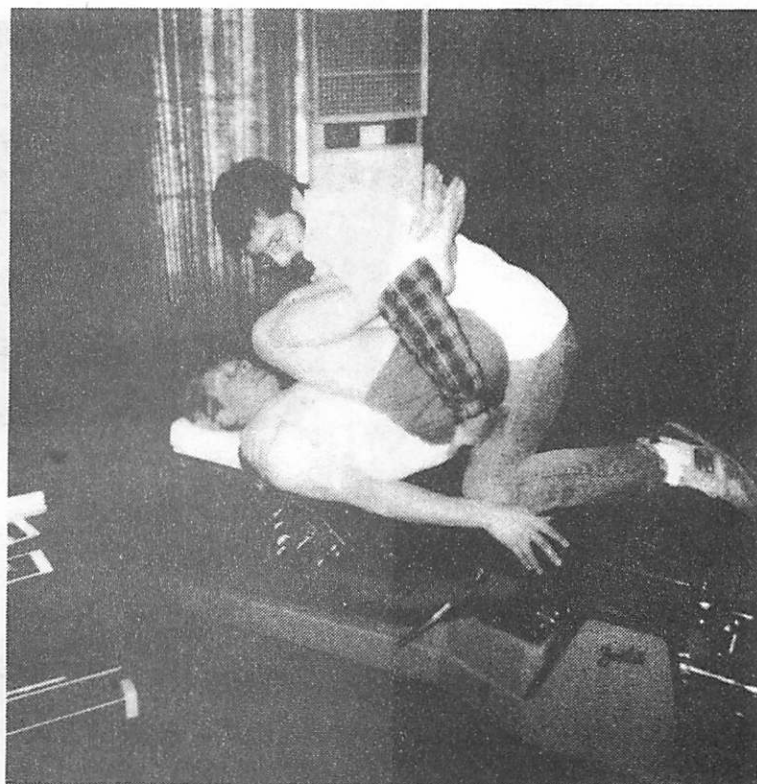


FIGURE 2 B

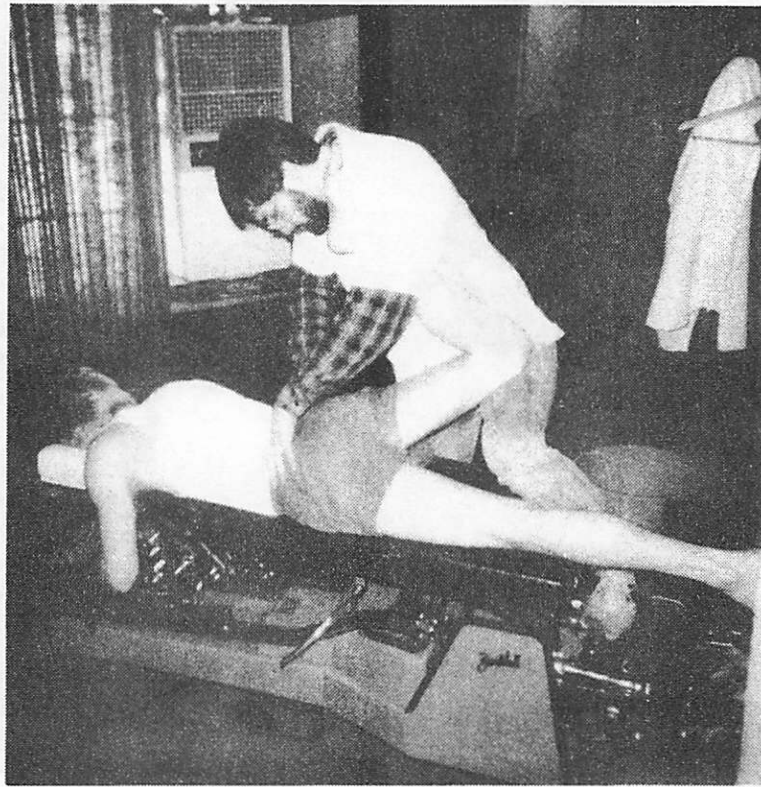


FIGURE 3

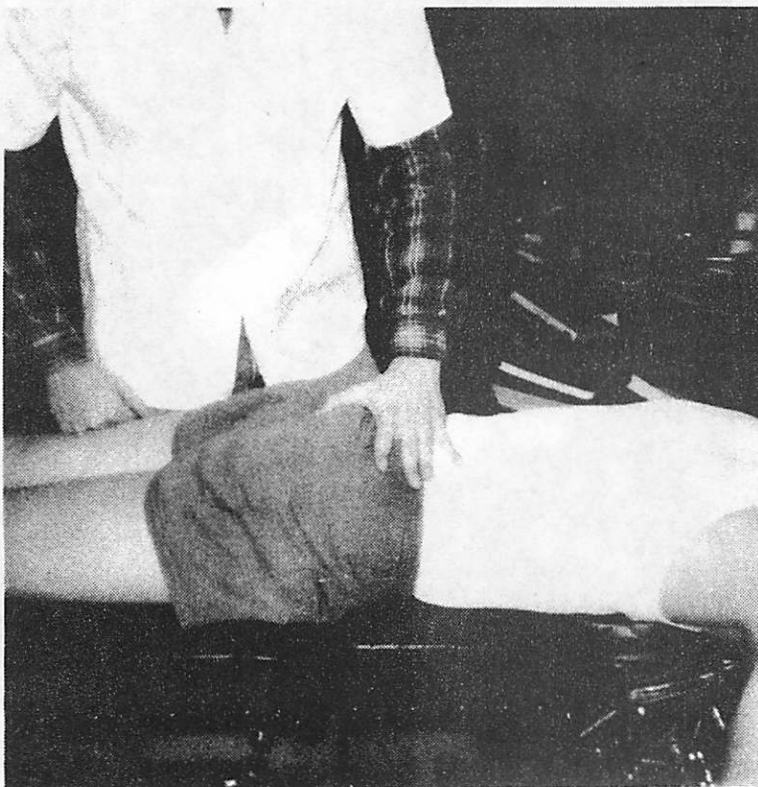


FIGURE 4 A

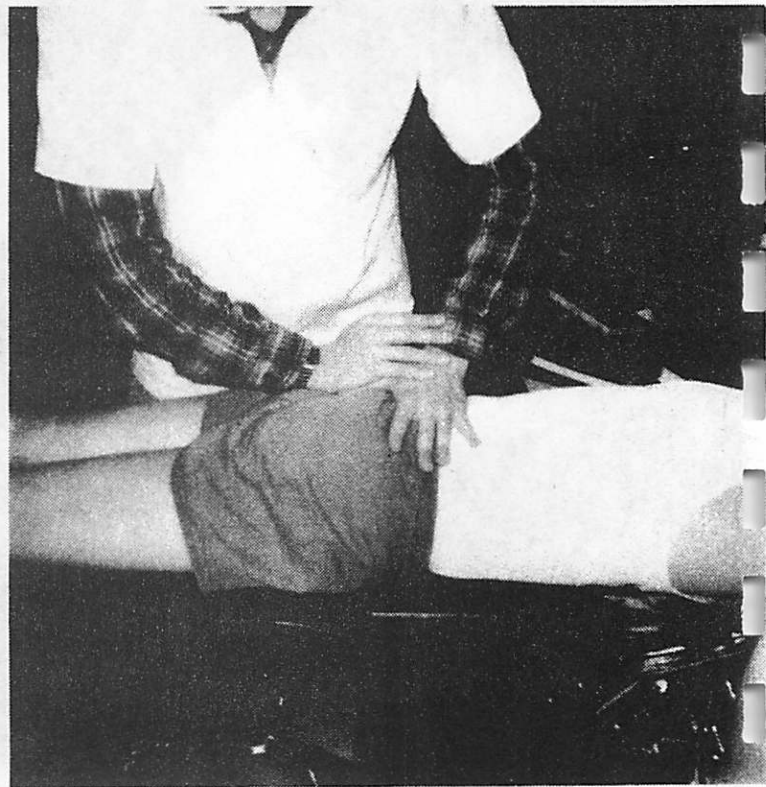


FIGURE 4 B

Stress and Disease

Burt Espy, B.S., M.S., D.C.

Abstract

The following concepts are discussed:

1. It is possible to predict illness based on the amount of stress in one's life.
2. Social stress is a very important factor in disease.
3. Poor diets are the final "stress that broke the camel's back."
4. Distress of the mind is the most powerful cancer-causing influence to anyone.
5. All disease is merely stress or bad energy.

The Adaptation Syndrome

Dr. Hans Selye's "Story of the Adaptation Syndrome" was first published in 1952.¹ It had gradually emerged out of his interest in the "non-specific" reactions to stress. He had noticed that while physicians were taught to concentrate on symptoms specific to one disease, that only a few signs were actually characteristic to any one disease. Most are common to many or even to all diseases. It was in this book that Selye first used the term "stress" for the "non-specific" reactions and it met with immediate disapproval by his colleagues and adverse public opinion. The connotation that Selye had intended was as a "state of non-specific tension in living matter", which manifests itself by tangible morphologic changes in various organs and particularly in the endocrine glands which are under the control of the anterior pituitary. Dr. Selye understood early that the "syndrome

of just being sick" was mediated through the pituitary-adrenocortical system, an integral part of the adaptation syndrome elicited by all stressors. Although the basic response is useful, too often excess production of such adaptive hormones can cause naturally occurring pathological organ changes. 2

Arthur C. Guyton agreed in his Medical Physiology Textbook,⁶ stating that "almost any type of physical or even mental stress can lead within minutes to greatly enhanced secretion of hormones, ACTH(anterior pituitary) and glucocorticoids(adrenal cortex), often increasing cortisol secretion(adrenal cortex) as much as 20 fold".

However during the last ten years, no aspect of health and disease has elicited more interest than stress.² A growing body of well-controlled studies are documenting how stressors affect the various body systems and overall health.

Dr. Carl and Stephanie Simington and James Creighton state clearly in their book. "Getting Well Again",³ that there is a clear link between stress and illness, a link so strong that it is possible to predict illness based on the amount of stress in peoples lives. They suggest that the effects of emotional stress can suppress the immune system, thus hampering the body's natural defenses against disease.

Most physicians have observed that usually illness occurs following especially stressful events in peoples lives. Although I had accepted that this was true, a personal experience verified

it for me.

I was preparing for a seminar. The afternoon before leaving, I came home from the office early and found my 13 year old step-daughter baking cookies. She didn't speak as usual, and when the cookies were done, she didn't offer one. I let that upset me and spent the next hour waiting for my wife to return home so that I could get the hurt out. Anyway, I left for the seminar the next morning with a sore throat that quickly turned into a full-blown cold by that evening. I was feeling so miserable that I asked a fellow doctor to work on me. His kinesiology diagnosis coming off a TL(therapy localization) to my inflamed nose ended in a positive chakra requiring a Bach remedy dealing with an emotion of disappointment and distress. Thus the misery and cold that I was feeling had surely been brought on by the anger and hurt I had felt from the rejection by my stepdaughter.

Dr. Thomas H. Holmes and his associates at the Washington School of Medicine developed a Social Readjustment Rating Scale to put a numerical value on the amount of stress in a persons life.⁴ Thus totaling the appropriate values in each case is an indicator of the amount of stress involved. Since then, others have modified the scale, but they all work on the same principle: that social stress is a very important factor in disease.

Stress is nothing new to modern man. It has always been a threat to all animals as they have shared the following three fundamental stresses as part of their primoidal heritage:⁵

1. Threat of mortal combat.
2. Threat of Survival(getting enough to eat).
3. Certainty that one day we will die.

The last threat above is one that is a problem with no solution. You can attack or flee an enemy and you can always search or beg for food, but how do we handle the certainty that one day we will die? Probably the best ideas would involve making your life worth living, to make each day count by approaching each with a positive attitude, and most importantly developing a firm religious philosophy by which to live. However a lot of modern men and women have not learned. They prey on their own physical health and that of those around them. Social stress manifests as frustration and unhappiness which grate together to make them sick in body and spirit.

In addition to the emotional stresses that the pressures of our busy lives place upon us, I find that in the majority of my patients, poor diets are the "stress that broke the camel's back"! Modern diets are culprits particularly due to their high contents of fat, sugar, cholesterol, and salt. Excessive amounts of these items cause stress or disease to the following systems:

fat & cholesterol	heart & circulatory system
sugar	pancreas
salt	kidney & fluid balance

To better illustrate how stress is always present in the initial stages of disease, the following section reviews some of the variety of symptoms that are associated with stress:

Stress Affects the Bodies Systems²

The Cardiovascular System:

Responds clearly at the slightest threat, even by such a minor sensation as stage fright. The entire tempo of your body will change to a fast pace, increased blood pressure, extremities turn cold, etc., repeated stressors such as the above, if not successfully adapted to, may develop into a number of conditions such as simple arrhythmias, eccentric heartbeat, hypertension, angina, migraine, atherosclerosis, and even the fatal coronary attack.

The Digestive System:

"Treats food as the mind treats life itself, accepting most of it, mulling on it, savoring it's flavors, extracting what it can use, and outright rejecting some of it". The fact that eating forms so much of our social structure, it so closely connects our nourishment with the total of our private lives. It is not surprising that when you are under pressure, this system is the first to experience real stress resulting in distress. Such conditions as ulcers, colitis, constipation, diarrhea, hiatal hernia, heartburn, upset stomach, diabetes, and gallstones represent this system.

The Immune System:

Has a complex and curious role in health and disease and most definitely is not well understood. However it is hard hit by stress. This system protects against infection, but when suppressed by stress, leaves the body open to anything. Particularly intriguing is recent evidence that immune system re-

sponses in animals can be conditioned, strongly suggesting the presence of mechanisms through which the brain can modulate immune activity.^{7,8}

Of the diseases attributed to the immune system, they would include the following: infections, allergies, auto-immune diseases, influenza, mononucleosis, rheumatoid arthritis, multiple sclerosis, and cancer. Some of these are also classified as metabolic diseases.

The Musculo-skeletal System:

People express themselves by the way they move. A smile is a muscular act, so is a frown. Bones don't just float out of place, muscles pull them out, generally due to a stress on an associated organ. Considering all people who suffer from ailments of the musculo-skeletal system, only some are the strong physical-action types. You see, muscles and bones are not only used to express feelings, but also to repress them. Diseases of this system would include backache, tension headache, neck pain, arthritis, and the accident prone.

The above sections discuss correlation between numerous diseases and stress. Now as an example, lets take the most serious and feared disease of our time, cancer. Men have known of the connection between cancer and emotional states for nearly 2000 years. From the early writings of the physician Galen, who observed that "cheerful women were less prone to cancer than were women of a depressed nature". Many other writings of that time also concluded

the same thing. In 1865, Dr. Claude Bernard in his text, "Experimental Medicine", cautioned that "living must be considered as a Harmonious whole". In 1970, Sir James Paget expressed his conviction that "depression plays a vital role in the occurrence of cancer". In 1893, Snow in his book, "Cancers and the cancer process", concluded that neurotic agencies are the most powerful cancer-causing influences, singling-out distress of the mind as the most common. And finally to reinforce this idea, Snow brought out that "idiots and lunatics, where thought and worry are minimal or non-existent, are remarkably exempt from cancer in every shape".³ Historically, It is clear that there is a definitive link between cancer and stress!

Summary and Conclusions

I submit that all disease is merely stress or bad energy manifesting differently in each person due to their individual strengths, weaknesses, genetic and emotional makeups. It usually manifests as a combination of chemical(nutrition), structural (mechanical), or electro-magnetic(physic or emotional) factors although it can involve only one.⁹

A number of studies have well documented that a precipitating event 6-18 months prior to the beginning of a major health problem. I have explored this and most of my patients have been able to pinpoint a major stress preceding sickness. They were also very much aware that the event was involved. I even have one patient that remembers a divorce between his patients at age 4. That event

was powerful enough for him to precipitate a significant health problem.

Going back to the cold discussed earlier that I had experienced due to stress, I believe that it is vital to be able to individually deal with the stress or to get professional help (remember the stress can be chemical, structural, or emotional). Otherwise we become a liability to our employer, anyone else depending on us, and to ourselves.

One last example shows how nutritional stress can affect our health. A young lady came into our office limping from a skiing accident. I started off my diagnosis with a therapy localization to the left knee which was definitely sprained and the body showed stress on the liver/gallbladder. I then asked the patient what she had eaten the day of the accident and she replied, "peanut butter sandwiches". That explained it, because peanut butter is high fat which stressed the gallbladder. The gallbladder in turn, turned off the popliteus muscle (back of the knee). When she went to turn right and put heavy stress on the left knee, it was weakened from the gallbladder stress and gave way, injuring the knee. She had skied many times before without such an injury. Everything was just right: the time since eating, what she ate, her digestion, and the physical stress to allow the accident to happen. But basically the stress from the peanut butter at lunch predisposed her for the accident. How often do we set ourselves up for accidents or sickness to happen?

As I hope each of you know, we heal nothing! We can only remove obstacles or adaptations that are blocking the bodies natural abilities for healing. The adaptations are communication links, hormone, fluid, or actual tissue changes that have been modified by the body for survival of a past stress, but are no longer functional for the good of the individual. Then finally when we have removed or corrected enough adaptations, the bodies own innate intelligence takes over and heals itself.¹⁰

Burt Espy, B.S.,M.S.,D.C.

REFERENCES

1. Selye, Hans, M.D., Ph.D., D.Sc., F.R.S., "The Story of the Adaptation Syndrome", ACTA, Inc., Montreal, 1952.
2. Elliot, Glen R., Ph.D., M.D., & Eisdorfer, Carl, Ph.D., M.D., editors, "Stress and Human Health", Springer Publishing Company, New York, 1982.
3. Simonton, Carl O., M.D. & Stephanie Matthews, & Creighton, James, "Getting Well Again", J.P. Tarcher, Inc., Los Angeles, 1978.
4. Holms, T.H., & Rahe, R.H., "The Social Readjustment Rating Scale", Journal of Psychosomatic Research, 1967.
5. McQuade, Walter & Aikman, Ann, "Stress", Bantum Books, New York, 1974.
6. Guyton, Arthur C., M.D., "Medical Physiology", W.B. Saunders Co., Philadelphia, 1976.
7. Ader, R. & Coen, N., "Behaviorally Conditioned Immunosuppression", Psychom. Med., 37:333-340, 1975.
8. Cohen, N., "Conditioned Suppression of a Thymus-independent Antibody Response", Psychom. Med., 41:487-491, 1979.
9. Harper, William D., B.S., M.S., D.C., Ph.C., "Anything Can Cause Anything", Privately published, Pasadena, Texas, 1974.
10. Beardall, Alan G., Lectures and personal consultations, 1980-1985.

UNIVERSAL SACRAL FAULT

by Edward E. Evans, D.C.

Abstract.

There has been much written and demonstrated by I.C.A.K. members about Category I, II, and III. Dr. John Brimhall's paper¹ for the winter meeting 1985 was excellent, and I follow these procedures. Dr. Carl Ferreri's paper on the T.M.J.² should be investigated because of the influence on the different categories. This paper is written to demonstrate that after these procedures are investigated and corrected there will be, 90% of the time, a sacral-occipit fault still remaining.

Procedure.

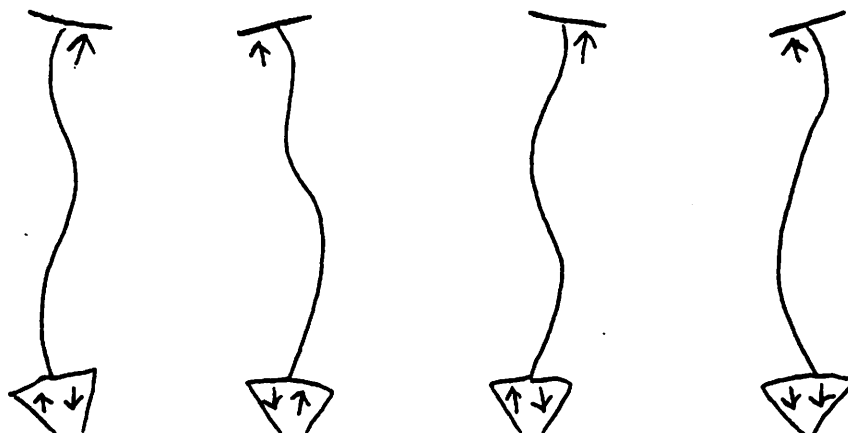
Patient supine check for Category II; Internal or External Fixation, and possible Adrenal ligament weakness. Check for hidden Category II by Dr. Carl Ferreri's T.M.J.² procedure. Patient prone check for Categories I and III and correct. Now challenge the left sacral base superior with one hand while you challenge the right sacral base inferior with the other hand, and test a previously strong muscle for weakness. Then challenge the right sacral base superior and the left sacral base inferior. Note the result. Next challenge the occipital base on the right superior and test a previously strong muscle. Then challenge the opposite occipit and note your results. Many times you will find the sacral challenge negative until after you have found and corrected the occipit. If the sacral challenge is negative and the occipit positive, correct the occipit first. After you have corrected the occipit jam, then most of the time you will find a universal cranial fault that will almost always be corrected by torquing the mastoid superior on the side of the jammed inferior occipit.

Correction.

You can correct the sacrum by adjusting in the prone position in the direction that created the weakness on challenge, but it will not hold after the patient is in weight-bearing again. I did this for five months until I found the sacrotuberous and/or the sacrospinous ligament must be corrected to let the sacrum normalize. To find which side the ligaments are weak on, have the patient lay three fingers beside the sacral Apex and Coccyx area and the Ischium. While their fingers are there, you challenge the sacrum as before and the side that neutralizes the challenge is the side the ligaments are treated on. To treat the ligaments, stand on the side of the table that the ligaments are involved and slide three fingers into the pocket between Coccyx and the Ischium until you contact insertion of sacrotuberous ligament. If sacrum is inferior on that side, rub superior until tension is released. If sacrum is superior on the side of Therapy Localization, contact farther superior to sacrospinous ligament insertion and rub in a inferior lateral direction. This will clear the sacral challenge and let the sacral base normalize. To correct the occipit first, rub the tension out of the Posterior Atlanto-occipital ligament and then adjust the occipit superior to unjam on atlas. Next, challenge and correct the Universal Cranial Fault.

Notes.

After sacral correction, the Iliolumbar ligament, if involved, will more readily challenge and maintain correction. Sometimes the short sacral ligaments need to be treated also, and you can do this while you are treating the sacral ligaments.



References.

- 1 Brimhall, John W., Collected paper; Winter, 1985.
- 2 Ferreri, Carl A., The Marvelous T.M.J. Collected paper; Winter 1985.

The Utilization of Lips Apart and Lips Together
in Food Allergy Muscle Testing

by Kenneth S. Feder, D.C.

Abstract: The procedure of separating the lips and keeping the lips together during manual muscle testing for allergies is presented as an adjunct to standard A.K. allergy testing procedures.

INTRODUCTION

The concept of lips together and lips apart as presented on Dr. Goodheart's tape provided the idea of utilizing the procedure for food allergy testing. Reference was made on the research tape that when the lips were together, there was an increase of the energy level in the body as contrasted to separating the lips. This related to the fact that the conception vessel and governing vessel terminate on the lower and upper lips, and when the lips are brought together, there is an increase of body energy and the energy strength pattern. As theorized by John Diamond, M.D., the thymus gland has something to do with regulating the energy flow throughout the body. He also theorizes that the thymus is the first organ to be affected by mental attitudes and stress. It is the overloading of the thymus by various stressors that influence its role in immunology and, therefore, lowers the body's energy level. The correlation of the role the thymus plays in energy level control and the testing procedure of lips together and lips apart and its energy level relationship lead to the new allergy testing procedure.

BACKGROUND

Previous A.K. allergy testing procedure is performed in the following manner:

- (1) The patient is tested for normal muscle strength utilizing the appropriate muscle correlated to the substance tested.

Lips Apart-Allergy Testing

Kenneth S. Feder, D.C.

- (2) Once the indicator muscle has tested strong, the substance to be tested is placed under the tongue and previously strong indicator muscle is retested.
- (3) If the patient is sensitive to the food or substance, the indicator muscle will now weaken.

NEW PROCEDURE

The previous muscle testing procedure is followed as indicated above. The substance to be tested is placed under the tongue, and the indicator muscle is tested. If the indicator muscle remains strong upon the challenge with the substance, the patient is then instructed to separate the lips and the indicator muscle is retested. If there is an altered energy level threshold indicating thymus weakness, the previously negative allergy test response may now reveal a positive allergy response by weakening of the indicator muscle. It may be necessary to test the infraspinatus muscle which is related to the thymus in order to determine the hidden response.

CORRECTION

Once the offender foods or substances have been determined, elimination of these substances from the diet should be implemented with rotation of the substances back into the diet only after retesting for sensitivity. The supplementation of raw thymus with each meal may allow for immediate reinstatement of the offender foods into the diet. The procedure to determine if raw thymus tissue is required is to place a thymus tablet into the mouth along with the offender substance which caused previous indicator muscle weakness. If the thymus supplementation is indicated, the muscle weakness will be neutralized.

Kenneth S. Feder, D.C.

DISCUSSION

Since the thymus and its specialized lymphocytes, called T cells, are responsible for maintaining the immune system of the body and influence the normal energy threshold, any procedure to evaluate stressors affecting the thymus is necessary for allowing normal body healing to occur. The separation of the lips with standard A.K. allergy testing procedures has added a new dimension in revealing those stressors which affect thymus activity and the body energy level.

Reference

1. Goodheart, George J., Research Tape #93, privately produced and distributed, Detroit, Michigan, 1985.

The Cure For Dyslexia and Learning Disabilities

UPDATE

Dr. Carl A. Ferreri

Abstract

Dyslexia, the most recognized of the Learning Disabilities, has been identified as a multi-faceted syndrome which manifests itself in numerous ways, all based in the patient's inability to properly process language, be it spoken, written or symbolic. The ensuing problems pervade all areas of the patient's life: academics, concentration span, coordination, memory, emotional stability, coping mechanisms, etc.. To try to define or name the varieties of this condition in relation to how it affects the individual is essentially an exercise in academic futility, as one gets no closer to the solution by doing so.

The medical and educational communities have been grappling with the symptoms of this and other learning disabilities for years. No treatment or remedial protocols have had any real success. Many learn to cope with this frustrating condition and some have attained great success in their life. Most do not.

Applied Kinesiology, a chiropractic specialty which deals specifically with the integration of the central nervous system, is ideally suited to deal with the manifestations inherent in all learning disabilities. Utilizing Neural Organization Technique to combine the organizational effects of the Cloacal, Labyrinthine and Ocular Centering/Righting Reflex Mechanisms, with correction of the specific cranial faults and a unique correction of the fascia of the eye muscles found in all learning disabled treated by the author, has led to a predictable cure for Dyslexia and all Learning Disabilities. The procedures are performed by hand, with no introduction of drugs or any other foreign substances or modalities.

INTRODUCTION

One of the most frustrating, and, in many cases, debilitating conditions [both emotionally and socially] that has plagued mankind is a condition known as Dyslexia. Dyslexia is the best known terminology for a group of conditions dealing with the inability to properly process language, be it written, spoken or symbolic [numbers, for example]. It does not manifest itself solely in the academic world of school, as some think, but involves every part of our existence. Just consider the following possibilities:

- *Difficulty with reading, writing and mathematics.
- *Difficulty in understanding words in normal conversation.
- *Inability to relate to people in groups or to understand the conversation.
- *Poor or non-existent sense of direction.
- *Little or no concept of time.
- *Inability to concentrate, even when involved in a particular activity, such as a game.
- *Dysequilibrium [balance dysfunction].
- *Constant bumping into things or dropping things.
- *Stuttering, hesitant speech, poor word recall.
- *Inability to remember names.
- *Sharp emotional or mood swings.
- *Need to reread the same word or phrase to get any meaning out of it.
- *Difficulty in following sequential instructions or events.
- *Difficulty in following motion or moving things [balls, people, traffic].
- *Phobias of all sorts including height, motion related [escalators, elevators, bridges, etc.].

- *Getting lost easily or all the time.
- *Unable to or unsure in making descisions.
- *Feeling of inferiority, stupidity, clumsiness.
- *Inobility to organize daily activities, particularly in allotting proper time.
- *Doing opposite of what was told.
- *Getting drowsy or tending to fall asleep while reading or driving on a highway or open road.
- *And many, many more.

This is a multi-faceted condition, which escapes detection many times because of its diverse symptomatology.

Unfortunately, until recently, Dyslexia and/or Learning Disabilities was not recognized as a specific problem, but was labeled Minimal Brain Damage, Psychosis of one sort or another, Inferior Mentality, Dumb, Lazy, Inattentive, etc.. Some ideas die slowly. The concept that the various problems found in our school systems and society in general, are indeed dyslexic in origin has been ignored in many educational, law enforcement and other circles. Parents were told by pediatriitions and educators alike that nothing was wrong: "He'll grow out of it", "He's just immature", "He's not trying hard enough", "He's not paying attention", etc.. Parents were confused, teachers were frustrated and the child was tormented by failure, isolation and the knowledge of being different. Nowhere was any help available.

Eye-tracking problems were recognized, eye exercises, and/or special lenses were tried. Equilibrium faults were recognized, and various drugs were used to suppress these symptoms and hyperactivity and attention deficits. Coordination faults were noticed and special exercises were

devised. Allergies were finally recognized as contributing factors, and modified diets have been prescribed. Special educational protocols have been instituted with very limited success, in most cases. Any gain was considered a major breakthrough and was hailed as a "cure". For some it seemed to be, but nothing to date has been of any meaningful or lasting benefit. As soon as the special activity or drug was stopped, the symptoms returned with a vengeance. The child or adult always had to modify or overcompensate his or her life style, to accommodate the limits imposed by this disability.

The frustration of this bewildering and complex condition is responsible for most, if not all, of the teenage suicides, the promiscuous fires in school and empty buildings, brush fires etc. [the teenage dyslectic is fascinated with fire and wheels], most of the automobile accidents in the under 25 population [monocular vision, no depth-of-field and inability to see or follow motion], most crime [92 percent of all inmates cannot read or write], and most divorce [the stress of dealing with the dyslectic child or adult is too much to cope with].

There are a minimum of 25 million dyslectic people in the United States alone.

The Cure For Dyslexia And Learning Disabilities

The most recent investigation into the Learning Disabilities maze has brought most investigators to the conclusion that these conditions, no matter what the specific designation; i.e. Dyslexia, Dysphonia, Dysgraphia, etc., are essentially a peculiar disorganization of the central nervous system which interferes with its ability to process or interpret the information coming in through the senses. The disorganization must obviously be complex in nature as it manifests itself both in the neuro-

muscular and cognitive functions of the central nervous system. If we look at the total picture of a dyslexic or learning disabled, we find gait discoordination, hand-eye discoordination, dysequilibrium, confusion as to right and left-handedness, directional confusion, inability to understand some spoken or written language, mirror-image sight or reversal of letters and/or numbers and symbols, short term memory problems, no time comprehension, etc.. Dyslexia and Learning Disabilities are therefore essentially switching problems, and as we will see, with predictable and very specific patterns.

The general disorganization presented by the typical dyslectic or learning disabled person indicates specifically the basic organizational reflex mechanisms which are involved in the various disorganizations noted. The ultimate switching for this condition will be found in the cranium, but if there are body switching and disorganization of gaits, for example, then, unless they are corrected, the cranial corrections will not hold. We need to begin the organizational corrections, which will ultimately eliminate this condition on what appears to be a relatively permanent basis, with the basic or innate switching and coordination reflex mechanisms. These reflexes have been found through the application of Applied Kinesiology Techniques in a system of organization called Neural Organization Technique (1).

Because this condition is one of almost total disorganization, there are certain first steps necessary to render the patient response accurate and predictable.

With the patient prone to start, the heel length is noted and then the heel height with the knees bent to 90 degrees. If one leg is short and stays short or gets shorter at 90 degrees, this indicates a lateral atlas on the

side of shortness, which must be adjusted [modified Derifield Test]. The next step is to test both hamstring muscles. These muscles give vital information. If one hamstring is found weak, this indicates a fixation of the sacrum and a 3rd cervical laterality on the side of weakness. If both hamstrings are found weak, this indicates a fixation of the occiput, which must be adjusted. This now renders the indicator muscles accurate as both are strong and major neural interference has been eliminated. The next logical step would be to test for the major posterior switching faults. Coccyx - Umbilicus [a must have in L.D.] and Coccyx - K27. Correct as found with heavy rubbing on the areas indicated.

Because many Learning Disabled are allergic, the Limbic System indicators should be tested. They are found by simultaneous cross therapy localization on the transverses at the transitional vertebral levels of 7C - 1D and 12D - 1L in fixation [one with the other] with 2, 8, 10D in respiratory fixation [no respiratory motion to that segment]. If found 7C on the right and 1D on the left in a / direction, the indication is for sugar [refined carbohydrate] intolerance. If 7C on the left and 1D on the right is found in a \ direction, the indication is for digestive problems and a sensitivity to protein substances. If found in combination in an X pattern, the indications are for multiple allergies or hydrocarbon sensitivity. These should be programmed to reduce or eliminate the reactivity to help maintain stability of the corrections, particularly the cranial corrections. (2).

The Posterior Cloacal Centering and the Labyrinthine Righting Reflex Systems are next examined [a must have fault in L.D.] This is important because the combination of these two reflex systems plus their anterior equivalents [Anterior Cloacal Centering and Ocular Righting Reflex

Systems] are the basis for all our gait mechanisms (3). We further know that the gait mechanisms, particularly the cross gait or crawl patterns are essential for neural integration and organization.

These systems are tested by therapy localization individually because they have specific individual function, the cloacal to center the pelvis and the labyrinthine to right the head to gravity, and in combination because they must function together to combine these centering/righting functions in the gait mechanism (4). The points for testing these reflexes are found, for the posterior cloacal centering system, on the medial aspect of the apex of the sacrum in the sacro-tuberous ligament (5) and/or on the ischial tuberosity (6). Either is equally effective as an indicator. The labyrinthine righting reflex points are found to be in a V groove on the suture between the posterior portion of the mastoid process of the temporal bone and the occiput (7). Any faults in these systems found by a weakening of the strong indicator muscle (8) are corrected either individually or in combination, as found, with either a respiratory assist movement, that is, moving the part into its normal respiratory motion [the ischium moves in an arc, medial and upward toward the opposite shoulder on inspiration and the mastoid moves anterior and medial on inspiration.] or with a heavy rubbing (9) or with a wet hand contact until a pulse is felt (10). It is essential to remember that the above testing procedures and corrections are made with the eyes open and with the eyes closed.(11) This is a must have fault in the L.D. patient. This completes the posterior organization.

With the patient now supine the first neural indicator to be tested is the Universal Cranial Fault or Lateral Occiput [or Anterior Atlas]. This is a must have fault in a L.D. patient. If either a lateral occiput or an anterior

atlas exists any further testing or correction will prove inconclusive as no neural organization is possible under this circumstance (12). Have the patient protrude his tongue right and left, or double hand contact on one side of the occiput and then the other, using a strong muscle indicator. Correction is made by adjusting the occiput on the atlas on the side of tongue protrusion or on side opposite the double hand therapy localization. In the event of an anterior atlas, the correction is made either intra-orally [on the anterior ring of atlas] or with a sharp bilateral thrust on the anterior aspect of the transverse processes of the atlas, on inspiration [have patient protrude jaw].

The anterior or master switch K27 is the next neural mechanism to be addressed. All L.D. patients must have this fault. It can be tested with or without the umbilicus. Both K27s must be stimulated. If one is found with the umbilicus and corrected, the other will then be found on retest [major and minor]. It is always bilateral. Ideally, the rubbing stimulation should be continued until tenderness subsides, but because this is a very painful procedure, it is frequently not possible and may need to be followed up on subsequent visits. The tenderness may last for 2 or 3 days. K27 must be non-sensitive on completion of the treatment protocol.

All L.D. patients will have a T.M.J. involvement. The T.M.J. must be tested with a bilateral hand contact with the exception of the specific single side T.M.J. involvements. 1/Bilateral, in the clear [no movement], [spread the jaw]; 2/Test for imbrication [L hand on L jaw, R hand on L hand and visa versa] 3/Bilateral, mouth wide open, [lateral pterygoid both sides]; 4/Bilateral, bite down, [buccinator, both sides]; 5/Bilateral, chew, [masseter and temporalis, both sides]; 6/Bilateral, lateralize, [both pterygoids, medial and lateral, both sides]; 7/Bilateral, protrude, [medial

pterygoids]; 8/Bilateral, retrude, [posterior 1/3 of temporalis, both sides]; 9/ Bilateral , swallow, [stylo-hyoid away from weakness; push hyoid into weakness, T.L. for 1,2,3C involvement]; 10/Bilateral, phonate, [as above, no C involvement]; 11/Right Jaw in clear, [R masseter and temporalis, then reactive L pterygoid, then reactive L masseter and temporalis]; 12/Left Jaw in the clear, [L masseter and temporalis, then temporal bone correction, C.S.M. pivot, rub, neck flexor, extensor N.L.,N.V. - This is a Cat. II of the pelvis of the skull]. (13)

The Anterior Cloacal Centering and Ocular Righting Reflex Systems must now be addressed as they are part of basic neural organization and with the posterior reflex systems noted above are responsible for the gait integration and coordination. They, like the posterior reflex systems, must be examined individually and in combination. The anterior cloacal reflex points are therapy localized on the superior border of the pubic bones at the medial aspect of the obturator foramen. The ocular righting reflex points are located in the supraorbital notch of the frontal bone.(14) The correction for the anterior cloacal reflex is made with a respiratory assist movement to the ilium by contacting the anterior superior spine of the ilium and on inspiration rolling the ilium lateral and inferior in its normal respiratory motion while the ocular reflex correction is made by contacting the frontal bone on the metopic suture with the heel of the hand and with the finger tips on the lateral aspect of the bone lift the lateral edge of the frontal. The frontal bone flexes from the center like the wings of a gull, on respiration A heavy rubbing on the points or a wet hand contact, as mentioned above, can be used. The respiratory assist is preferred by the author as we are dealing with many children and it is preferable to stay away from the genital area as would be required with

the rub or wet hand contact. These examinations and corrections must be made with the eyes open and with the eyes closed.

If two labyrinthine or ocular righting reflexes are found at fault in the same eye option, open or closed, a cranial injury is indicated (15). The cranial injury could have happened at any stage of the patient's life and may have been multiple. The skull has lost its physiological centering. It must be corrected. The complex is found by therapy localization of the ocular and labyrinthine righting reflexes together with the eyes open and the eyes closed. Correction is made as described above for the labyrinthine and ocular righting reflexes but must be done in the combinations as found. Respiratory assist correction is best as sutural synchronization is the need. This restores physiological centering of the skull.

If a cranial injury complex is found then the Neck Righting Reflex will be at fault. The neck righting reflex points are found in the laminal groove of the 1,2,3 cervical vertebra. This area must be therapy localized bilaterally to show the fault, with the eyes open and with the eyes closed. It will not show with unilateral therapy localization. It is corrected by heavy rubbing in the laminal groove with the eye options.

This then completes the neural organization of the body. The complex of disorganization found in the body presents a series of specific faults which form a pattern, each of which is correctible. The cranial aspects of the learning disabled condition must now be addressed.

Upon investigation of the skull of a learning disabled person a pattern of disorganization can be found which represents both anatomical position and motion and physiological function of the cranial bones. The cranium houses, protects and supports the brain. Its shape somewhat determines the shape of the brain and determines the electromagnetic lines of force

and the force field itself. Studies have been done on other parts of the body to determine that the electromagnetic lines of force are laid down in the connective tissues of the body, particularly in the bones. This then could easily be extrapolated to the bones of the skull. We will consider the sphenoid, the occiput, the temporal, and the frontal bones which make up the floor and sides of the skull on which or between which the brain sits.

The sphenoid, the center bone of the skull, articulates with fourteen bones of the skull. Its function therefore must affect most of the other skull functions. It has been determined that the sphenoid with all its parts maintains five separate motions at the same time. There is flexion of the greater and lesser wings, flexion of the body itself, a rocking and torquing motion as it articulates with the occiput, all similar to the flying motion of a bat. The lesser wings are therapy localized by placing the thumbs on the junction of the hard and soft palate on the roof of the mouth. The body flexion is therapy localized by spreading the maxilla and palate. The rocking motion which is the sphenoid part of the sphenobasilar primary respiratory motion as it articulates with the occiput is therapy localized either by contacting the lateral masses of the greater wings, by therapy localizing the palatine suture or by inspiration, expiration fault. The author prefers the lateral contact. The torquing motion fault is therapy localized by contacting the lateral masses of the greater wings in a diagonal manner, on the upper part on one side and the lower part on the other. The flexion of the greater wings is therapy localized like the torque but in an X pattern. The basic pattern of all learning disabled examined by this author (approximately two thousand at this writing) indicates the lesser wings in flexion, the sphenobasilar motion in flexion, the sphenoid

in lateral torque, high on the right and low on the left. In addition to these must have faults the patient may have the body in flexion [found in all speech impediments], which necessitates a cross K27 and a homolateral gait pattern, in relation to the sphenoid, and the patient may have the greater wings in flexion [found with all emotional problems]. It should be noted that the greater wing flexion of the sphenoid, just as any of the sphenoid faults, can be found individually or in combinations of two [never more] in other conditions, and is always found if the patient is under emotional stress. The particular sphenoid tilt position can be specifically palpated as a definite ridge on the lateral aspect of the skull on the high side on the right and as a definite depression on the low side on the left. The left hamate process of the sphenoid is palpably lower than the right and feels much longer.

Corrections are made as found with a respiratory assist. The lesser wing flexion correction is made by contacting the junction of the hard and soft palate in the mouth with the index finger and lifting toward the back of the eye on that side while rotating the mastoid portion of the temporal bone anterior to accommodate the lift. The flexion of the body of the sphenoid correction is made by first finding and correcting the homolateral gait fault and then rubbing K27 to eliminate the cross energy and then spread the maxilla with both index fingers contacting the maxilla at the level of the first molar teeth. The spheno-basilar [rocking] motion correction is made by contacting the base of the occiput with fingertips of one hand and the superior ridge of the orbits [or contact the hard palate in the mouth] and gently but firmly lifting the whole structure headward. The tilt of the sphenoid correction is made by contacting the lateral masses of the greater wings on the side of the skull, the fingertips of the right

hand on the superior ridge on the right, pushing footward while the finger tips of the left hand contact the inferior border on the left, lifting headward. Hold this position until a motion is felt under your fingertips. This contact made with one hand while the other hand is lifting the low hamate process on the left side is an additional or alternative method of correction in some cases. When the greater wing of the sphenoid is down on one side, the frontal bone on the low side will be in descent and must be lifted. Contact the frontal bone, in this case on the low left side with the heel of the hand and lift with inspiration. If the X therapy localization indicates the greater wings are in flexion or descent, the lateral masses are contacted on the inferior portion on both sides and must be lifted until a motion is felt under the fingertips. This should be done first before the tilt correction. Both frontal bones must then be lifted and then the low side again as the bilateral lift only corrects the frontal in relation to the wing flexion and not to the tilt, which is a separate fault.

The temporal bone is now therapy localized with a finger in each ear canal. This therapy localizes the vestibular function of the temporal as apposed to the labyrinthine function in the righting reflex mechanism. The correction is made by pulling the lobes of the ear out and down at a 45 degree angle until an opening is sensed or felt.

The above faults and corrections represent the anatomical position and motion of those cranial bone faults found in the learning disabled person. These faults interfere with the normal physiological function of the brain in its perceptual and cognitive abilities. The cranial vault has physiological motion which manifests itself in reciprocal activity of flexion and extension of the bone itself and its relation to the same activity of an adjacent bone. The author has found this activity to be

involved in the ability of the perceptual and cognitive functions of the brain to concentrate, be less distractible and be able to focus thought patterns and enhance short term memory patterns.

The physiological fault patterns are found in three reflex mechanisms. 1/ The Vestibulo-Ocular Reflex, important in equilibrium and the ability to concentrate, has been found at fault in all learning disabled persons treated by the author. A fault in this reflex system has been recognized by other investigators (16) to be present in learning disabled and scoliotics. This fact led the author to reexamine all the scoliotics treated previously and it was found that all the scoliotics were also learning disabled to some degree. The vestibulo-ocular reflex is therapy localized by inserting a finger of one hand in the ear canal and contacting the supraorbital notch with the other with eye options to the right, center and left. Both sides are tested. Correction is made as found with respiratory assist and with appropriate eye options by pulling the ear lobe down and lateral at a 45 degree angle while lifting the frontal bone on the side of fault, with respiration assist. 2/ The Spheno-Vestibular Reflex System, discovered by the author, relates to equilibrium, concentration, and distractibility and possibly memory. A fault in this reflex mechanism has always been found in the learning disabled treated by the author. The spheno-vestibular reflex is therapy localized by inserting a finger of one hand in the ear canal and the thumb of the other on one side of the roof of the mouth on the junction of the hard and soft palate with eye options right, center and left. Corrections are made in combinations found by pulling the ear lobe down and lateral at 45 degrees on the side of fault while lifting the palate toward the back of the eye on the side of fault with the appropriate eye option. 3/ The Spheno-Ocular Reflex System,

discovered by the author, relates to focus of mind and eyes, distractability and a sense of stability. The speno-ocular reflex is therapy localized by contacting one side of the roof of the mouth at the junction of the hard and soft palate with the thumb of one hand while contacting the supraorbital notch with the other, with eye options right, center and left. Corrections are made as found with respiration assist, by lifting the palate toward the back of the eye on the side of fault and lifting the frontal wing on the side of fault with the appropriate eye option.

Once the cranial corrections are made the final corrections must be made to the fascia of the eye muscles. Because the eye muscles are attached to the cranial bones, which were not in proper anatomical position and therefore could not function or move properly, the connective tissue (fascia) shortened or elongated as the case may be for the specific eye muscle and we find a 1 inch muscle in a 7/8 inch cover or the reverse. The proprioceptor feedback must of necessity be confused and not only can't the eyes function in fine coordination but the sensory input is stressed, the message "distorted", and not only do the eye muscles quickly tire but the whole nervous system is turned down and the visual stress induces sleep when reading or traveling in a car or moving vehicle. The brain attempts to close off this discoordination of the eyes and blocks the visual input of one eye and therefore most learning disabled people have monocular vision as opposed to binocular vision. Therefore, depth-of-field or third dimension is lacking. Often refinement of color is lacking. Only the extremes are seen and not the variations in between. In some cases color blindness is the result.

The author has found the field of vision involved is from one o'clock to nine o'clock. The eyes are tested in these directions using an indicator

muscle. They can be tested with reading material or in the clear. If reading material is used for the first part of the test the muscle indicator will weaken when the patient attempts to read. 1-a/ The patient is directed to look in the directions indicated. Muscle weakening is noted in specific directions and corrections to the fascia of the eye muscles are made into the directions of weakness. This is done by inserting the tips of the doctor's thumbs, or finger he may prefer, in the corner of the eye socket opposite the direction of weakness and on inspiration the eyeball is stressed with a rotatory motion into the direction of weakness. The stressing is repeated three or four times and the indicator muscle is again tested for strength. b/ The test is repeated with the patient holding some reading material or contacting K27. Faults are noted and corrections made as above. c/ The test is repeated with patient holding some reading material while his legs are crossed or while maintaining cross K27 contact. Faults are noted and corrections made as above. These corrections will program the patient to be able to read or be taught to read. 2/ Patient holds writing instrument. The directional tests are repeated. Faults are noted and corrections are made as above while writing instrument is held. These corrections will program the patient to be able to form the letters or numbers properly and on the appropriate part of the page. 3/ Patient holds paper with sequential and mathematical numbers and symbols written on it. The directional tests are made. Faults are noted and corrections are made as above. These corrections program the patient to process sequential numbers and things and recognize the mathematical significance of numbers. 4/Patient holds a dictionary or a page with the word "spelling" on it. The directional tests are made. Faults are noted and corrections made. These corrections program the patient to be able to

learn the spell and remember the spelling. 5/ repeat #4 but add a writing instrument to the equation. These corrections program the patient to write with proper letter sequence. 6/ With patient looking straight ahead, rapidly move an object on one side and then the other in the peripheral vision. Direction of fault is noted. Correction is made as above. These corrections will program the patient so that peripheral motion will not disorient or put him to sleep [driving, etc.]. 7/ Special applications of the eye technique can be made in regard to special tools, keyboards, objects, etc..

If done with skill, the protocol generally requires 3 to 5 treatments with reevaluation in 2 to 3 weeks, then ideally on a monthly basis for 6 months and after any severe illness, high fever or trauma, both emotional and physical.

Many times the patient is hyperactive. There is always a specific allergy related to this hyperactivity. The allergic reaction may recreate the reversals and sometimes the sphenoid tilt fault. Try to find the most dramatic allergen [many times it is pink in color, chewing gum, icing, baloney, etc.]. Program the specific substance when known and recheck for a sphenoid tilt. With the offending substance on the skin, therapy localize for the limbic fixation pattern [7C,1D- 12D,1L]. Make corrections accordingly, adjust 2,8,10D , tap SP21 on the left and K27 on the right simultaneously, thump on thymus and treat the liver N.L. and N.V. areas. Therapy localize T.S.B, if active do CMRT procedure. If a tilt is found, correct the sphenoid fault with the allergen in the mouth or on the skin. This will deprogram the allergy

There is frequently an emotional component to this frustrating condition which should be specifically addressed. The patient and his

family have been under great stress trying to cope with all the difficulties encountered in daily living. Many times there is a very dramatic emotional release when the eyes are directed to the right or left in the cranial correction part of this treatment protocol. If this occurs, continue to have patient look in the direction of distress while holding the particular corrective procedure. When the emotional episode subsides, continue with treatment until completion. The author employs a neuro-linguistic therapist to follow up the treatment to try to send the patient into his new world better prepared, without the negative emotional "baggage" of past failures and frustrations.

There are certain things the patient can do to enhance the treatment results. Because his diaphragm is usually weak, blowing up balloons is a good exercise. Instruct the patient to buy one hundred balloons and blow one up every day. This will strengthen his diaphragm dramatically. Marching in place or in a hall or around the block [cross patterning] will help in the organizational program. Rubbing K27 daily will also help. They must practice their new skills. At least 10 hours of reading will help establish his reading ability. Freeform writing [not copied] is important to facilitate his writing skills. Writing sequential numbers such as phone numbers of all his friends and family and doing mathematical exercises will enhance his ability to handle these diversified numerical concepts..

Six to eight weeks after treatment dramatic improvement in the scholastic abilities of most of the children has been reported. Emotional immaturity is usual in the child or young adult. This immaturity may be as great as half their chronological age. It usually takes seven or eight months for this part of the condition to reverse itself. Their self image improves greatly as they learn to function in a world of signs, books, language, media and personal relationships.

PROTOCOL TO EFFECT THE BEST RESULTS FOR DYSLEXIA AND L.D. TECHNIQUE

By Carl A. Ferreri, D.C.

Because we are attempting to establish neural organization in a neurally disorganized person, certain steps must be taken in addition to the basic protocol. Nothing we do can work well if we do not do basic procedures to establish a base to work from.

START WITH PATIENT PRONE --

- 1 - Check for and eliminate heel tension.
- 2 - Modified Derifield test for lateral atlas - short leg stays short or gets shorter at 90 degrees. Adjust laterally if present.
- 3 - Test both hamstring muscles for equal strength. 1 weak indicates fixation of sacrum on side of weakness and a 3rd cervical laterality on that side. This is a dural torque indicator. 2 hamstrings weak indicates occipital fixation. This must be corrected. Retest for clearing.
- 4 - Test for posterior switching -- tip of coccyx and umbilicus, MUST HAVE, and tip of coccyx and k27 both sides, MAY HAVE. Make corrections with heavy rubbing.
- 5 - Limbic fixation 7C -1D and 12D - 1L. TL transverse processes in both directions. If found then T.L. 2-8-19D for respiratory fixation. Adjust in 3 phases of respiration. At least 30% of Learning Disabled are allergic. If present, then when supine Tap SP21, K27, together, Thump Thymus [upper part of sternum], Rub NL for Liver and HOLD NV for Liver. TL for TSB for further liver involvement. If active rub it while holding CMRT liver point [tip of rib cage at 10th rib]
- 6 - TL Posterior Cloacal reflex points seperately, TL Labyrinthine righting reflex points separately, find and fix. Then TL together. Find and

fix. Use respiratory assist correction. Remember, these reflex points MUST be done with eyes OPEN AND CLOSED!!! THIS IS A MUST HAVE IN ANY COMBINATION!!!

With patient supine

1 - Lateral Occiput or Anterior Atlas. [tongue direction or 2 hand TL on occiput] If one side, is lat. occiput, if two sides, is ant. atlas. Adjust as found. This is a MUST HAVE. [Do this first] [occasionally eyes R and L]

2 - K 27. This is a MUST HAVE and is done next.

3 - T.M.J. -- Test ALL possibilities. 1 - a 2 Hand contact in the clear. [no open, bite, etc.] - [spread mandible]. 2 - a 2 hand contact, mouth open wide, [lat. pterygoids]. 3 - a 2 hand contact, bite down, [buccinator]. 4 - a 2 hand contact, chew, [temporalis]. 5 - a 2 hand contact, lateralize, [both pterygoids]. 6 - a 2 hand contact, jaw anterior, [med. pterygoid]. 7 - a 2 hand contact, retro jaw, [post 1/3 temporalis] 8 - a 2 hand contact, swallow, [hyoid muscle plus 1,2,3C] TL for side, spindle down on side away from weakness and then push [stress] hyoid into weakness, adjust cervicals on TL side. 9 - a 2 hand contact, phonate [hyoid muscles away from weakness and stress hyoid into weakness. 10 - Right hand contact, in clear, [sequential jaw - masseter and temporalis R, then lat. pterygoid L, then masseter and temporalis L] Test with Left gluteus medius indicator. 11 - Left hand contact in clear [L masseter and temporalis] Test with Right gluteus medius indicator. MUST HAVE A T.M.J.!!!!

4 - TL for ANTERIOR CLOACAL REFLEX separately and OCULAR RIGHTING REFLEX separately and then TOGETHER with EYES OPEN AND CLOSED. Make corrections as necessary. MUST HAVE AN ANTERIOR CLOACAL AND OCULAR

RIGHTING REFLEX involvement.

5 - If a Cranial Injury Complex is found [2 Labrynthine or Ocular Righting reflexes in the same eye option] TL for combinations and fix with respiration fix.

CRANIAL COMPLEX FOUND IN ALL LEARNING DISABILITIES

Test ALL Sphenoid possibilities.

1 - 2 Thumbs on roof of mouth, tests for R and L lesser wings of sphenoid. Eyes R, Center, L. Make corrections as necessary. This is a MUST HAVE FAULT.

2 - 2 Thumbs on roof of mouth, spread palate and maxilla, this tests flexion of the body of the sphenoid. This distortion is found in all speech impediments [stuttering, hesitant speech, etc.] If found will then generate a cross K27 and a homolateral gait. Test anterior and posterior gait pattern and correct [cloacal and ocular or labyrinthine reflexes together as found] Rub K27, then spread palate after fixing both lateral pterygoids if necessary. Eyes R,C,L. This is a MAY HAVE.

3 - TL for Spheno Basilar Fault. Eyes R,C,L. Fix. This is a MUST HAVE.

4 - TL for Sphenoid Tilt, high on right low on left. Eyes R,C,L. TL for lat. pterygoid on low side, fix if still present [sphenoid will be better able to position properly], then make Sphenoid correction. THIS IS A MUST HAVE. [this is the primary fault].

4a- If there is a strong emotional factor in patient in relation to this condition, then TL sphenoid in an X pattern [high,low, both sides] Eyes R,C,L. When found it means a contraction of the greater wings along with the tilt. This is an emotional overlay [look for this in ANY emotional

patient). Contact the greater wings on sides of head with fingertips and

lift. When motion is felt under your fingers then proceed with usual tilt correction. There will be a bilateral frontal descent present. Lift both frontals. [will not correct frontal for tilt, this must then be done on low (left) side]. THIS IS A MAY HAVE.

5 - 2 hand TL on left Frontal or challenge direction will indicate descent on left. Fix with eye options found for sphenoid tilt by lifting frontal. This is a MUST HAVE.

6 - TL index fingers in ears for temporal bone [Vestibular] involvement. Eyes R,C,L. Fix with ear pull technique. [out and down @ 45 degrees] This is a MUST HAVE.

7 - TL Vestibulo-Ocular Reflex. Finger in ear and other hand fingers on supraorbital notch both sides [one at a time]. Eyes R,C,L. Correction is made by pulling ear out and down and lifting the frontal together with respiration as found. This helps to synchronize the "picture with the sound" and helps eliminate confusion. This is a MUST HAVE.

8 - TL Spheno-Vestibular Reflex. Thumb on roof of mouth, one side then the other, with finger in ear, one side then the other. Eyes R,C,L. Fix together, with respiration. This is necessary to unlock the temporal Bone to establish better balance and coordination and concentration. This is a MUST HAVE.

9 - TL Spheno-Ocular Reflex. Thumb on roof of mouth, one side then the other, with each supra orbital notch. Fix with respiration by lifting sphenoid [in the mouth] toward back of eye on that side, while lifting frontal. This is a MUST HAVE.

Cranial corrections for this condition must be challenged with eye options R,C,L. as many only appear under those conditions.

EYE MUSCLE OPTIONS FOUND ONLY IN LEARNING DISABILITIES

Eye option change will always fail to the left. Starting from 1 o'clock to 6 o'clock with some extending to the right at 7 and occasionally to 9 o'clock. Oddly enough the better compensated person has the right options along with the left.

1 - Eyes tested in the clear or while the doctor holds reading material, indicator muscle will fail anywhere from 1 o'clock on the left to 9 o'clock on the right.

2 - Eyes tested with K27 or while patient holds reading material using an indicator muscle. [same as above]

3- Eyes tested with reverse K27 or legs crossed or with patient holding the reading material with legs crossed.[same as above]

4 - Eyes tested while holding a writing instrument [pen, pencil,etc.] Failure usually from 3 to 7 o'clock. Make corrections as found.

4a- Eyes tested with patient holding a special tool, computer keyboard, phone dial, etc. [Special hand eye coordination]. Make corrections as found.

5 - Eyes tested while patient holds paper with numbers on it. There should be both sequential and mathematical numbers, as each is a different concept. Make corrections as found.

6 - Eyes are tested while patient holds a dictionary or page therefrom. Or a piece of paper with "spelling" written on it. Make corrections as found. This will allow his computer to start to recognize the code of words. Usually anything learned after this will be spelled correctly. Make

corrections as found.

7 - * 6 with a writing instrument added (pen or pencil) Correct as found.

8 - With eyes straight ahead [center], rapidly move your hand or any object up and down on one side and then the other. Indicator muscle will fail on one or both sides, occasionally in a downward direction with movement under the gaze. Correction is made with eyes holding center using eye technique into weakness.

Correction to the eye option failures is to insert the thumb tips into the corner of the eye socket and with a lifting or rotating motion, move the eyeball into the direction of failure. The object is to stretch the fascia of the eye muscles.

Occasionally in correcting the eye options, great emotional releases are experienced by the patient. If at all possible, try to keep the emotion going with the eye direction until the patient quiets. This will make great changes in the condition of the patient. Sometimes, after the treatment, the patient will get very emotional or somewhat "spaced". Put them in a quiet place and let them get it out of their system.

If you have any problems or a particularly difficult case call or write ---

Dr. Carl A. Ferreri, Neural Organization Technique Centers, 3850 Flatlands Ave. Brooklyn, N.Y. 11234 [718] 253 9702

by

Terry L. Franks, D.C.

ABSTRACT: The treatment of parasites is discussed both conceptionally and clinically.

Parasites are not uncommon; they are simply misdiagnosed. (1) We as a population are often exposed to parasites. Three factors seem to be involved when one has parasites. First, is exposure to the parasite; second, is a basic physical weakness within the system that does not allow the body to reject or attack the parasite; (2) the third is the emotional factor. Although it is not in the literature, it has been my experience that this factor is very significant.

When parasites are present in the body, I find that there is an emotional involvement in eighty to ninety percent of such patients. If a tapeworm is present, there seems to be an emotional involvement in one-hundred percent of these patients. The pattern appears to be that the person has an emotional attachment to something that they experienced in the first three years of life, almost always within the first six years. Parasites have been accepted into the body and seem to fill an emotional need.

The standard medical approach to the problem of parasites is to take a stool sample. Other diagnostic techniques are much more invasive, such as examination of bile obtained by duodenal drainage. (3) If there are eggs or the parasite is present, a specific drug is prescribed. This method does not deal with the physical weakness within the body, nor with the emotional factor inherent in the body's tolerance of their presence.

My approach at present involves all three factors. First, I identify the appropriate herbal combination to poison the parasites. With the second level, which is the body's physical weakness, a homeopathic remedy is usually indicated. This has the capability of stimulating the body to make a deep physical correction of the basic weakness. The third and most difficult problem is emotional. Parasites may represent a form of self-punishment. They seem to thrive on suppressed guilt, anger, or anything that

would prevent the body from attacking them as a normal infectious process. The body apparently accepts their presence and learns to tolerate the toxic side effects in a chronic manner. Our approach at this level is the identification of what is going on emotionally and the belief system behind it. The patient then must confront the belief system and release it.

The traditional approach to emotionally caused problems is a long process which has to be layered out gradually until there is a resolution of the condition. (4) I do not always find this process to be necessary. If an individual is truly willing to confront the actual belief system, this block can be released in a short time. The body, with the help of the herbal compound and the homeopathic remedy, will usually kill or reject the parasites within one to three weeks.

For the first few days following the destruction of these invaders in the system, the patient feels a sense of physical and emotional well-being. However, the parasites, having died within the system, must now be eliminated. The individual will go into a detoxification for three to seven days, with an actual increase in symptoms. After moving through the detoxification, there is usually a sense of well-being and vitality which the patient has not experienced in a long time.

I find parasites in thirty to forty percent of my patients. The most common type of parasite I have found is roundworm, the second most common is hookworm, third is whipworm, and fourth is tapeworm. The common factor in all these types of parasites is the toxicity of the patient. It manifests as a lowered vitality, low grade depression, digestive disturbance, and an emotional block that is allowing the situation to continue. The lowered vitality may be the reason the presence of parasites is frequently accompanied by major allergies, heavy metal toxicities, and other types of chronic poisoning which are all long-term stress factors upon the body.

The traditional medical diagnosis of a stool sample appears to be largely ineffective. The diagnostic techniques of applied kinesiology are consistent with what is found clinically. The biocomputer model, as developed by

Dr. Alan Beardall, appears to be the only diagnostic procedure which has the capability of identifying all the factors involved with parasites.

I find that parasites cause such a variety of symptoms, that what is in the textbooks as a classic description does not apply. I believe for this reason that parasites are often not even suspected and therefore not diagnosed. A system of diagnosis is needed which takes the practitioner beyond the logical or left brain rationale. Applied Kinesiology is such a system. It allows the body to assist us in discovering the presence of parasites and then treating them.

REFERENCES

- ¹Markell, Edward K., Ph.D., M.D., and Voge, Marietta, Ph.D. Medical Parasitology. W.B. Saunders, 1981. Page 1
- ² Ibid Page 10
- ³ Ibid Page 148
- ⁴Peck, M. Scott, M.D., The Road Less Traveled. Simon & Schuster, 1978. Page 11

PREPELVIC TAP

By Richard Guidry, D.C.

ABSTRACT

This paper focuses attention on a procedure that parallels the precordial tap technique developed by Dr. George Goodheart in 1985. The "Philosophical Physiology" has not been formulated but I have observed that it is effective; therefore I present this possibility to you.

DISCUSSION

When Dr. Goodheart presented his finding , explanation and procedure of the precordial tap technique at the 1985 ICAK Winter Meeting in ST. Thomas, it of course captured my attention. In a subsequent conversation with a colleague we discussed the Tibiten proverb that man has three brains; in the skull in the heart and in his pelvis. In the weeks following the winter meeting I had the opportunity to use this new procedure, but occasionally with a twist.

Paralleling Dr. Goodheat's approach in diagnosing the need for this procedure I discovered a Gluteus Medius that Therapy Localized as being weak but muscle tested as strong. The five I.V.F. factors were negative. However, when I tested against left and right brain activity there was a marked weakening. I proceeded to apply the correction we are all familiar with by tapping the right side of the brain using the left brain activity and as expected I got a good response.

However, when I challenged the correction by tapping the left side using humming the condition returned. I then proceeded to use the precordial tap technique as demonstrated by Dr. Goodheart. Then by challenging the correction, it again became weak.

I then proceeded to apply the identical procedure using the pelvis as the "Brain". In this case however, when I challenged the correction it remained strong.

I find the primary muscle that requires correction by the prepelvic tap technique is the Gluters Medius. On occasions orther muscles of the pelvis and of the lower ectremities require this technique. The muscles above the pelvis rarely need it.

CONCLUSION

It will be interesting to hear others' concepulization of the multi-demensional hypothesis of why and how this works. For example, some people think with their pelvis or thei pelvis is where your brain is, is a good start. Regardless, this procedure is effective. Enjoy!

References"

George J. Goodheart, Applied Kinesiology
1985 Workshop Procedure Manuel, Page 16-38

Submitted by Richard I. Guidry, Jr., D.C.

OBSERVATIONS ON TONSILLITIS AND THE SORE THROAT

By Richard Guidry, D.C.

ABSTRACT

Tonsillitis and sore throat are synonymous. Both have the same etiological factor. You contract sore throat only if the tonsils have been removed, if not, you get tonsillitis.

DISCUSSION

I have been observing this phenomena for a number of years and have a high percentage track record of giving instant relief and total recovery in a very short period of time, depending on the severity.

The primary etiological factor is the Iliodecal Valve Syndrome coupled with a toxic overload of the liver. When the ICV malfunctions, the small intestine continually absorbs what ever is in the ilium. The portal system carries an abnormal amount of toxins to the liver. The toxic liver causes the tonsils to swell in order to encourage the person to stop eating. It's like a signal..." stop eating we have trouble down the line."

Initially I fix the ICV point and B57 on the same side until I feel the "pulse" synchronaize. I then proceed to the NL for the liver followed by the CMRT liver pump if indicated. Remember to check the Gall Bladder duct to make sure that it is open before you give a Liver Pump.

Secondly, a small intestine, stomach, Pancretic and gall bladder duct accompanies the primary ICV syndrome and liver. I usually correct these by a deep mesenteric massage. I do not automatically give a "shotgun" mesenteric. All procedures are adked for through Therapy Localization and a priority system. Efficiency is increased by challenging the direction of your massage. You can feel the organs soften and relax as the patient feels the discomfort lessen. Sometimes the etiological factors and secondary

procedures are hidden. For example, you may have to remedy a mental/emotional or Now Point before you start the soft tissue manipulations.

I generally find L1 and L4 on opposite sides needing to be adjusted. Thoracic 5,8 and 10 in many incidences need to be adjusted but they are not as predictable as the lumbar. On the cervical, I fix what I find.

I have observed that I get the sore throat whenever I eat while I am in a rush, or am angry or anxious. Stress associated with eating is what usually triggers this phenomena.

This syndrome usually is or is the major accompaniment to the "Flu". It is always there. It may be second or third in priority but when restored, it is the most powerful healing procedure that changes the two-week flu into a one-to-three day ordeal.

CONCLUSION

You will be amazed at the effectiveness of this procedure. There is a saying that will help you remember the presentation, "Do not take out the sink if your plumbing is stopped up. Unclog the pipes. You need your sink!"

Submitted by Richard I. Guidry, Jr., D.C.

ENDO NASAL INSUFFLATION

by

CHRISTOPHER L. HARRISON, D.C.

DIPLOMATE

INTERNATIONAL COLLEGE OF APPLIED KINESIOLOGY

ABSTRACT

In this paper, the author gives a brief history of endo nasal insufflation along with a clinical description of the technique and its indications.

Endo nasal insufflation is a technique whereby the doctor inserts an inflatable instrument into the nasal turbinates and induces air pressure into the instrument, thereby creating an explosive force into the turbinate walls.

The technique was originally created by the osteopathic profession and passed down to the chiropractic profession by Dr. J.R. Stober, a Chiropractor, from Portland Oregon. The author studied with Dr. Stober in 1973 and has been using endo nasal technique since that time. Endo nasal insufflation can be considered a "general" cranial technique and, however, has the following specific uses that the author has found the technique to be indispensable for:

1. Sinus congestion and inflammation
2. Chronic headache that is nonresponsive to chiropractic and other cranial technique.
3. Epilepsy
4. Stubborn cranial problems

The instrument consists of a blood pressure inflation bulb; the author recommends the Bristol brand with the metal connector and finger cots attached to the metal connector attached with a rubber band. I use a minimum of three layers of cots and use the green triple dipped for the first two layers. It is important to replace the bottom layers frequently, in order to avoid the finger cots deteriorating. The more layers of finger of cots one uses the stronger the force of the treatment. When the desired number of finger cots are placed on the bulb, the outermost layer is lubed with K-Y Jelly and the finger cots are gently placed into the inferior turbinates on one side of the nose. When the

finger cots are inserted into the turbinates they are nudged along with the use of a toothpick. When inserting into the inferior turbinates one has to direct the cots superior then up over the hump and inferior. When the placement is made squeeze the patients nose bilaterally, have them open their mouth and inflate the cots. It is wise to begin the treatment with a moderate inflation as it is often painful and sometimes scary for the patient. They should be prepared for the "cracking" sound that the turbinates often make when inflated. When both sides are inflated, enter the middle turbinates by placing the cots superiorward and posteriorward and again, pinch the nostrils closed and inflate, repeat on the opposite side. Then enter the superior turbinates by placing the lubed cots almost straight superior. Inflate and again hold the nostrils closed while the patients mouth is open, repeat on the opposite side.

Not frequently, there are some side effects, although I have never seen any serious ones in the hundreds of applications that I have rendered. You might find occasionally that a patient will suffer a nosebleed after application, in which case, assist them to the sink have them hang the head over it and instruct them to breathe through the nose which will dry up the nose bleed usually quite fast. The most common side effect, is just the momentary pain that the patient suffers during the split second of application. I have found it best to advise them that the treatment will most likely be uncomfortable and possibly painful, to advise them otherwise can cause distrust, and believe me you need the patients trust for this treatment.

Sinus congestion and inflammation-infection responds wonderfully to endo nasal insufflation, especially when followed by the DeJarnette "fruitjar" cranial manipulation and patient home therapy of alternate hot and cold packs to the sinuses.

Chronic headaches will respond to endo nasal technique when no other therapy appears to work. I always balance the pelvis and check for meningeals and perform a rectal meningeal when positive prior to the endo nasal work.

I have had the opportunity of working on three epileptics, two of which were completely cured of eilepsy. Don't be surprised if they go into seizure during tratment, Dr. Stober reports one patient slept on his table for one entire day with a resultant complete remission upon awakening and a complete cure in successive years. One patient that I treated for chronic headaches with meningeal-endo nasal had to stop his car on the way home after treatment and slept on the side of the road for an hour before resuming home. Actually its a good idea to have the patient bring a member of the family to drive home after this treatment.

This is heavy duty, serious work and not routine treatment. I do not recommend its application for everyone, nor, for treatment when normal chiropractic and applied kinesiology will do the job. However, when you find that the patient is not responding to your best efforts, use endo nasal insufflation when indicated. Our results have been most gratifying.

Christopher L. Harrison, D.C.

Palo Alto, California

February 1986

APPLIED KINESIOLOGY TESTING IN THE DIAGNOSIS
OF CANDIDA ALBICANS

Darrel W. Hestdalen, D.C.

ABSTRACT:

A correlation is given for the use of the oral challenge, a yeast symptom questionnaire, and identification of serum yeast using darkfield microscopy in the diagnosis of candidiasis.

INTRODUCTION:

Numerous papers, articles and demonstrations have been presented utilizing applied kinesiology (AK) testing with an oral challenge of various substances to show allergies, sensitivities, and/or nutritional need. I have utilized this method for several years with good clinical results. The procedure, also called muscle response testing, has been criticized as not having specificity, sensitivity, or scientific data to back up the findings.¹

Oral absorption and neurological pathways from the oral cavity to the brain have been demonstrated and would appear to be the basis for the quick muscle response noted in the AK oral challenge testing.² In utilizing AK in allergy testing and in studying the use of this method I have not found a consistent means of determining the degree of sensitivity or allergy or need for the substances being tested. The purpose of the study presented in this paper is to correlate AK testing of yeast with other diagnostic measurements of candidiasis.

The diagnosis of candidiasis has been of particular frustration to the physician utilizing the standard medical diagnostic approach. Trying to identify the candida invasion of the body by finding indication of

infection or allergy through the antibody tests or skin tests or culturing have not given conclusive results. Symptomology, patient history, and response to treatment has been the best method of confirming the candidiasis diagnosis.³

William G. Crook, M.D. published a Candida Questionnaire that has been used to indicate the probability of candidiasis as a factor in various health problems.⁴

Philip Hoekstra III, Ph.D. has identified Candida Albicans in the serum utilizing darkfield microscopy and cell wall deficient culture techniques. The Candida Albicans is present as either blastospores or spheroplasts in the serum and can be easily observed with darkfield microscopy. The blastospore form is more active and virulent compared to the spheroplast which is less active and less virulent.⁵ The difference in these two forms has shown to be significant in the relationship of the AK testing and the patient's symptomology and will be discussed later in this paper.

PROCEDURE:

Patients with a history and symptomology suggestive of candidiasis were tested in the following manner.

1. AK oral challenge with bakers yeast
2. Yeast Questionnaire
3. Darkfield microscopy of the blood

The AK oral challenge was done in the following manner. A few grains of bakers yeast were placed on the center of the patient's tongue. After the patient could taste the yeast, a previously strong indicator was tested for inhibition or weakening. The muscle test used was a general straight arm test. Bakers yeast was used as any form of yeast, mold, or fungus will produce a reaction in most candidiasis patients. Other forms

of yeast have been used by others in testing for yeast problems.⁶

If the patient tested positive (muscle weakened with the oral challenge) then they were asked to complete the Yeast Questionnaire and a darkfield microscopic evaluation was done of their blood using the LIVCELL ANALYSIS system. The AK test was done first so as to minimize tester prejudice that may have been involved if the results of the questionnaire and/or lab test were known before muscle testing.

The yeast observed in the serum were quantitatively measured at the 40X objective and grouped as to less than 5, 5 - 10, 10 -20, greater than 20 groups of yeast per visual field. The number of blastospores(3-5 micrometers in size) was also noted and counted as less than 5, 5-10, greater than 10 per visual field. Four visual fields were observed for each test. The areas observed were the areas where the blood cells had sufficient room to separate and the other serum contents could be observed adequately.

DISCUSSION:

The patients with the worst symptoms generally had 10 or more groups of spheroplasts per visual field, and this number usually decreased as the patient demonstrated improvement. The number of blastospores per visual field demonstrated a direct correlation with the symptomatic picture of the patient. The number of spheroplasts is of less significance probably due to the fact that they can be found in the serum of symptomatically normal individuals. The spheroplasts are of the size(0.2 micrometers) that probably allows persorption through the intestinal wall and are therefore found in the blood.⁷

The scores determined by the Yeast Questionnaire show a strong

correlation with symptomology and AK testing. The questionnaire is of little value in post therapy evaluation due to the fact that the first section reflects the history of drug useage which is not pertinent to the effectiveness of the therapy or the present state of the patient. For that reason the questionnaire was not used in the retesting.

Retesting of the patient, after therapy, with the AK oral challenge and the darkfield microscopy showed a strong correlation with a negative AK test and the absence or greatly reduced number of blastospores (less than 5 per visual field). The presence of spheroplasts was often less but not with the significance of the blastospores.

Therapy consisted of individualized nutritional support, diet, and chiropractic and other treatment as indicated by the AK approach to the triad of health.

A negative AK test does not mean that the patient is well or cured of the condition. The negative test correlates with the other findings that the patient has returned to a better symbiotic relationship with the Candida Albicans. The underlying factors that allowed the candidiasis to develop need continued care to return the patient to health.

CONCLUSION:

AK oral challenge with yeast is a reliable indicator of Candida Albicans having a detrimental effect on the individual. The correlation of a positive AK test and the presence of the virulent blastospores in the blood is very high. In the presence of symptomology suggestive of candidiasis and a positive AK oral challenge for yeast I feel that the diagnosis of candidiasis is justified and the appropriate therapy should be recommended.

REFERENCES:

1. Gerard E. Stavish, D.C., "Clinical Basics In Allergy And Immunology", The American Chiropractor, p. 38, July 1985.
2. David S. Walther, D.C., Applied Kinesiology, The Advanced Approach In Chiropractic, Systems D.C., Pueblo, CO. p.48, 1976.
3. C. Orian Truss, M.D., The Missing Diagnosis, C.Orian Truss, M.D., Birmingham, Ala. pp.33-35. 1982.
4. William G. Crook, M.D., The Yeast Connection, A Medical Breakthrough, Professional Books, Jackson, Tenn. pp.29-33. 1983
5. Seminar notes from 1985 Annual Owners Meeting, Livcell Analysis.
6. Walter H. Schmitt Jr., D.C. "Nutritional Assessment of Patients", Seminar notes, 1984
7. W. Krause, H. Matheis, K. Wulf, "Fungaemia and Funguria After Oral Administration of Candida Albicans", Lancet, 1969.

CLAVICLE SUBLUXATION IN RECTUS FEMORIS DYSFUNCTION

Darrel W. Hestdalen, D.C.

ABSTRACT: A discussion of clavicle subluxation and its relationship to dysfunction of the ipsilateral rectus femoris in the gait position is presented. Clinical observation has found this dysfunction related to dural torque, knee, hip, and pelvic problems.

Introduction

The function of the rectus femoris muscle is of special importance as it crosses two joints, the hip and the knee. It also has two actions as a hip flexor and lower leg extensor.¹ It also serves as an anterior hip stabilizer and a stabilizer of the patella and knee.

G.J. Goodheart Jr., D.C. has discussed the function of the sternocleidomastoideus and the rectus femoris in the gait mechanism.² It has been observed in AK that a joint subluxation can alter the proprioceptive functioning of a muscle associated with that joint.

Procedure

With the patient in a supine position, test the rectus femoris in the manner described by Alan Beardall, D.C.³ and as shown by David Walther, D.C..¹ If the muscle tests normal have the patient raise his/her head off the table activating the anterior neck flexors. If the rectus femoris now tests weak or inhibited, challenge the sternoclavicular joint for subluxation. The challenge is performed with the patient in the neutral supine position. Correct the clavicle subluxation as indicated by challenge and retest the rectus femoris in the head up position.

Discussion

This phenomenon follows the pattern of the reactive muscle. I have not found the lasting correction with spindle cell treatment as I have achieved with the correction of the clavicle subluxation. Occasionally spindle cell therapy to the SCM is needed as well as the adjustment to the sterno-clavicular joint.

The rectus femoris test as shown by Walther has not been found to show this reactive pattern as frequently as the rectus femoris straight head test as shown by Beardall. This difference probably has to do with the dual innervation of this muscle and the contraction of different fibers in each test. I feel that this difference emphasizes the importance of testing a muscle in different phases of function. This significance was also indicated by Dr. Christopher L. Harrison's paper on uni-vector multiposition testing.⁴

I have found this reactive muscle pattern to be significant in recurring knee and cervical problems. It has also been associated with dural torque problems and the P.R.Y.T. patterns.

The clavicle subluxation can be determined by other means using AK but the test presented here is another example of structure and function and gives insight to the interactions of the body and how dysfunction can have a distant causative factor.

References

1. Applied Kinesiology Vol.I Basic Procedures and Muscle Testing, David S. Walther, D.C.; pp.270.
2. Applied Kinesiology 1982 Workshop Procedure Manual, 18th Ed. G.J. Goodheart Jr., D.C. pp. 30-37.

3. Clinical Kinesiology Vol.II, Pelvis and Thigh, Alan Beardall, D.C.
pp. 41.
4. Multi-positional Uni-vector Muscle Testing, Christopher L. Harrison,
D.C., Collected Papers of the Members of the I.C.A.K., 1984 Summer
Meeting, pp.119-121.

GALL BLADDER MERIDIAN IMBALANCE IN RECURRENT HYDROCHLORIC ACID DEFICIENCY

By James D. Hogg, D.C.

ABSTRACT

The relationship between gallbladder meridian imbalance and the temporal bulge cranial fault is discussed and a reverse piezo-electric effect is hypothesized.

As is often the case, this piece of research originated out of frustration I was experiencing with a couple of difficult cases. In this situation I had two patients with temporal bulge faults (1) and the attendant hypochlorhydria which were recurring with depressing regularity. After checking and clearing other factors such as other cranial faults, TMJ problems, head leveling muscles, foot, pelvic, spinal, dural and other structural imbalances it became evident that these patients were unlikely to respond to "conventional" treatment.

It was at this point that I recalled a presentation by Dr. Wally Schmitt at the Super 20 Weekend. During his presentation on gallbladder therapy he mentioned that patients with gallbladder problems sometimes would complain of a temporal headache as a result of gallbladder meridian disturbances (2). I put this together with information I remembered on the piezo-electric effect which states that when mechanical force is applied to a crystalline structure an electrical charge is created. I then began to postulate a sort of "reverse" piezo-electric effect. Meridian energy is electro-magnetic in nature (3). The pathway of the gallbladder meridian takes it in a zig-zag pattern across the temporo-parietal area of the cranium (4). I started to wonder if perhaps an imbalance in electro-magnetic energy could create a mechanical force! I checked these problem patients and found that they both had deficient gallbladder meridians. After correcting the temporal bulge fault in the normal manner, I then corrected the gallbladder meridian deficiency using five element principles (5). These patients had both had temporal bulge faults that recurred on a weekly basis. After the above treatment one patient had no recurrence whatsoever while the second required two additional treatments for permanent correction.

Since then I have used this technique many times in different ways. When faced with recurrent temporal bulge faults I have tried first correcting

any gallbladder meridian imbalance that is present. I find that in about 70% of the cases the temporal bulge fault will clear spontaneously after the meridian work. This is especially true in situations where the temporal bulge fault occurs in the absence of an inspiratory assist or sphenobasilar fault(6). In the remaining 30% I find it necessary to adjust the temporal bulge, inspiratory assist or sphenobasilar fault in a normal manner in addition to correcting the gallbladder meridian imbalance. In both cases, I have found the temporal bulge fault correction to be of a much more lasting, often permanent nature. Although the temporal bulge fault often clears spontaneously when the gallbladder meridian is treated, the greatest permanency of treatment seems to be attained when the appropriate cranial fault is treated directly in the same appointment as the gallbladder meridian. When I stopped keeping statistics I had successfully used this approach 150 times.

In summary it seems that a sort of "reverse piezo-electric effect" exists in the relationship between the temporo-parietal area of the cranium and the gallbladder meridian. This relationship may cause a recurrence of the temporal bulge cranial fault if a gallbladder meridian imbalance is left uncorrected. Correction of both the cranial and meridian problems in the same appointment generally yields greatly increased permanency in the correction of the temporal bulge cranial fault. It seems reasonable to wonder if similar relationships exist between other meridians and osseous structures.

1. David Walther, D.C., Applied Kinesiology Volume 11, Systems

D.C. pp.174

2. David Walther, D.C., Applied Kinesiology The Advanced Approach In Chiropractic, Systems D.C.

1976, pp.170

3. Ibid, pp.157

4. Ibid, pp.170

5. Ibid, pp.189

6. Op cit, pp.157,165

Gallbladder Meridian Imbalance in Recurrent HCL Deficiency page 2

STATISTICAL BEFORE & AFTER EXAMINATION RESULTS

By: Alex P. Karpowicz, D.C.

I.C.A.K.

ABSTRACT:

In response to the request at the Summer 1985 Meeting of the I.C.A.K. for more statistical or comparisons done in our work in Applied Kinesiology, I respectfully submit the following findings on the Standard before and after examination results that I did in my practice on the majority of my patients in the past year. I have also enclosed a copy of my standard examination form sheet. At times of course we do other examinations, tailored to the patient's symptoms or need to determine cause and related treatment situations.

RESULTS:

I. POSTURE ANALYSIS

	Abnormal before	Normal after
Head tilt	30	22
Ear high on	30	22
Cervical muscle tension	43	40
Shoulder high on	51	39
Thoracic curvature		
Thoracic muscle tension	31	27

	Abnormal before	Normal after
Lumbar curvature		
Lumbar muscle tension	42	38
High Ilium	47	30

II. ORTHOPEDIC TESTS

	Abnormal before	Normal after
Fabere-Patrick	16	16
Babinski Sign	26	18
Ankle Clonus	2	2
Naffziger	9	9
Kemp's Sign	52	45
Soto-Hall	33	30
Laseque Test	27	20
Goldthwait	26	22

III. RANGE OF MOTION

A. Dorsal Lumbar Spine

	Abnormal before	Improved	Normal after
Flexion	28	7	20
Extension	17	4	12
Lateral to right	11	0	9
Lateral to left	10	0	9
Rotation to right	3	0	3
Rotation to left	4	0	4

Page -3-

B. Cervical spine

	Abnormal before	Improved	Normal after
Flexion	2	0	2
Extension	2	0	2
Lateral to right	3	2	1
Lateral to left	5	1	4
Rotation to right	2	0	2
Rotation to left	2	0	2

CONCLUSION:

The standard period of time between the initial visit and examination and re-examination was approximately six weeks duration. An interesting observation was that the majority of my practice was typical of chiropractic in that lowback problems represented the most common symptom being treated. In conclusion, there appeared a high percentage of normal test results in the re-examination, validating the Chiropractic--Applied Kinesiological approach.

NON-KINETIC PHYSIOLOGICAL INDICATORS IN EXAMINATION OF THE NEW PATIENT

Gary N. Klepper, D.C.

ABSTRACT: The patient whose examination by muscle testing on their first visit to the Chiropractor's office reveals simple, clear, and obvious indications as to their true condition is the exception rather than the rule. Often overlooked are some simple examination procedures which reveal much valuable information about the patient's true status much more clearly than will muscle testing procedures alone.

INTRODUCTION

As we teach students the basics of Applied Kinesiology, including the use of muscle testing to determine which important structural faults and visceral disorders are present and needing attention, often the student is left with an incorrect impression. He somehow tends to get the idea that a functional disorder of the liver will always be seen as a weak sternal division of the pectoralis major muscle, that an unstable sacroiliac articulation will always be demonstrable by a positive therapy localization to the involved sacroiliac joint, that a microavulsion injury will always be able to be detected by a weakness in the damaged muscle. Failure to be able to diagnose the obvious by standard simple introductory AK testing procedures will sometimes lead the new student to the brink of despair and cause him to discard the entire system.

Difficulty in interpreting the results of initial muscle testing examination derives from two major causes. One is the tendency to have numerous significant stress patterns superimposed so that many weak muscles are found, but they seem to fit no rational pattern that would lead one to think of one

major cause for the entire body of findings. The other cause of confusion is represented by the patient who has adapted well to his disorders, and while being overtly symptomatic, the muscle testing examination reveals no or few weaknesses.

When either of these scenarios are presented, the attention given to the examination of numerous physiological indicators other than muscle testing will often give a great deal of guidance as to where to begin the process of helping the patient move toward true health.

The purpose of this paper is to mention a few of these systems of physiological indications of health status which most of us know about, but have either not given them the attention they deserve, or have let them fall into disuse. This discussion will be restricted to factors related to metabolic conditions rather than structural ones.

FACE

The appearance of the face will tell a great deal at a glance as to the patient's metabolic and emotional status. Does the skin have a good full coloration. A whitish pasty look is often seen when many food allergies are present and /or when intestinal parasites are prevalent. Darkness under the eyes indicates kidney dysfunction, perhaps manifesting as ileocecal valve incompetence. A greenish complexion will be seen in liver or biliary disorders.

EYES

Glance at the coloration and texture of the sclera. It should be a clean white, smooth, no apparent dryness, no dilation of arteries. A yellowish cast suggests biliary stasis. Dryness

is indicative of liver weakness, specifically deficient liver yin. Presence of pinguiculae raises the suspicion of faulty fat metabolism. Dilation of or nodulation on specific arteries in the sclera may reflect stress or degeneration of particular tissues in the body, and many books have been published detailing the sclera as a representational system for the entire body, just has been done with the iris in the study of iridology.

EARS

Observe the structure of the outer ear. Palpate it for flexibility or rigidity. Keep in mind the function of the outer ear as an antenna for electromagnetic energy. With this in mind, do the ears protrude as if in an attempt to gather up all the energy they can to resupply a depleted system? Are they plastered rigidly against the skull as if in an attempt to filter out an overload? Observe the skin in the outer ear. Any puffy whitened areas or reddened spots will suggest stress in the tissues represented according to traditional auriculotherapy charts.

Look into the ear canal with an otoscope. Moderate reddening of the walls of the external canal, especially towards the eardrum, in the absence of infection, is suggestive of allergies. Any excess of cerumen causes a suspicion of faulty fat metabolism, especially biliary dysfunction.

MOUTH

Any investigation into digestive disorders requires a look at the teeth. Are any teeth present? Are enough important grinding surfaces absent so as to affect the ability to chew food

properly. Do the teeth meet in such a way as to make possible proper TMJ function?

Are there numerous fillings? A history of lots of dental caries suggests poor nutrition early in life. Presence of numerous amalgams necessitates a good dietary mineral status so as to avoid mercury toxicity trouble. Presence of more than one metal will likely create high galvanic activity in the mouth, which can be the source of much trouble.

Obviously, the coloration of the membranes of the cheeks will, by its correlation with haemoglobin status, sometimes be your first clue as to an anemic condition.

The tongue, by its coloration, texture, presence or absence of various lesions, represents much regarding the systemic health. Many fine books are available on oriental tongue diagnosis.

NAILS

Observe the nails of the toes and especially of the fingers. Are the nails smooth or ridged? Nail ridging, white spots in the nails, nails that have been chewed, all are suggestive of mineral deficiencies. Fungal infection of the nail beds may indicate the presence of serious immunodeficiency.

Observe the lunae. Absence of lunae in the fingernails implies hypothyroidism. As thyroid function fades away, the lunae disappear in a ulnar to radial direction, and as it regenerates they reappear from radial to ulnar.

PULSES

Therapy localization to the radial artery pulse areas commonly used in oriental diagnosis was introduced by Goodheart

as a means for determining a pattern of meridian imbalance that has reached acute proportions. While this method is simple and useful, it comes nowhere near revealing the depth of information that can be determined by actual palpation of the diagnostic pulse areas.

The chiropractor who is attempting to learn some of the principles of acupuncture will understandably be resistant to taking on another system of diagnosis which requires such subtlety of skill as does pulse diagnosis. However, even the most elementary pulse findings which require almost no training to detect are quite useful.

For instance, on beginning the training in pulse diagnosis, keep it simple by using the 6 pulse locations as indicative of relative strength of energy in each of the elements only, using this simplified scheme of representation:

	RIGHT WRIST	LEFT WRIST
PROXIMAL	Kidney Yang	Kidney Yin
MIDDLE	Earth	Wood
DISTAL	Metal	Fire

What is frequently felt in the pulses of the patient with endocrine disorders is deficiency of the kidney pulses, as the kidney energy is the basic driving force of the glandular system. The patient who is quite deficient in intensity of pulse at both kidney yang and kidney yin positions will probably require long term and elegantly diagnosed therapy in order to be brought to optimum health. The patient who is predominantly deficient in kidney yang rather than kidney yin will respond quite well to

nutritional support with glandular substances. The patient who is predominantly kidney yin deficient rather than kidney yang deficient will not tend to achieve good symptom change with glandulars alone, even if they display findings such as overt weakness of sartorius/gracilis groups which responds well to chewing adrenal substance. The differentiation between these different types will quickly clue the practitioner as to which types of therapy to expect the best responses from.

Once one has learned to differentiate deficiency or excess in each element, one can progress to feeling first the deep pulse position to ascertain the status of the yin aspect of the energy at each element, then release partially the contact to feel superficially the pulse, to ascertain the quality of the yang aspect of each elemental energy. This representation is the one we are used to seeing, and looks like this:

	RIGHT WRIST		LEFT WRIST	
	YIN	YANG	YIN	YANG
PROXIMAL	CX	TW	KI	BL
MIDDLE	SP	ST	LV	GB
DISTAL	LU	LI	HT	SI

It is of course assumed here that basic meridian abbreviations are known to the reader. The chart above is given for quick review purposes only.

Let's say for example that a patient presents with digestive discomfort in the form of epigastric pain and belching. Palpation of the pulses shows adequate energy at all elements, but examination of the deep and superficial pulses at the earth element shows an overly vigorous bounding pulse superficially

(ST), but a very weak deep pulse (SP). This patient has a deficiency of spleen yin expressed as exaggerated stomach yang with rebellious stomach chi. This instantly tells you that you should examine the T7 area for fixation, and examine the T5 area for irritative lesions; it suggests the efficacy of acupuncture to SP Luo point or other points necessary to obtain SP yin; it suggests the use of herbs which bias the vital energy towards spleen while calming the stomach, such as Chionanthus or Phyto-Pan. It then takes only a matter of seconds to use AK testing to investigate which of these would actually benefit the patient, and thus which therapies to actually employ at that visit.

While the example given above may seem complicated to those unfamiliar with acupuncture, the most elementary study of classical acupuncture will reveal the simplicity of the logic given here.

ABDOMINAL PALPATION

Abdominal palpation is mentioned here because it is so often not performed in a chiropractic examination, yet no other form of examination gives such direct ability to feel the condition of the viscera.

A belly full of gas suggests poor digestive function. Any areas of tension, spasm, and tenderness indicate irritated, overworked, possibly ischemic tissues. Fecus should not be palpable anywhere proximal to the sigmoid colon. No border of the liver should be palpable.

It is amazing to note the regularity with which highly stressed tissue can be palpated in the abdomen. This is

routinely ignored by the medical physician, but should not be routinely ignored by the chiropractor.

CONCLUSION

Over the years, many systems of examination have been developed by our colleges in the chiropractic profession as well as our friends the osteopaths, the naturopaths, and doctors of oriental medicine. These systems for the most part are all wonderful, non-invasive tools for diagnosing and monitoring the status of our patients.

Routine utilization of these diagnostic indices will not only make the doctor an exceptional diagnostician, but will avoid much of the frustration that comes from having a sick patient and not knowing what to do.

The intent of this paper has not been to serve as a reference work on diagnosis, nor to extensively cover any area, but to remind the doctor of much that he already knows, and to encourage its implementation for the good of his patients.

As the facts represented in this paper consist of a combination of helpful hints passed on to me by my mentors, and of common textbook information, no specific references will be given here.

PATIENT THERAPY LOCALIZATION VERSUS DOCTOR THERAPY LOCALIZATION
A PILOT STUDY

By
Gary N. Klepper, D.C.
1440 28th Street, Suite 1
Boulder, CO 80303

ABSTRACT: A brief investigation was made into differences in data obtained by classical therapy localization by the patient versus data obtained by the doctor placing his hand over the lesion area. Electromagnetic disturbance in the doctor is suggested as one explanation for differences in data obtained.

INTRODUCTION

It has been the posture of the instructors of classical Applied Kinesiology that to therapy localize a suspected lesion area, it is imperative that the patient be the one who puts his hands on the area being investigated (patient TL) rather than the doctor using his hands for this purpose (doctor TL). Nevertheless, we have all seen certain doctors demonstrate their ability to effortlessly obtain data by doctor TL. Also, we have seen doctors with the apparent ability to muscle test with great technical skill, but who don't seem to be able to get many positive findings on patients(1).

This was being discussed recently at a meeting of the Association of Boulder Chiropractors. An impromptu study was done involving myself and 4 other doctors who practice AK.

METHODS

A volunteer was selected to act as the patient. This volunteer was a doctor who has some knowledge of AK, but does not profess to practice it. I did a cursory examination, and

obtained a positive TL to the right lower rib cage over the liver. This was done unobserved by the other participating doctors.

Each of the four doctors was then asked to first test a right generic straight arm test to get a baseline of strength or weakness. No coaching was done as to proper artful testing procedure, nor was an effort made to standardize the procedure within the parameters of doctor-initiated versus patient-initiated testing(2).

Each of the doctors were then asked to obtain results of the straight arm test with: 1- the patient placing his left hand over the liver; 2- the doctor placing his hand over the liver and testing with the other hand; 3- the doctor placing his hand over the liver and me making the muscle test.

Each of the doctors was then examined for electromagnetic imbalance using a simple procedure by Alan Beardall known as coupled meridian challenges(3). This consists of investigating as to whether or not the patient is functioning within the adaptive mechanism of pulling energy from a pair of meridians representing a particular phase of energy (greater yang, yang ming, lesser yang, greater yin, lesser yin, absolute yin). If none of the coupled meridian challenges was positive, the four minicomputers were checked(4). Appropriate corrections were made by acupatching the appropriate points. This procedure was chosen because it is very simple and fast, and because none of the other doctors would know what I was doing. I offered no explanation as to the intent of my proceedings.

Doctor #1 was positive in lesser yang. Patches were applied

to TW5 bilaterally.

Doctor #2 had no positive coupled meridian challenges, no weak group muscles, no positive therapy localization to the anterior surface of his body anywhere, and even arm and leg length (absolute yang). Investigation of minicomputers revealed a positive LV cerebral adaptive circuit at the primary minicomputer. LV Luo was patched bilaterally.

Doctor #3 was positive in lesser yin. Patches were applied to KI 6, 10, and 27 bilaterally.

Doctor #4 was positive in lesser yin. Acupatches were applied to KI 2, 6, and 10 bilaterally.

It should be noted that the procedure used of applying acupatches to the four doctors was not intended to obtain any particular therapeutic effect, but simply to alter the electromagnetic status in those doctors for the purposes of this study.

After the completion of this procedure, each of the doctors was again asked to re-obtain their original findings on the patient by the three methods of liver TL.

RESULTS

Findings before and after examination and acupatching of the doctor are given in the chart below. Pos indicates a positive or weak straight arm test. Neg indicates a negative or strong straight arm test. All doctors found the straight arm test strong in the clear both before and after.

	Doctor TL	Patient TL	Doctor TL/me testing
Doctor	before/after	before/after	before/after
#1	pos/pos	neg/pos	neg/pos
#2	pos/pos	pos/neg	pos/pos
#3	neg/pos	neg/pos	pos/pos
#4	neg/neg	neg/neg	neg/pos

DISCUSSION

Interesting to note is that:

- 1- None of the 4 doctors obtained exactly the same data in the initial testing sequence.
- 2- Significant change in test results were seen after the procedure was performed on the doctors. Of the twelve possible tests (3 procedures each for 4 doctors), changes were obtained in seven of these test areas comparing results before and after.
- 3- The tendency in the change of results obtained before and after was toward a negative therapy localization becoming a positive therapy localization after the procedure (83%); and for a positive therapy localization to stay positive (75%).

CONCLUSIONS

Although this study was obtained with limited numbers of subjects, the results are striking enough to suggest certain things.

First of all, it is apparent that the electromagnetic status of the doctor will markedly affect the data that he obtains with certain procedures. Thus, it can be concluded that doctors need to be treated. This especially applies to doctors who have difficulty obtaining positive AK findings regardless of their dedication to lengthy sessions of training to develop their

technical expertise in artful muscle testing. It is also suggested that if a doctor can not reproduce a procedure that he sees another doctor perform, then one possibility is that the doctor who can not reproduce the procedure is in lesion.

The posture of the ICAK has been to endorse only those procedures that seem to be almost universally reproducible. This is probably wise as a general way to reduce the amount of erroneous data obtained by the doctor. It is, however, not giving the whole story to simply label a procedure as unreproducible or dependent on the projection of certain mental postulates, and not to investigate fully the phenomena that make it reproducible under some circumstances and not others. Failure to do so will only lead to more and more defensiveness and devisiveness among practitioners of AK, as certain sincere practitioners have their fondest discoveries and developments totally and wordlessly disregarded by those representing AK mainstream thought. Within this category of insufficiently investigated phenomena fall the testing of nutrients, herbs, and homoeopathic remedies in the mouth versus on the body. There is much room for objective investigation and honest egoless communication among practitioners of chiropractic, and this would be exceptionally valuable within ICAK.

REFERENCES

1- Engel, David P., D.C., **Testing Consistency Among Experienced Applied Kinesiologists**, Collected Papers of the Members of the International College of Applied Kinesiology, Park City, Utah: ICAK, Summer 1985, pp 107-113.

2- Schmitt, Walter H., Jr., D.C., **Muscle Testing As Functional Neurology; Differentiating Functional Upper Motorneuron and Functional Lower Motorneuron Problems**, Collected Papers of the

Members of the International College of Applied Kinesiology, Shawnee Mission, Kansas: ICAK, Winter 1985, pp 325-353.

3- Beardall, Alan G., D.C., **Clinical Kinesiology Biocomputer Hand Modes**, Lake Oswego, Oregon: Clinical Kinesiology, 1984, pp 7.

4- Beardall, Alan G., D.C., **Clinical Kinesiology Systemic Acute Therapy**, Lake Oswego, Oregon: Clinical Kinesiology, 1985, pp 24.

ABSTRACT:

A pattern of patient orientation is presented using charts, modules, x-rays, a light, etc. The author believes that patient acquaintance with neuroanatomy and physiology is essential to convert the patient to our management model.

This is a report with embellishment of material presented to ICAK in 1976. A sort of anniversary re-issue.

Originality - "The ability to conceal one's sources".

PATIENT ORIENTATION - George N. Koffeman, D.C.

During a practice spanning 35-plus years, I have accumulated some "tools" for enlarging patient knowledge of what we do. First presented to ICAK in 1976, the material in a more inclusive format may be helpful to some of the younger members.

- Equipment
- (1) X-ray illuminators with patient's films
 - (2) Charts:
 - (a) Voluntary nervous system
 - (b) Muscles
 - (c) Autonomic nervous system
 - (d) Reostated light
 - (e) About 15 dominoes
 - (f) A board with chalk or colored markers

Report of Findings - whatever is usually done down to showing radiographs. In showing films I point out anatomical features - head spine, 7 cervicals, 12 thoracics, 5 lumbar, sacrum, coccyx, two innominates make up pelvis, hip joints, speak about fractures of neck of femur. Show collar bone, shoulder blade, heart, diaphragm, gas in bowels, etc. Next, point out distortions from center of gravity line and rotations.

Next, go to spine model show nerve impingement. Point to chart of voluntary system, show where nerves ramify; examples: upper C into head causing eye trouble, ear trouble, sinus trouble, headaches, etc., lower C - down arms through brachial plexus - causes numbness of hands and fingers, elbow problems (tennis elbow), shoulder problems - bursitis, tendonitis, etc. Nerves emit from thoracic spine ramify

between ribs, may cause chest pains, on left side may mimic heart problems, out of lumbar spine give belly pains. Lower lumbar and sacral plexus down leg causing foot, ankle, knee, hip problems and sciatica. This nervous system is the voluntary nervous system - if I want to pick something up, I activate the nerves here (brachial plexus) and lift it. That is under my control because this part of the nervous system controls the muscles of the body. That is why it is called the voluntary system (point to appropriate charts). But, coming off from these nerve trunks (point to spinal nerves) is this set of nerve tissue which goes to this set of nerve tissue along each side of spine called the ganglionated chain; one on each side of the spine (point to autonomic chart.)

The ganglionated chain is the autonomic nervous system. It is called autonomic because it is automatic. It runs the organs and tissues of the body. (Give examples - heart in running, stomach when eating.) Autonomic is divided into parasympathetic and sympathetic. Parasympathetic slows things down; sympathetic speeds things up. Good health is like two kids on a teeter. If they weigh 100 lbs. each they can function. If one weighs 80 and the other 100, they don't teeter well. Then, the light kid hollers to his mother/father (depends on whether patient is female or male) and says, "I can't teeter." Mom/dad pumps the light side of the teeter board for a while. Then he/she gets tired and says, "Go slide." That's medicine! Medicine looks at you organ by organ, (point to chart) and says, you have heart irregularity - her's digitalis, you have lung problems - here's adrenalin, you have an ulcer - her's a soup and slop diet and an alkalizer, you have constipation (which they caused with the ulcer treatment), here's a laxative. What the doctor is doing is trying to force normal action on organs by introducing foreign chemicals (not drugs) into the body without any regard for what's happening here (point to the spine). When you come to the chiropractor, kinesiologist, whatever, his interest is focused in this area (point to the spine.) He traces down interferences to normal functioning of your nervous system (point to a nerve.) This nerve could be impinged and it might only give you some pain around the abdomen, or it might travel upward three segmental levels out through this plexus and over a 25 year period give you a heart attack, or it could travel down as far as three segmental levels, go through this plexus, (point) and give you a bowel abscess, and be the very same nerve.

We mentioned before the parasympathetic/sympathetic nervous system - people should be balanced so that they can shift back and forth as body needs dictate (athletics, sympathetic; digestion, parasympathetic, etc.)

Many people become dominant in one or the other nervous component. These people have certain disease patterns. The sympathetic dominated patient is the go getter who is going to be president of the company by age 40 and drops dead at 38. He has the early heart attack, stroke, kidney failure, etc. (Montgomery Clift, Wally Cox - embellish as much as you care to here. Give your own examples.)

Parasympathetic dominant person may have asthma, low blood pressure, anemias, later in life, osteoarthritis - this is the little old lady who never had a well day in her life and lived to be 107.

NOW THE LIGHT - Turn the reostated light to medium - say "Mr. and Mrs. X (try to have couples together during report) do you remember that we tested certain muscles and they were weak and when you put your finger on a spot, they became strong? Yes. That was under-function. And do you remember that some muscles were strong but when you put your finger on a spot they became weak? Yes, that was an area of over-function. Now if we look at this light and see this level of function as normal then this (turn up light) is overfunction - abnormal (dim light) and this is under function. A.K. tries to bring this (low) up to here (normal) and bring all functions that are here (high) down to normal, because this is health. You know this if you think about it Mr. X but we usually think of disease in chemical terms. But it can also be viewed as a biomagnetic model. In that context we can illustrate this principle with the light. (High light) In the thyroid this is goiter (low light) and this is hypothyroidism), in the heart this (L) is bradycardia or slow heart and this (H) is tachycardia or rapid heart and in the stomach this (H) is ulcer and this (L) is gastritis and in the pancreas this (L) is diabetes and this (H) is hypoglycemia. In the bowels this (H) is diarrhea, and this (L) constipation.

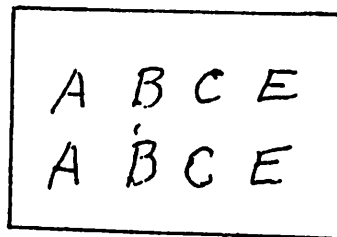
"Medicine is an effect treatment, they try to force nature. They cut rotten spots out of apples but seldom do anything to keep an apple from rotting. Chiropractic and A.K., on the other hand, try to raise the level of total health to a point where if you're healthy, you're not sick! (Light in a dark room, etc.).

GO TO DOMINOES - ask question while setting up about 15 dominoes, now talk stress; knock down first domino (Finger represents any stress! Give AK book on stress.) talk about each domino as cause of next and each after as "effect" until last domino drops producing symptoms. M.D. usually recognizes last domino drop. He says, "Yes, I see the problem, the last domino has dropped, I'll prop it up"; but he does not say that. He says "I'll give you a prescription." - patient feels better, but pressure is still on, down goes last domino and back comes symptoms. M.D. says, "I'll give you another prescription," etc. as long as he can do that, you get along, i.e. feel better symptomatically, but most of the time you are gradually getting worse.

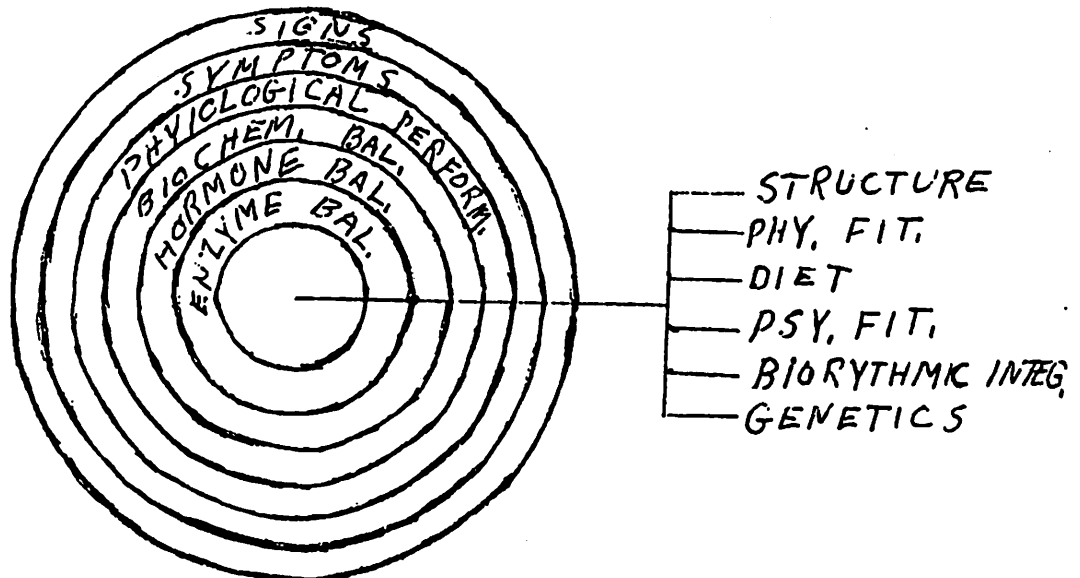
When you come to us we do it this way - (go to 1st domino and set it up, then second, etc. eventually you get to the last and patient is well and with stability!)

Make recommendations for treatment.

Sometime in the course of treatment supplements will come up. Use A B C E chart to explain.



Use modified Cheraskin chart to explain factors that maintain health. (Usually the more intelligent patients or those with unusual interest in what you do).



Profession Outline of the "Heilpraktiker"

Matthias Lesch, HP

Alfred Schatz, HP

At the annual meeting in Santa Monica in 1985 some members of the ICAK suggested to us to give a description of our profession in the form of a paper because we are not chiropractors, a profession that does not exist in Germany, and because the majority of the members of the ICAK does not know the profession of the "Heilpraktiker".

In Germany there are three professions with the permission to diagnose and treat independently: the medical practitioner, the dentist and the "Heilpraktiker". Compared to the medical practitioner the "Heilpraktiker" is subject to certain limitations:

He is not entitled to order the use of drugs available only on prescription by medical practitioners, to treat certain infectious and venereal diseases and to assist at a birth. Otherwise, he is authorized to do anything a medical practitioner can do, e.g. to give injections and infusions or to carry out X-ray examinations. In practice the "Heilpraktiker" concentrates on alternative cures such as natural cures, homeopathy, acupuncture, chiropractic, magnetic therapy, ozone therapy, dietetics etc. The training of the "Heilpraktiker" lasts 3 - 4 years at the various schools, then the examination at the public health department must be passed and the authorization must be granted.

The classic nature healing itself is to be seen as a reaction, as an alternative to the development of a purely causal-analytical, scientific medicine. It is the creation of three ingenious "Heilpraktiker" and a few

medical practitioners stigmatized as outsiders.

In the middle of the last century the farmer Vinzenz Prießnitz (1799) became the new founder of the modern hydrotherapy, Arnold Rikli the founder of the light, air and sun treatment and Johann Schroth founded a dietetic therapy based on nature healing. In the period following and up to the present, "Heilpraktiker" - such as J.H.Rausse, Th.Hahn, Eduard Baltzer, Louis Kuhne, Parish Priest Kneipp, Vicar Felke, Herm.Canitz and many others and a number of distinguished medical outsiders have further developed the nature healing methods.

The essence, the core of the profession of the "Heilpraktiker" is identical with the fundamental philosophy of nature healing. The diagnosis and therapy of the "Heilpraktiker" are based on the holistic view of man, on the psychosomatic indivisibility of man and contrasts with the mainly local-pathological, system-oriented philosophy of the analytical-scientific medicine. The "Heilpraktiker" is quite aware of the fact that the holistic view and the concepts of disease and cure, life and death are, after all, metaphysical concepts and consequently defy a causal-analytical interpretation. The holistic philosophy of the "Heilpraktiker", however, is not restricted of the view of man as a psychosomatic unity (whole), but consciously sees man in the higher unity of life community and nature; it starts from the indivisibility of inner life and environment, of nature and cosmos.

The profession of the "Heilpraktiker" is acknowledged by the German public. An investigation has shown that about 60 % of the German

population have already been treated by a "Heilpraktiker" and 25 % are treated regularly.

The Applied Kinesiology can be excellently integrated into the area of responsibility of the "Heilpraktiker", because the chiropractic profession does not exist in Germany and the chiropractic methods are only used by the "Heilpraktiker" and some physiotherapists and medical practitioners. Only about 900 of the 170.000 medical practitioners in Germany are interested in alternativ healing methods, so it is the task of about 7000 "Heilpraktiker" and 18.000 physiotherapists to make use of the beneficial potential of the AK in future and to improve the well-being of their patients in practice.

APPLIED KINESIOLOGY AND REIKI

Nancy L. McBride, D.C.

ABSTRACT: A clinical study involving observable improvement in the overall condition of tested patients who were exposed to Reiki energy therapy and evaluated by Applied Kinesiology muscle testing procedures.

Introduction: As you are probably aware California abounds with all kinds of therapies mystical and abstract as well as those based on very sound and practical principles. I hear of so many different types of approach to healing weekly that I think I am sometimes immune and wouldn't be open to recognize a truly useful method or therapy. My practice is blessed with professional and intelligent free thinkers however, and in the case of Reiki therapy this was my saving grace. Several of my patients have been involved in learning the technique called Reiki energy therapy. In the words of Barbara Ray, Ph.D., founder of the American Reiki Association and Reiki Center in Atlanta, Georgia, "Reiki is a technique for connecting oneself to life-force energy and for applying this energy. Reiki is in its essence a freeing, liberating, healing natural energy."

Reiki originated in the Far East centuries ago and was unknown in the Western world until Dr. Ray discovered it through an elderly Japanese woman who trained Dr. Ray in the complete Reiki system. The ancient technique of Reiki has re-emerged as a transformative tool for energy balancing, for natural healing, for wholing, and for creating peace, joy, love, and ultimately, for achieving higher consciousness and enlightenment.

Tony Moscato, a dear friend and also one of my patients, who is a trained Reiki therapist, approached me about the possibility of doing a research project together. He asked me if there was a method of evaluating patients and then reevaluating them after they had been given a Reiki therapy treatment. Of course Applied Kinesiology lends itself very nicely to this

kind of investigation.

In lieu of what Tony had told me about Reiki therapy and the benefits that could be derived from the Reiki energy treatment I wanted to find out if a Reiki energy therapy was given to a patient without any kinesiologic balancing techniques being done first, would any of the previously found weaknesses be abolished. I picked what are known in our business as "basket cases". We decided to use twelve patients. Some of the people chosen were new patients to my office and some were indoctrinated and seasoned A-K patients. All of the people used in the study had multiple areas of complaint such as pain in a hip-leg, lower back pain, sacro-iliac area pain, neck pain, headaches, tension and so on. We only used people who during a routine exam of muscle testing showed weakness in many areas. I simply recorded on my treatment record what I found during the examination phase. I then took the patient into another room with Tony Moscato and he proceeded with the Reiki treatment. I was not present during the Reiki session. After the session was completed I came into the room and began to reevaluate the patient testing again only those muscles which had previously tested weak.

The results were outstanding. In every single case the previously weak muscles now tested strong. I had also tested some of the patients for ileo-cecal valve involvement, sacro-iliac affection and fixation patterns. Regardless of what had previously shown up as weak or needing adjusting or balancing, if you will, after the treatment it was not there, "in the clear". I did not leave these patients without any further treatment but had my assistant do all the N-E, N-V, and acupressure balancing we would have done under normal circumstances. I did not do any manipulation on the patients because none of them would challenge as needing it at that time. I do not know how long it lasts.

REFERENCES

- 1
Walther, David S. APPLIED KINESIOLOGY - THE ADVANCED APPROACH IN CHIROPRACTIC.
Systems D.C. Pueblo, Co. 1976
- 2
Ray, Barbara THE REIKI FACTOR. Radiance Associates St. Petersburg, Fl. 1985
- 3
Ray, Barbara THE OFFICIAL REIKI HANDBOOK. A.I.R.A. Atlanta, Ga. 1982

LOW BACK PAIN REPORT

Richard MELDENER D.C.

Diplomate I.C.A.K.

ABSTRACT:

A patient with a residual low back pain was relieved by exchanging his poorly fitting glasses with contact lenses.

E.S. is a 19 years old male student who has been consulting for a chronic low back pain. He has improved 70% with A.K. but still complains about 30% residual pain which appears at the end of the day.

The idea came to me of a possible visual nociceptive impulse which could be present and trigger the low back.

E.S. is wearing glasses & has no visual complains. His glasses which he wears all the time appear to adequately compensate for his myopia. Both himself & the Optometrist are satisfied with the glasses he currently uses.

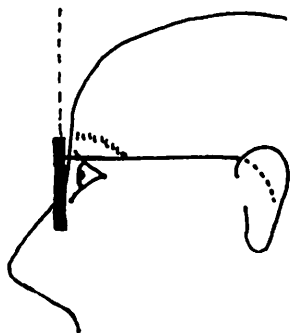
Upon A.K. examination my attention is attracted by the position where the frame of the glasses sits on his nose. It does not allow for the opticals to maintain against the orbits.

LOW BACK PAIN REPORT

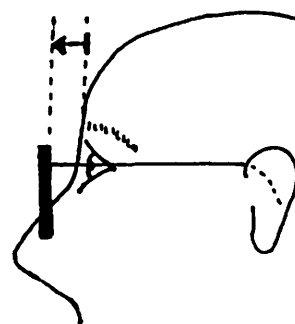
Richard MELDENER D.C

Page N°2

In contrario, the frame have the tendency to slide 1 cm toward the tip of the nose particularly when the patient reads or writes which he does at least 8 to 10 hours a day.



Good frame position



1 Cm anterior frame position

A.K. examination proceeds by instructing the patient to read a magazine with his glasses on. The patient is sitting on a chair & the magazine is laying in front of him on a desk at 33 Cms away from his eyes.

The glasses are in the habitual 1 Cm down the nose position. Right & then left deltoid are muscle tested while he is reading. they are both found to be weak under this testing condition. During this reading test the following observation are made

The patient is switched, upper cervical pain is present and bilateral gluteus maximus weakness is found. Lumbar 5 Therapy localizes and palpates painfull.

All these various indicators disappears within 30 seconds as soon as the patient continues to read with the glasses maintained with the index finger in the glabellar position where they have been designed to be.

LOW BACK PAIN REPORT

Richard MELDENER D.C

Page N° 3

The patient cannot wear the glasses without having them slide 1 Cm toward the tip of his nose .

As soon as he reads or writes, the frame does not stay at the glabella & drops anterior.

He has developed the habit of pushing the frame back with his index finger thousands of time per day.

The patient is advised for treatment to consult an optician for adjustment of the branches for better fitting around his ears.

In this case the adjustment of the branches of the glasses did not succeed to prevent them from dropping on the tip of the patient's nose as it did before.

Some noses belong to a morphology which makes glasses frames difficult to stay where they should belong by the glabella.

Patient E.S. was advised to use contact lenses which he has now for several months & has been low back pain free since.

Malocclusion & Iatrogenic
Side Effects.

Richard MELDENER D.C.

In the Summer 1984 issue of the Collected Papers of the Members of the I.C.A.K. I wrote an article entitled: " Malocclusion & Iatrogenic Side Effects."

In this article an error of terminology was introduced.

The word "Discovery" was used Page N°207 line before last & Page N° 213 last paragraph.

It should not have appeared in this two instances.

The word: "Observation" should have been used instead.

HAIR SAMPLES AND STRESS FRACTURES IN RUNNERS
by Gordon D. Mendenhall, DC

ABSTRACT: Hair analysis samples were collected on ten runners who had stress fractures of the legs and feet which were proven on x-rays (bone scans). These runners' mileage averaged from 60 to 100 plus miles per week. Hair analyses were also done on runners and non-runners with injuries to the same areas but with non-stress fracture diagnosis.

The non-stress injuries consisted of two female soccer players with trauma injuries to their metatarsals (see results #1A and 1B). One lady had a fracture to the ribs due to osteoporosis (result #1C). One lady age 40 walked three miles per day (result #A). Letters B-F are all runners; runners B,E,F, all had injuries to the ankles and E also had a plantar fascia problem. Letters C and D are a husband and wife. C had no injury at this time, but D, who did the 200 and 400yd. dash had a hamstring problem.

No conclusion is drawn from this data as it is presented here for general information. Some of the factors which can influence an injury are types of shoes, style of running, type of training (track or road work), speed or non-speed work, hills verses non-hills, and number of races per month, etc.

When collecting data on running injuries one has to make sure the runner has seen a doctor and that the doctor has not made an educated guess regarding the type of injury. There should be x-rays taken such as bone scans. Also, hair samples should be taken within a limited time after the injury has occurred and has been diagnosed.

All hair samples were tested at Parmae Laboratories in Dallas, Texas.

1

Stress fracture

218

LOG #
DATE

PATIENT	AGE: 36	SEX: M	DOCTOR: GORDON D. MENDENHALL, DC
			NAT. HAIR COLOR: BRN
TINT:			

ESSENTIAL ELEMENTS	L	N	H	RESULT (mg%)	NORMAL RANGE	LOW	OPTIMUM	HIGH	OFF CHART
CALCIUM			*	103.	32- 72				*
MAGNESIUM	*			2.	3.2- 7.2				
SODIUM		*		37.	17- 62				*
POTASSIUM	*			5.	16- 46				
COPPER	*			1.	1.2- 3.2				
ZINC	*			12	13- 21				
PHOSPHORUS		*		13.	9- 15				*
IRON	*			.8	1.8- 4.5				
MANGANESE	*			.03	.07- .23				
CHROMIUM		*		.04	.07- .08				*
NICKEL	*			.1	.15- .45				
SELENIUM		*		.12	.07- .12				*

TOXIC ELEMENTS	L	N	H	RESULT	NORMAL RANGE	LOW	MODERATE	HIGH
ARSENIC		*		.01	.01- .03			
MERCURY		*		.08	.01- .2			
CADMIUM		*		.04	.01- .15			
LEAD		*		.2	.1- 2			

OTHER ELEMENTS (Essentiality - Toxicity not well documented)	L	N	H	RESULT	NORMAL RANGE	LOW	MODERATE	HIGH
ALUMINUM		*		.2	.01- 2			
SILICON		*		.16	.03- .25			
COBALT		*		.05	.07- .16			
LITHIUM		*		.01	.01- .03			

SIGNIFICANT RATIOS	L	N	H	RATIO	RESULT	LOW	OPTIMUM	HIGH
1 Ca to Mg			*		51.5		*****	*
2 Ca to Zn			*		8.6		*****	*
3 Zn to Cu			*		12.0		*****	*
4 Na to K			*		6.8		*****	*
5 Fe to Mn		*			25.7		**	
6 Ca to Cu			*		103.0		*****	*
7 Ca to P			*		7.9		*****	*
8 Zn to Fe			*		15.0		*****	*
9 Fe to Cu	*				.8		*****	*
10 Fe to Pb		*			4.0		*	
Ca to Fe			*		128.8		*****	*
Mg to P	*				.2		*****	*
Zn to Mn			*		400.0		*****	*
K to Fe	*				6.3		*****	*
Pb to Mn		*			6.7		*	
Ca to Pb			*		515.0		*****	*
Zn to Cr		*			300.0		*	
Zn to Cd		*			300.0		*	
Zn to Mg			*		6.0		*****	*
P to Al	*				65.0		*	

2

rc, stress fracture.

LOG # :
DATE REPC

PATIENT:	DOCTOR: GORDON D. MENDENHALL, DC
AGE: 35	NAT. HAIR COLOR: BLD
SEX: M	TINT:

ESSENTIAL ELEMENTS	L	N	H	RESULT (mg%)	NORMAL RANGE	LOW	OPTIMUM	HIGH	OFF CHART
CALCIUM	*			25.	32- 72	Co	*		
MAGNESIUM	*			2.	3.2- 7.2	Mg	*		
SODIUM	*			15.	19- 62	Na	*		
POTASSIUM	*			12.	16- 46	K	*		
COPPER			*	7.4	1.2- 3.2	Cu			*
ZINC		*		14	13- 21	Zn	*		
PHOSPHORUS		*		14.	9- 15	P	*		
IRON	*			1.6	1.8- 4.5	Fe	*		
MANGANESE		*		.07	.07- .23	Mn	*		
CHROMIUM		*		.04	.04- .08	Cr	*		
NICKEL		*		.3	.15- .45	Ni	*		
SELENIUM		*		.04	.04- .12	Se	*		

Co Mg No K Cu Zn P Fe Mn Cr Ni Se

TOXIC ELEMENTS	L	N	H	RESULT	NORMAL RANGE	LOW	MODERATE	HIGH
ARSENIC		*		.01	.01- .03	As	*	
MERCURY			*	.24	.01- .2	Hg		*
CADMIUM		*		.04	.01- .15	Cd	*	
LEAD		*		.4	.1- 2	Pb	*	

As Hg Cd Pb

OTHER ELEMENTS (Essentiality -Toxicity not well documented)	L	N	H	RESULT	NORMAL RANGE	MODERATE	HIGH
ALUMINUM		*		.8	.01- 2	Al	*
SILICON		*		.09	.08- .25	Si	*
COBALT		*		.11	.04- .16	Co	*
LITHIUM		*		.01	.01- .03	Li	*

Al Si Co Li

SIGNIFICANT RATIOS	L	N	H	RESULT	LOW	OPTIMUM	HIGH
Ca to Mg		*		12.5		***	
Ca to Zn	*			1.8	*****		
Zn to Cu	*			1.9	*****		
Na to K		*		1.3		*	
Fe to Mn		*		22.9		*	
Ca to Cu	*			3.4	*****		
Ca to P	*			1.8	*****		
Zn to Fe			*	8.8		*****	
Fe to Cu	*			.2	*****		
Fe to Pb		*		4.0		*	
Ca to Fe		*		15.6		*	
Mg to P	*			.1	*****		
Zn to Mn			*	200.0		*****	
K to Fe		*		7.5		*****	
Pb to Mn		*		5.7		***	
Ca to Pb		*		62.5		*	
Zn to Cr		*		350.0		****	
Zn to Cd		*		350.0		*	
Zn to Mg			*	7.0		*****	
P to Al		*		17.5		*	

7
6
5

3

stress fracture, foot

220

LOG #:

DATE REP:

PATIENT		DOCTOR: GORDON D. MENDENHALL, DC	
AGE: 41	SEX: M	NAT. HAIR COLOR: BRN	TINT:

ESSENTIAL ELEMENTS	L	N	H	RESULT (mg%)	NORMAL RANGE	LOW	OPTIMUM	HIGH	OFF CHART
CALCIUM		*		35.	32-72		*		
MAGNESIUM	*			2.	3.2-7.2	*			
SODIUM		*		23.	19-62		*		
POTASSIUM	*			15.	16-46		*		
COPPER		*		1.7	1.2-3.2		*		
ZINC		*		17	13-21		*		
PHOSPHORUS		*		13.	9-15		*		
IRON	*			1.7	1.8-4.5		*		
MANGANESE	*			.05	.07-.23	*			
CHROMIUM	*			.01	.04-.08		*		
NICKEL		*		.2	.15-.45		*		
SELENIUM		*		.04	.04-.12		*		

Ca Mg No K Cu Zn P Fe Mn Cr Ni Se

TOXIC ELEMENTS	L	N	H	RESULT	NORMAL RANGE	LOW	MODERATE	HIGH
ARSENIC		*		.01	.01-.03	*		
MERCURY		*		.06	.01-.2		*	
CADMIUM		*		.03	.01-.15		*	
LEAD		*		.3	.1-2		*	

As Hg Cd Pb

OTHER ELEMENTS (Essentiality - Toxicity not well documented)	L	N	H	RESULT	NORMAL RANGE	LOW	MODERATE	HIGH
ALUMINUM		*		.7	.01-2		*	
SILICON	*			.02	.08-.25	*		
COBALT		*		.09	.04-.16		*	
LITHIUM		*		.01	.01-.03		*	

Al Si Co Li

SIGNIFICANT RATIOS	L	N	H	RESULT	LOW	OPTIMUM	HIGH
Ca to Mg			*	17.5		*****	
Ca to Zn	*			2.1		*****	
Zn to Cu		*		10.0		***	
Na to K		*		1.5		*	
Fe to Mn		*		34.0		****	
Ca to Cu		*		20.6		***	
Ca to P	*			2.7		*****	
Zn to Fe			*	10.0		*****	
Fe to Cu	*			1.0		*****	
Fe to Pb		*		5.7		*	
Ca to Fe		*		20.6		**	
Mg to P	*			.2	*****		
Zn to Mn			*	340.0		*****	
K to Fe		*		8.8		**	
Pb to Mn		*		6.0		**	
Ca to Pb		*		116.7		*	
Zn to Cr			*	1700		*****	
Zn to Cd		*		566.7		***	
Zn to Mg			*	8.5		*****	
P to Al		*		18.6		*	

Stress fracture, foot

4

LOG #
DATE REF

221

PATIENT	DOCTOR: GORDON D. MENDENHALL, DC
AGE 31 SEX F	NAT. HAIR COLOR BRN TINT

ESSENTIAL ELEMENTS	L	N	H	RESULT (mg%)	NORMAL RANGE	LOW	OPTIMUM	HIGH	OFF CHART
CALCIUM		*		86.	40- 87				*
MAGNESIUM			*	22.	6- 10				*
SODIUM	*			14.	19- 42		*		
POTASSIUM	*			13.	16- 46		*		
COPPER			*	7.1	1.2- 3.2				*
ZINC	*			10	15- 21		*		
PHOSPHORUS		*		12.	9- 15		*		
IRON	*			1.2	2.7- 5.5		*		
MANGANESE		*		.15	.07- .23		*		
CHROMIUM			*	.09	.04- .08		*		
NICKEL		*		.3	.15- .45		*		
SELENIUM		*		.06	.04- .12		*		

TOXIC ELEMENTS	L	N	H	RESULT	NORMAL RANGE	LOW	MODERATE	HIGH
ARSENIC		*		.01	.01- .03	*		
MERCURY			*	.21	.01- .2		*	
CADMIUM	*			.07	.01- .15		*	
LEAD	*			.8	.1- 2		*	

OTHER ELEMENTS (Essentiality - Toxicity not well documented)	L	N	H	RESULT	NORMAL RANGE	LOW	MODERATE	HIGH
ALUMINUM		*		.9	.01- 2		*	
SILICON		*		.14	.08- .25		*	
COBALT	*			.07	.04- .16		*	
LITHIUM	*			.01	.01- .03	*		

SIGNIFICANT RATIOS	L	N	H	RATIO	RESULT	LOW	OPTIMUM	HIGH
Ca to Mg	*				3.9		*****	
Ca to Zn			*		8.6		*****	
Zn to Cu	*				1.4		*****	
Na to K		*			1.1		****	
Fe to Mn	*				8.0		*****	
Ca to Cu	*				12.1		*****	
Ca to P			*		7.2		*****	
Zn to Fe			*		8.3		*****	
Fe to Cu	*				.2		*****	
Fe to Pb	*				1.5		*****	
Ca to Fe			*		71.7		*****	
Mg to P			*		1.8		*****	
Zn to Mn	*				66.7		*****	
K to Fe		*			10.8		*****	
Pb to Mn		*			5.3		****	
Ca to Pb		*			107.5		*	
Zn to Cr	*				111.1		*****	
Zn to Cd	*				142.9		*****	
Zn to Mg	*				.5		*****	
P to Al		*			13.3		*	

5

Stress fracture, leg

222

LOG # :
DATE REF

PATIENT		DOCTOR: GORDON D. MENDENHALL, DC	
AGE: 36	SEX: M	NAT. HAIR COLOR: BRN	TINT.

ESSENTIAL ELEMENTS	L	N	H	RESULT (mg%)	NORMAL RANGE	LOW	OPTIMUM	HIGH	OFF CHART
CALCIUM		*		50.	32- 72		*		
MAGNESIUM		*		4.	3.2- 7.2		*		
SODIUM	*			10.	19- 62	*			
POTASSIUM	*			9.	16- 46	*			
COPPER			*	5.3	1.2- 3.2			*	
ZINC		*		19	13- 21		*		
PHOSPHORUS		*		12.	9- 15		*		
IRON	*			1.1	1.8- 4.5	*			
MANGANESE	*			.03	.07- .23	*			
CHROMIUM	*			.01	.04- .08		*		
NICKEL	*			.1	.15- .45	*			
SELENIUM			*	.16	.04- .12			*	

TOXIC ELEMENTS	L	N	H	RESULT	NORMAL RANGE	LOW	MODERATE	HIGH
ARSENIC		*		.01	.01- .03	*		
MERCURY		*		.02	.01- .2	*		
CADMIUM		*		.05	.01- .15		*	
LEAD		*		.3	.1- 2	*		

OTHER ELEMENTS (Essentiality -Toxicity not well documented)	L	N	H	RESULT	NORMAL RANGE	LOW	MODERATE	HIGH
ALUMINUM		*		.8	.01- 2		*	
SILICON	*			.02	.08- .25	*		
COBALT		*		.06	.04- .16		*	
LITHIUM		*		.01	.01- .03		*	

SIGNIFICANT RATIOS	L	N	H	RESULT	LOW	OPTIMUM	HIGH
Ca to Mg		*		12.5		***	
Ca to Zn		*		2.6		****	
Zn to Cu	*			3.6	*****		
Na to K		*		1.1		***	
Fe to Mn		*		36.7		*****	
Ca to Cu	*			9.4	*****		
Ca to P		*		4.2		*	
Zn to Fe			*	17.3		*****	
Fe to Cu	*			.2	*****		
Fe to P			*	3.7		*	
Ca to Fe			*	45.5		*****	
Mg to P	*			.3		*****	
Zn to Mn			*	633.3		*****	
K to Fe		*		8.2		****	
Pb to Mn		*		10.0		**	
Ca to Pb		*		166.7		**	
Zn to Cr			*	1900		*****	
Zn to Cd			*	380.0		*	
Zn to Mg			*	4.8		*****	
P to Al		*		15.0		*	

6 Stress fracture

LOG #
DATE REF

PATIENT				DOCTOR	GORDON D. MENDENHALL, DC	
AGE	38	SEX	M	NAT HAIR COLOR	BRN	TINT

ESSENTIAL ELEMENTS	L	N	H	RESULT (mg%)	NORMAL RANGE	LOW	OPTIMUM	HIGH	OFF CHART
CALCIUM			*	92.	32- 72	Co			*
MAGNESIUM		*		5.	3.2- 7.2	Mg			*
SODIUM		*		22.	19- 62	Na			*
POTASSIUM		*		16.	16- 46	K			*
COPPER		*		1.6	1.2- 3.2	Cu			*
ZINC		*		16	13- 21	Zn			*
PHOSPHORUS		*		13.	9- 15	P			*
IRON		*		1.8	1.8- 4.5	Fe			*
MANGANESE		*		.1	.07- .23	Mn			*
CHROMIUM		*		.04	.04- .08	Cr			*
NICKEL		*		.3	.15- .45	Ni			*
SELENIUM	*			.02	.04- .12	Se			/*

TOXIC ELEMENTS	L	N	H	RESULT	NORMAL RANGE	LOW	MODERATE	HIGH
ARSENIC		*		.01	.01- .03	As		*
MERCURY		*		.09	.01- .2	Hg		*
CADMIUM		*		.05	.01- .15	Cd		*
LEAD		*		.5	.1- 2	Pb		*

OTHER ELEMENTS (Essentiality - Toxicity not well documented)	L	N	H	RESULT	NORMAL RANGE	LOW	MODERATE	HIGH
ALUMINUM		*		.7	.01- 2	Al		*
SILICON	*			.02	.08- .25	Si		*
COBALT		*		.14	.04- .16	Co		*
LITHIUM		*		.01	.01- .03	Li		*

SIGNIFICANT RATIOS	RATIO	L	N	H	RESULT	LOW	OPTIMUM	HIGH
Ca to Mg				*	18.4		*****	
Ca to Zn				*	5.8		*****	
Zn to Cu			*		10.0		***	
Na to K			*		1.4		*	
Fe to Mn			*		18.0		***	
Cu to Co			*		57.5		*****	
Ca to P			*		7.1		*****	
Zn to Fe			*		8.9		*****	
Fe to Cu			*		1.1		*****	
Fe to Pb			*		3.6		*	
Ca to Fe			*		51.1		*****	
Mg to P			*		.4		***	
Zn to Mn			*		160.0		****	
K to Fe			*		8.9		**	
Pb to Mn			*		5.0		****	
Ca to Pb			*		184.0		**	
Zn to Cr			*		400.0		*****	
Zn to Cd			*		320.0		*	
Zn to Mg			*		3.2		*	
P to Al			*		18.6		*	

7

stress fracture, leg

224

LOG #
DATE REP

PATIENT: 18 AGE: 18 SEX: F
 DOCTOR: GORDON D. MENDENHALL, DC
 NAT. HAIR COLOR: BLD
 TINT:

ESSENTIAL ELEMENTS	RESULT	UNIT	LOW	NORMAL RANGE	HIGH	OFF CHART
CALCIUM	88	mg %	40-87			
MAGNESIUM	4	mg %	6-10			
SODIUM	163	mg %	19-62			
POTASSIUM	67	mg %	16-46			
COPPER	2.4	mg %	1.2-3.2			
ZINC	11	mg %	15-21			
PHOSPHORUS	13	mg %	9-15			
IRON	2.4	mg %	2.7-5.5			
MANGANESE	0.06	mg %	0.07-0.23			
CHROMIUM	0.07	mg %	0.04-0.08			
NICKEL	0.3	mg %	0.15-0.45			
SELENIUM	0.04	mg %	0.04-0.12			

TOXIC ELEMENTS	RESULT	UNIT	LOW	MODERATE	HIGH
ARSENIC	0.01	mg %	0.01-0.03		
MERCURY	0.09	mg %	0.01-0.2		
CADMIUM	0.04	mg %	0.01-0.15		
LEAD	0.2	mg %	0.1-2		

OTHER ELEMENTS (Essentially - Toxicity not well documented)	RESULT	UNIT	MODERATE	HIGH
ALUMINUM	0.6	mg %	0.01-2	
SILICON	0.03	mg %	0.08-0.25	
COBALT	0.07	mg %	0.04-0.16	
LITHIUM	0.01	mg %	0.01-0.03	

SIGNIFICANT RATIOS	RESULT	UNIT	LOW	OPTIMUM	HIGH
Co to Mg	22.0				
Co to Zn	8.0				
Zn to Cu	4.6				
Na to K	2.4				
Fe to Mn	40.0				
Ca to Cu	36.7				
Ca to P	6.8				
Zn to Fe	4.6				
Fe to Cu	1.0				
Fe to Pb	12.0				
Co to Fe	36.7				
Mg to P	3				
Zn to Mn	183.3				
K to Fe	27.9				
Pb to Mn	3.3				
Ca to Pb	440.0				
Zn to Cd	275.0				
Zn to Mg	2.8				
P to Al	21.7				

8

Stress fracture, leg

LOG # 225
DATE RI

PATIENT: _____	DOCTOR: GORDON D. MENDENHALL, DC
AGE 31 SEX F	NAT. HAIR COLOR: BRN TINT: _____

ESSENTIAL ELEMENTS	L	N	H	RESULT (mg%)	NORMAL RANGE	LOW	OPTIMUM	HIGH	OFF CHART
CALCIUM			*	97.	40-87	Ca	*		
MAGNESIUM		*		6.	6-10	Mg	*		
SODIUM		*		20.	19-62	Na	*		
POTASSIUM	*			7.	16-46	K	*		
COPPER			*	8.3	1.2-3.2	Cu	*		
ZINC		*		21	15-21	Zn	*		
PHOSPHORUS		*		13.	9-15	P	*		
IRON	*			1.4	2.7-5.5	Fe	*		
MANGANESE		*		.08	.07-.23	Mn	*		
CHROMIUM		*		.07	.04-.08	Cr	*		
NICKEL		*		.2	.15-.45	Ni	*		
SELENIUM	*			.02	.04-.12	Se	*		

TOXIC ELEMENTS	L	N	H	RESULT	NORMAL RANGE	LOW	MODERATE	HIGH
ARSENIC		*		.02	.01-.03	As	*	
MERCURY		*		.12	.01-.2	Hg	*	
CADMIUM		*		.07	.01-.15	Cd	*	
LEAD		*		1.5	.1-2	Pb	*	

OTHER ELEMENTS (Essentiality - Toxicity not well documented)	L	N	H	RESULT	NORMAL RANGE	MODERATE	HIGH
ALUMINUM		*		.7	.01-2	Al	*
SILICON		*		.1	.08-.25	Si	*
COBALT		*		.11	.04-.16	Co	*
LITHIUM		*		.01	.01-.03	Li	*

SIGNIFICANT RATIOS	L	N	H	RESULT	LOW	OPTIMUM	HIGH
Ca to Mg			*	16.2		*****	
Ca to Zn			*	4.6		*****	
Zn to Cu	*			2.5		*****	
Na to K			*	2.9		*****	
Fe to Mn	*			17.5		*****	
Ca to Cu	*			11.7		*****	
Ca to P			*	7.5		*****	
Zn to Fe			*	15.0		*****	
Fe to Cu	*			.2		*****	
Fe to Pb	*			.9		*****	
Ca to Fe			*	69.3		*****	
Mg to P	*			.5		*****	
Zn to Mn			*	262.5		*****	
K to Fe	*			5.0		*****	
Pb to Mn			*	18.8		*****	
Ca to Pb		*		64.7		*	
Zn to Cr		*		300.0		*	
Zn to Cd		*		300.0		*	
Zn to Mg		*		3.5		*****	
P to Al		*		18.6		*	

9

Stress fracture, leg.
226

LOG #
DATE REPC

PATIENT		DOCTOR	
AGE: 53	SEX: M	GORDON D. MENDENHALL, DC	
		RACE: BLK	TINT: N

ESSENTIAL ELEMENTS	L	N	H	RESULT (mg%)	NORMAL RANGE	LOW	OPTIMUM	HIGH	OFF CHART
CALCIUM		*		38.	32-72		*		
MAGNESIUM	*			3.	3.2-7.2		*		
SODIUM		*		34.	19-62		*		
POTASSIUM		*		17.	16-46		*		
COPPER		*		1.8	1.2-3.2		*		
ZINC	*			11	13-21		*		
PHOSPHORUS		*		10.	9-15		*		
IRON		*		3.5	1.8-4.5		*		
MANGANESE		*		.11	.07-.23		*		
CHROMIUM	*			.03	.04-.08		*		
NICKEL			*	.8	.15-.45				*
SELENIUM	*			.03	.04-.12		*		

TOXIC ELEMENTS	L	N	H	RESULT	NORMAL RANGE	LOW	MODERATE	HIGH
ARSENIC		*		.01	.01-.03	*		
MERCURY		*		.05	.01-.2		*	
CADMIUM		*		.07	.01-.15		*	
LEAD		*		.3	.1-2	*		

OTHER ELEMENTS (Essentiality - Toxicity not well documented)	L	N	H	RESULT	NORMAL RANGE	LOW	MODERATE	HIGH
ALUMINUM		*		.7	.01-2		*	
SILICON		*		.08	.08-.25		*	
COBALT		*		.12	.04-.16		*	
LITHIUM		*		.02	.01-.03		*	

SIGNIFICANT RATIOS	L	N	H	RATIO	RESULT	LOW	OPTIMUM	HIGH
Ca to Mg		*			12.7		***	
Ca to Zn		*			3.5		**	
Zn to Cu	*				6.1		*****	
Na to K		*			2.0		****	
Fe to Mn		*			31.8		****	
Ca to Cu		*			21.1		**	
Ca to F		*			3.8		***	
Zn to Fe	*				3.1		*****	
Fe to Cu		*			1.9		***	
Fe to Pb		*			11.7		***	
Cu to Fe	*				10.9		*****	
Mg to P	*				.3		*****	
Zn to Mn		*			100.0		***	
K to Fe	*				4.9		*****	
Pb to Mn	*				2.7		*****	
Ca to Pb		*			126.7		*	
Zn to Cr		*			366.7		*****	
Zn to Cd	*				157.1		*****	
Zn to Mg		*			3.7		*	
P to Al		*			14.3		*	

10

LOG #
DATE REP

227

PATIENT	DOCTOR	GORDON D. MENDENHALL, DC	
AGE: 51	SEX: M	NAT. HAIR COLOR: GRY	TINT:

3rd met foot

ESSENTIAL ELEMENTS	L	N	H	RESULT (mg%)	NORMAL RANGE	LOW	OPTIMUM	HIGH	OFF CHART
CALCIUM		*		34.	32- 72		*		
MAGNESIUM	*			3.	3.2- 7.2		*		
SODIUM			*	169.	19- 62				*
POTASSIUM		*		35.	16- 46		*		
COPPER		*		2.2	1.2- 3.2		*		
ZINC		*		14	13- 21		*		
PHOSPHORUS		*		10.	9- 15		*		
IRON		*		3.7	1.8- 4.5		*		
MANGANESE		*		.2	.07- .23		*		
CHROMIUM			*	.11	.04- .08			*	
NICKEL		*		.2	.19- .45		*		
SELENIUM		*		.06	.04- .12		*		

TOXIC ELEMENTS	L	N	H	RESULT	NORMAL RANGE	LOW	MODERATE	HIGH
ARSENIC			*	.04	.01- .03			*
MERCURY		*		.09	.01- .2		*	
CADMIUM			*	.24	.01- .15			*
LEAD			*	3.1	.1- 2			*

OTHER ELEMENTS (Essentiality -Toxicity not well documented)	L	N	H	RESULT	NORMAL RANGE	LOW	MODERATE	HIGH
ALUMINUM		*		1.	.01- 2		*	
SILICON		*		.15	.03- .25		*	
COBALT	*			.03	.04- .16		*	
LITHIUM		*		.01	.01- .03		*	

SIGNIFICANT RATIOS	L	N	H	RESULT	LOW	OPTIMUM	HIGH
Ca to Mg		*		11.3		*	
Ca to Zn	*			2.4		*****	
Zn to Cu		*		6.4		*****	
Na to K			*	4.8		*****	
Fe to Mn		*		18.5		***	
Ca to Cu	*			15.5		*****	
Ca to P	*			3.4		*****	
Zn to Fe	*			3.8		*****	
Fe to Cu		*		1.7		*	
Fe to Pb	*			1.2		*****	
Ca to Fe	*			9.2		*****	
Mg to P	*			.3		*****	
Zn to Mn	*			70.0		*****	
K to Fe		*		9.9		*	
Pb to Mn			*	15.5		*****	
Ca to Pb	*			11.0		*****	
Zn to Cr	*			127.3		*****	
Zn to Cd	*			58.3		*****	
Zn to Mg			*	4.7		*****	
P to Al		*		10.0		****	

1-A 228 fracture, soccer

LOG #
DATE

PATIENT A	DOCTOR GORDON D. MENDENHALL, DC
AGE 11 SEX F	NAT. HAIR COLOR BRN TINT.

ESSENTIAL ELEMENTS	L	N	H	RESULT (mg%)	NORMAL RANGE	LOW	OPTIMUM	HIGH	OFF CHART
CALCIUM			*	185.	40- 87	Ca		*	
MAGNESIUM		*		10.	6- 10	Mg		*	
SODIUM		*		42.	19- 62	Na		*	
POTASSIUM		*		22.	16- 46	K	*		
COPPER		*		2.6	1.2- 3.2	Cu		*	
ZINC			*	25	15- 21	Zn		*	
PHOSPHORUS		*		10.	9- 15	P		*	
IRON	*			2.4	2.7- 5.5	Fe	*		
MANGANESE	*			.06	.07- .23	Mn	*		
CHROMIUM	*			.01	.04- .08	Cr	*		
NICKEL		*		.2	.15- .45	Ni	*		
SELENIUM			*	.71	.04- .12	Se			

TOXIC ELEMENTS	L	N	H	RESULT	NORMAL RANGE	LOW	MODERATE	HIGH
ARSENIC		*		.01	.01- .03	As	*	
MERCURY		*		.07	.01- .2	Hg	*	
CADMIUM		*		.05	.01- .15	Cd	*	
LEAD		*		.5	.1- 2	Pb	*	

OTHER ELEMENTS (Essentiality -Toxicity not well documented)	L	N	H	RESULT	NORMAL RANGE	LOW	MODERATE	HIGH
ALUMINUM		*		1.3	.01- 2	Al	*	
SILICON		*		.09	.08- .25	Si	*	
COBALT		*		.08	.04- .16	Co	*	
LITHIUM		*		.01	.01- .03	Li	*	

SIGNIFICANT RATIOS	L	N	H	RESULT	LOW	OPTIMUM	HIGH
Ca to Mg			*	18.5		*****	
Ca to Zn			*	7.4		*****	
Zn to Cu		*		9.6		**	
Na to K		*		1.9		***	
Fe to Mn		*		40.0		***	
Ca to Cu			*	71.2		*****	
Ca to P			*	18.5		*****	
Zn to Fe			*	10.4		*****	
Fe to Cu	*			.9		*****	
Fe to P		*		4.8		*	
Ca to Fe			*	77.1		*****	
Mg to P			*	1.0		*****	
Zn to Mn			*	416.7		*****	
K to Fe		*		9.2		**	
Pb to Mn		*		8.3		*	
Ca to Pb			*	370.0		*****	
Zn to Cr			*	2500		*****	
Zn to Cd			*	500.0		**	
Zn to Mg		*		2.5		***	
P to Al	*			7.7		*****	

1-B

soccer fracture.

LOG # 229
DATE REPO

PATIENT	AGE	SEX	DOCTOR	NAT. HAIR COLOR	TINT:
	13	F	GORDON D. MENDENHALL, DC	BLD	

ESSENTIAL ELEMENTS	L	N	H	RESULT (mg%)	NORMAL RANGE	LOW	OPTIMUM	HIGH	OFF CHART
CALCIUM	*			31	40-87	Ca	*		
MAGNESIUM	*			3	6-10	Mg	*		
SODIUM		*		23	19-62	Na	*		
POTASSIUM	*			15	16-46	K	*		
COPPER		*		2.8	1.2-3.2	Cu		*	
ZINC	*			17	15-21	Zn		*	
PHOSPHORUS		*		11	9-15	P		*	
IRON	*			1.4	2.7-5.5	Fe	*		
MANGANESE	*			.05	.07-.23	Mn	*		
CHROMIUM	*			.02	.04-.08	Cr	*		
NICKEI		*		.2	.15-.45	Ni	*		
SELENIUM	*			.02	.04-.12	Se	*		

Ca Mg Na K Cu Zn P Fe Mn Cr Ni Se

TOXIC ELEMENTS	L	N	H	RESULT	NORMAL RANGE	LOW	MODERATE	HIGH
ARSENIC		*		.01	.01-.03	As	*	
MERCURY			*	.27	.01-.2	Hg		*
CADMIUM		*		.04	.01-.15	Cd	*	
LEAD		*		.2	.1-.2	Pb	*	

As Hg Cd Pb

OTHER ELEMENTS (Essentiality - Toxicity not well documented)	L	N	H	RESULT	NORMAL RANGE	LOW	MODERATE	HIGH
ALUMINUM		*		.8	.01-2	Al	*	
SILICON	*			.06	.08-.25	Si	*	
COBALT		*		.11	.04-.16	Co	*	
LITHIUM		*		.01	.01-.03	Li	*	

Al Si Co Li

SIGNIFICANT RATIOS	L	N	H	RESULT	LOW	OPTIMUM	HIGH
Ca to Mg		*		10.3		*****	
Ca to Zn	*			1.8		*****	
Zn to Cu	*			6.1		*****	
Na to K		*		1.5		*	
Fe to Mn		*		28.0		*	
Ca to Cu	*			11.1		*****	
Ca to P	*			2.8		*****	
Zn to Fe			*	12.1		*****	
Fe to Cu	*			.5		*****	
Fe to Pb			*	7.0		*	
Ca to Fe			*	22.1		*****	
Mg to P	*			.3		*****	
Zn to Mn			*	340.0		*****	
K to Fe		*		10.7		*****	
Pb to Mn	*			4.0		*****	
Ca to Pb		*		155.0		*	
Zn to Cr			*	850.0		*****	
Zn to Cd			*	425.0		**	
Zn to Mg			*	5.7		*****	
P to Al		*		13.8		*	

1-C
230

LOC #
DATE REP

PATIENT NAME: GORDON D. MENDENHALL, DC
 DOCTOR: GRY
 NAT HAIR COLOR: TINI
 AGE: 65
 SEX: F
 NON RANNER
 312 R.L. F. Moore

ESSENTIAL ELEMENTS	L	N	H	RESULT	NORMAL RANGE		LOW	OPTIMUM	HIGH	OFF CHART
					Ca	Mg				
CALCIUM	*			68.	40-87					
MAGNESIUM	*			5.	6-10					
SODIUM	*			26.	19-62					
POTASSIUM	*			9.	16-46					
COPPER	*			.8	1.2-3.2					
ZINC	*			15	15-21					
PHOSPHORUS	*			9.	9-15					
IRON	*			2.	2.7-5.5					
MANGANESE	*			.04	.07-.23					
CHROMIUM	*			.01	.01-.08					
NICKEL	*			.1	.15-.45					
SELENIUM	*			.04	.04-.12					

TOXIC ELEMENTS	L	N	H	RESULT	NORMAL RANGE		LOW	MODERATE	HIGH
					As	Hg			
ARSENIC	*			.01	.01-.03				
MERCURY	*			.09	.01-.2				
CADMIUM	*			.03	.01-.15				
LEAD	*			.3	.1-2				

SIGNIFICANT RATIOS	L	N	H	RESULT	LOW	OPTIMUM	HIGH
Ca to Mg	*			13.6			
Ca to Zn	*			4.5			
Zn to Cu	*			18.8			
Mn to Fe	*			2.9			
Fe to Mn	*			50.0			
Ca to Cu	*			85.0			
Ca to Fe	*			7.6			
Zn to Fe	*			7.5			
Fe to Cu	*			2.5			
Fe to Pb	*			6.7			
Ca to Fe	*			34.0			
Mg to F	*			.6			
Zn to Mn	*			375.0			
K to Fe	*			4.5			
Pb to Mn	*			7.5			
Co to Pb	*			226.7			
Zn to Cr	*			1503			
Zn to Cd	*			300.0			
Zn to Mg	*			3.0			
P to Al	*			3.5			

planter f.

LOG #
DATE

231

A

PATIENT:	DOCTOR: GORDON D. MENDENHALL, DC
AGE: 40	SEX: F
NAT: RED	HAIR COLOR: RED
TINT:	

ESSENTIAL ELEMENTS	L	N	H	RESULT (mg%)	NORMAL RANGE	LOW	OPTIMUM	HIGH	OFF CHART
CALCIUM			*	106.	40-87	Ca	*		
MAGNESIUM		*		6.	6-10	Mg	*		
SODIUM		*		22.	19-62	Na	*		
POTASSIUM	*			13.	16-46	K	*		
COPPER		*		1.2	1.2-3.2	Cu	*		
ZINC	*			14	15-21	Zn	*		
PHOSPHORUS		*		12.	9-15	P	*		
IRON	*			2.2	2.7-5.5	Fe	*		
MANGANESE		*		.07	.07-.23	Mn	*		
CHROMIUM		*		.05	.04-.08	Cr	*		
NICKEL		*		.50	.15-.45	Ni	*		
SELENIUM		*		.06	.04-.12	Se	*		

TOXIC ELEMENTS	L	N	H	RESULT	NORMAL RANGE	LOW	MODERATE	HIGH
ARSENIC		*		.02	.01-.03	As	*	
MERCURY		*		.2	.01-.2	Hg	*	
CADMIUM		*		.2	.01-.15	Cd	*	
LEAD		*		2.8	.1-2	Pb	*	

OTHER ELEMENTS (Essentiality - Toxicity not well documented)	L	N	H	RESULT	NORMAL RANGE	LOW	MODERATE	HIGH
ALUMINUM		*		1.1	.01-2	Al	*	
SILICON		*		.1	.08-.25	Si	*	
COBALT		*		.1	.04-.16	Co	*	
LITHIUM		*		.01	.01-.03	Li	*	

SIGNIFICANT RATIOS	L	N	H	RESULT	LOW	OPTIMUM	HIGH
Ca to Mg			*	17.7		*****	
Ca to Zn			*	7.6		*****	
Zn to Cu			*	11.7		*****	
Na to K		*		1.7		**	
Fe to Mn		*		31.4		*	
Ca to Cr		*		88.3		*****	
Ca to P		*		8.8		*****	
Zn to Fe		*		6.4		*****	
Fe to Cu		*		1.8		*	
Fe to Pb	*			.8	*****		
Ca to Fe			*	48.2		*****	
Mg to P	*			.5		*****	
Zn to Mn			*	200.0		*****	
K to Fe		*		5.9		*****	
Pb to Mn		*		40.0		*****	
Ca to Pb	*			37.9		*****	
Zn to Cr		*		280.0		**	
Zn to Cd	*			70.0	*****		
Zn to Mg		*		2.3		*	
P to Al		*		10.9		**	

carle

B

LOG #
DATE P

PATIENT NAME: GORDON D. MENDENHALL, DC
 DOCTOR: BRN
 NATL HAIR COLOR: BRN
 TINT: []
 SEX: F
 AGE: 25

ESSENTIAL ELEMENTS	RESULT	L	N	H	UNIT	LOW	OPTIMUM	HIGH
CALCIUM	61				mg	40-87		
MAGNESIUM	2					6-10		
SODIUM	8					19-62		
POTASSIUM	2					16-46		
COPPER	2.6					1.2-3.2		
ZINC	14					15-21		
PHOSPHORUS	10					9-19		
IRON	1.1					2.7-5.9		
MANGANESE	.04					.07-.23		
CHROMIUM	.02					.01-.08		
NICKEL	.2					.15-.45		
SELENIUM	.07					.01-.12		

TOXIC ELEMENTS	RESULT	L	N	H	UNIT	LOW	MODERATE	HIGH
ARSENIC	.01					.01-.03		
MERCURY	.15					.01-.2		
CADMIUM	.02					.01-.15		
LEAD	.3					.1-2		

OTHER ELEMENTS (Essentially - Toxicity not well documented)	RESULT	L	N	H	UNIT	LOW	MODERATE	HIGH
ALUMINUM	.3					.01-2		
SILICON	.11					.03-.25		
COBALT	.09					.01-.16		
LITHIUM	.01					.01-.03		

SIGNIFICANT RATIOS	RESULT	L	N	H	UNIT	LOW	OPTIMUM	HIGH
Co to Mg	30.5					4.4		
Co to Zn	4.4					5.4		
Zn to Cu	5.4					4.0		
No to K	4.0					27.5		
Fe to Mn	27.5					23.5		
Co to Cu	23.5					6.1		
Zn to Fe	12.7					4		
Fe to Cu	4					3.7		
Fe to Fe	3.7					35.5		
Co to Fe	35.5					1.8		
K to Fe	1.8					7.9		
Pb to Mn	7.9					203.3		
Co to Pb	203.3					703.0		
Zn to Cr	703.0					7.0		
Zn to Cd	7.0					33.3		
Pb to Al	33.3							

C Control.

PATIENT:	DCTOR: GORDON D. MENDENHALL, DC		
AGE: 25	SEX: F	NAT: BLD	TINT:

ESSENTIAL ELEMENTS	L	N	H	RESULT mg%	NORMAL RANGE	LOW	OPTIMUM	HIGH	OFF CHART
CALCIUM		*		78.	40- 87		*		
MAGNESIUM		*		6.	6- 10		*		
SODIUM			*	171.	19- 62				
POTASSIUM		*		20.	16- 46		*		
COPPER		*		1.6	1.2- 3.2		*		
ZINC	*			13	15- 21		*		
PHOSPHORUS		*		11.	9- 15		*		
IRON		*		2.5	2.7- 5.5		*		
MANGANESE		*		.09	.07- .23		*		
CHROMIUM		*		.01	.04- .08		*		
NICKE		*		.2	.15- .45		*		
SELENIUM		*		.03	.04- .12		*		

TOXIC ELEMENTS	L	N	H	RESULT	NORMAL RANGE	LOW	MODERATE	HIGH
ARSENIC		*		.01	.01- .03	*		
MERCURY		*		.12	.01- .2		*	
CADMIUM		*		.06	.01- .15		*	
LEAD		*		.3	.1- 2	*		

OTHER ELEMENTS (Essentiality -Toxicity not well documented)	L	N	H	RESULT	NORMAL RANGE	LOW	MODERATE	HIGH
ALUMINUM		*		1.5	.01- 2		*	
SILICON	*			.05	.08- .25	*		
COBALT		*		.09	.04- .16		*	
LITHIUM		*		.01	.01- .03	*		

SIGNIFICANT RATIOS	L	N	H	RESULT	LOW	OPTIMUM	HIGH
Ca to Mg			*	13.0		*****	
Ca to Zn			*	6.0		*****	
Zn to Cu		*		8.1		*	
Na to K			*	8.6		*****	
Fe to Mn		*		27.8		*	
Ca to Cu			*	48.8		*****	
Ca to P			*	7.1		*****	
Zn to Fe		*		5.2		***	
Fe to Cr		*		1.6		****	
Fe to Pb		*		8.3		*	
Ca to Fe			*	31.2		*****	
Mg to P	*			.6		*****	
Zn to Mn		*		144.4		**	
K to Fe		*		8.0		*	
Pb to Mn	*			3.3		*****	
Ca to Pb		*		260.0		***	
Zn to Cr		*		1300		*****	
Zn to Cd		*		216.7		*	
Zn to Mg		*		2.2		*	
P to Al	*			7.3		*****	

If. Hamstring problem

D

234

LOG #
DATE RE

PATIENT		DOCTOR: GORDON D. MENDENHALL, DC	
AGE: 57	SEX: M	NAT. HAIR COLOR:	TINT:

ESSENTIAL ELEMENTS	L	N	H	RESULT (mg%)	NORMAL RANGE	LOW	OPTIMUM	HIGH	OFF CHART
CALCIUM	*			36.	30-70		*		
MAGNESIUM		*		4.	0.2-2.2				
SODIUM	*			5.	17-40				
POTASSIUM	*			1.	18-36				
COPPER		*		1.3	1.2-1.2		*		
ZINC		*		17	13-70		*		
PHOSPHORUS		*		14.	7-10		*		
IRON		*		1.9	1.2-4.3		*		
MANGANESE	*			.03	.07-.20		*		
CHROMIUM			*	.14	.04-.08			*	
NICKEL	*			.1	.15-.45		*		
SELENIUM		*		.05	.04-.12				

Ca Mg Na K Cu Zn P Fe Mn Cr Ni Se

TOXIC ELEMENTS	L	N	H	RESULT	NORMAL RANGE	LOW	MODERATE	HIGH
ARSENIC		*		.0	.01-.03			
MERCURY		*		.05	.01-.2		*	
CADMIUM		*		.04	.01-.10			
LEAD		*		.3	.1-2		*	

As Hg Cd Pb

OTHER ELEMENTS (Essentiality - Toxicity not well documented)	L	N	H	RESULT	NORMAL RANGE	LOW	MODERATE	HIGH
ALUMINUM		*		.9	.01-2		*	
SILICON	*				.08-.25		*	
COBALT	*				.04-.16		*	
LITHIUM		*		.01	.01-.03		*	

Al Si Co Li

SIGNIFICANT RATIOS	L	N	H	RESULT	LOW	OPTIMUM	HIGH
Ca to Mg	*			6.5		*****	
Ca to Zn	*			1.9		*****	
Zn to Cu		*		10.3		*****	
Na to K			*	7.0		*****	
Fe to Mn			*	63.3		*****	
Ca to Cu		*		20.0		*****	
Ca to P	*			1.9		*****	
Zn to Fe		*		7.4		*****	
Fe to Cu		*		1.5		*	
Fe to Pb		*		6.3		*	
Ca to Fe		*		13.7		*****	
Mg to P	*			.3		*****	
Zn to Mn			*	466.7		*****	
K to Fe	*			.5		*****	
Pb to Mn		*		13.0		**	
Ca to Pb		*		36.7		*	
Zn to Cr	*			100.0		*****	
Zn to Cd		*		350.0		*	
Zn to Mg		*		3.5		*	
P to Al		*		15.6		*	

E plantar. f.

LOG #
DATE REP

235

PATIENT	AGE: 32			SEX: F	DOCTOR	GORDON D. MENDENHALL D.D.		
					NAT. HAIR COLOR:	BRN		TINT:

ESSENTIAL ELEMENTS	L	N	H	RESULT (mg%)	NORMAL RANGE	LOW	OPTIMUM	HIGH	OFF CHART
CALCIUM	*			34.	40-107	Co	*		
MAGNESIUM		*		7.	6-10	Mg	*		
SODIUM	*			7.	17-62	Na	*		
POTASSIUM	*			3.	16-46	K	*		
COPPER		*		0.2	1.2-3.2	Cu		*	
ZINC	*			7	15-21	Zn	*		
PHOSPHORUS		*		13.	9-15	P		*	
IRON	*			1.7	2.7-5.8	Fe	*		
MANGANESE	*			.06	.07-.23	Mn	*		
CHROMIUM			*	.11	.04-.08	Cr		*	
NICKEL		*		.2	.15-.45	Ni		*	
SELENIUM		*		.04	.04-.12	Se	*		

Co Mg No K Cu Zn P Fe Mn Cr Ni Se

TOXIC ELEMENTS	L	N	H	RESULT	NORMAL RANGE	LOW	MODERATE	HIGH
ARSENIC		*		.01	.01-.03	As	*	
MERCURY		*		.13	.01-.02	Hg	*	
CADMIUM		*		.09	.01-.15	Cd	*	
LEAD			*	3.2	.1-0	Pb		*

As Hg Cd Pb

OTHER ELEMENTS (Essentiality - Toxicity not well documented)	L	N	H	RESULT	NORMAL RANGE	MODERATE	HIGH
ALUMINUM			*	3.6	.01-2	Al	*
SILICON	*				.03-.25	Si	*
COBALT	*				.04-.16	Co	*
LITHIUM		*		.01	.01-.03	Li	*

Al Si Co Li

SIGNIFICANT RATIOS	L	N	H	RATIO	RESULT	LOW	OPTIMUM	HIGH
Ca to Mg	*				4.7		*****	
Ca to Zn			*		4.7		*****	
Zn to Cu	*				3.2	*****		
Na to K		*			1.1		***	
Fe to Mn		*			28.3		*	
Ca to Cu	*				10.6	*****		
Ca to P	*				2.6	*****		
Zn to Fe		*			4.1		**	
Fe to Cu	*				.5	*****		
Fe to Pb	*				.5	*****		
Ca to Fe		*			20.0		***	
Mg to P	*				.5		*****	
Zn to Mn		*			116.7		*	
K to Fe	*				4.7	*****		
Pb to Mn			*		57.3		*****	
Ca to Pb	*				10.6	*****		
Zn to Cr	*				63.6	*****		
Zn to Cd	*				77.8	*****		
Zn to Mg	*				1.0	*****		
P to Al	*				3.6	*****		

236
 wcat angle

LOG #
 DATE REPC

PATIENT	AGE	SEX	COLOR	NAT HAIR COLOR	TINT
GORDON D. WENDENHALL, DC	25	F	BRN		

ESSENTIAL ELEMENTS	1	N	H	RESULT	NORMAL RANGE	LOW	OPTIMUM	HIGH
CALCIUM	*			102.	40-87			
MAGNESIUM	*			7.	6-10			
SODIUM	*			88.	19-62			
POTASSIUM	*			13.	16-46			
COPPER	*			1.5	1.2-3.2			
ZINC	*			14	15-21			
PHOSPHORUS	*			13.	9-15			
IRON	*			1.1	2.7-5.5			
MANGANESE	*			.06	.07-.23			
CHROMIUM	*			.03	.04-.08			
NICKEL	*			.4	.15-.49			
SELENIUM	*			.07	.04-.12			

TOXIC ELEMENTS	1	N	H	RESULT	LOW	MODERATE	HIGH
ARSENIC	*			.01	.01-.03		
MERCURY	*			.11	.01-.2		
CADMIUM	*			.04	.01-.15		
LEAD	*			.5	.1-2		

OTHER ELEMENTS (Essentiality - Toxicity not well documented)	1	N	H	RESULT	LOW	MODERATE	HIGH
ALUMINUM	*			.7	.01-2		
SILICON	*			.04	.08-.25		
COBALT	*			.15	.04-.15		
LITHIUM	*			.01	.01-.03		

SIGNIFICANT RATIOS	L	N	H	RESULT	LOW	OPTIMUM	HIGH
Co to Mg	*			14.6			
Co to Zn	*			7.3			
Zn to Cu	*			9.3			
Na to K	*			6.8			
Fe to Mn	*			18.3			
Co to Cu	*			68.0			
Co to F	*			7.9			
Zn to Fe	*			12.7			
Fe to Cu	*			.7			
Fe to Pb	*			2.2			
Ca to Fe	*			92.7			
Mg to F	*			.5			
Zn to Mn	*			233.3			
K to Fe	*			11.8			
Pb to Mn	*			8.3			
Co to Pb	*			204.0			
Zn to Cr	*			466.7			
Zn to Cd	*			350.0			
Zn to Mg	*			2.0			
P to Al	*			18.6			

IMPORTANCE OF CRANIOMANDIBULAR ALIGNMENT

By: Carl Mestman, D.D.S.
March 1986

Abstract:

This is an explanation of midline determination of the maxillo-mandibular relationship and the dangers of improper occlusal equilibration. Caution should be observed in allowing any bridges, partials, dentures or orthopedic appliances to be constructed to a deviate jaw position.

Most dentists are trained to line up the jaws by aligning the maxillary and mandibular central incisors in viewing the mouth from the front of the body. This method is correct only if the maxillary and mandibular frenums are also in alignment with the teeth in occlusion or commonly referred to by dentists as centric relation occlusion (CRO). See Diagram # 1.) 1.

In many cases today due to premature loss of a deciduous (baby) tooth or over retention of same the remaining teeth could shift so that the central incisors are no longer in alignment with the frenums. (See Diagram 1 A.) If an interproximal filling is placed so that it leaves a space between itself and the adjacent tooth, shifting and misalignment of all the teeth of that arch can occur. (See Diagram 2, A.B.C.D.) This now introduces a premature interfering occlusal contact that can deviate the jaw as it attempts to reach CRO. (See Diagram 2 D.)

Deviate swallowing habits can cause the tongue to deviate the teeth away from the midline. Genetic defects such as congenitally missing anterior teeth or a supernumerary tooth can re-arrange the midline of the arch. Trauma can also re-arrange the bones of an arch as well as the teeth to deviate from the midline.

The maxillary and mandibular frenums are therefore a more reliable centering reference for the jaws. In cases of severe oral trauma or surgical intervention the positions of the frenums could be suspect. A careful medical and dental history can rule out any mechanical alterations to the frenums. If the patient mentions any past injury requiring surgery, call the surgeon to find out if there was any necessary repositioning of the frenum or frenums in order to obtain healing of the area.

Many so called finished orthodontic cases are finished so that the maxillary and mandibular central incisors are perfectly lined up. However, when you look at the frenums there are discrepancies of five tenths to two millimeters. This could be compared to placing new front tires on a car that is out of alignment. In the beginning the tires look good, but once any amount of driving is accomplished the tires will rapidly wear unevenly. It would have been wiser to align the front end of the car first before any new tires were mounted. Likewise with misaligned jaws, it is much better to align the jaws first and then straighten the teeth. When the jaws are

Imp. of Craniomandibular Alignment--Mestman
Page 3

out of alignment, the muscles of the stomatognathic system are in spasm and do not function harmoniously. These disharmonic forces misalign the teeth and mishape the arch forms. When a misaligned jaw has the orthodontic braces removed it is only a matter of usually four or five years before the teeth again become misaligned due to the disharmonic action of the spastic muscles.²

When the muscles of the stomatognathic system are in spasm, they tend to contract with greater force than is physiologically necessary to occlude the teeth. This excessive closing force prevents the posterior teeth from erupting to their true genetic height. Due to this loss of height in the posterior segment the anterior teeth cannot articulate physiologically and the temporomandibular joint (TMJ) must compensate by placing its parts in a non-physiological position. Correction of these conditions allows the posterior teeth to erupt to their correct height which restores the patient's facial dimensions as well. (See Diagram 1, C & D)³. When bridges are built to the existing depressed position they are doomed to failure. When the correct height of the posterior teeth is restored, the first bridges must be destroyed and replaced with new bridges to the correct height (See Diagram 3, A.B.C.)

Disharmonious functioning of the tongue, cheek muscles and lips can create improper relationships of the maxillary and mandibular incisor teeth. (See Diagram 4). Overjet is the

distance horizontally between the maxillary and mandibular incisors. (See Diagram 4,B) Overbite is the distance vertically that the maxillary central incisor overlaps the mandibular central incisor. (See Diagram 4, C.)

Once the jaws are properly aligned so that the muscles are functioning normally, removable functional orthopedic appliances such as bionators, activators, bio-regulators, univators, Frankel, Schwarz, crozat, etc. can be used to correct the positions of these teeth. When completed the correction should hold because there are no longer any deviate forces acting on these teeth. A harmonious relationship between the muscles and the teeth maintains a normal relationship of all the involved parts.

In a misaligned jaw relationship or TMJ dysfunction the teeth have adjusted or accommodated to jaws out of their normal position. This is the same relationship found in the vertical column when a cervical vertebra is distorting to accommodate the meninges to a cranial stress by activating its lovett brother relation in the lumbar region. If the lumbar is adjusted you are only correcting a symptom of the cause which is really in the cranium.⁴ If a dentist grinds any teeth in a TMJ dysfunction case only a symptom is being addressed, not the cause. When the jaws are corrected, those ground teeth will have to be restored by the dentist.

Imp. of Craniomandibular Alignment--Mestman
Page 5

This paper was written because too many chiropractors have asked me to tell them why they still don't feel better after having their teeth fixed. When I examine them, everyone has been fixed in the wrong jaw posture. I hope this paper will prevent this from reoccurring.

References:

1. Temporomandibular Joint Dysfunction & Occlusal Equilibration, 2nd Edition by Nathan Allen Shore, D.D.S. J.B.Lippincot Co. P 89.
2. Preventive Dental Research Foundation, Dental Orthopedics and Applied Kinesiology, by Harold Ravins, D.D.S. 12381 Wilshire Blvd., West Los Angeles, California 90025.
3. Wilbur May, D.D.S., Healthview Newsletter, Vol 1 Nos. 7 & 8 (1976)
4. Applied Kinesiology, by David Walthers, D.C., Systems D.C. Pueblo, Colorado.

Imp. of Craniomandibular Alignment--Mestman
Page 6

DIAGRAM 1.

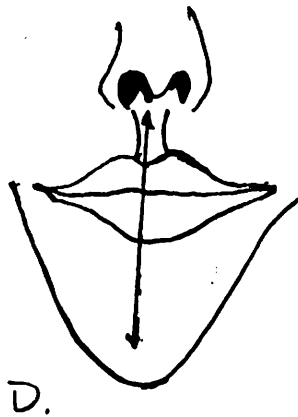
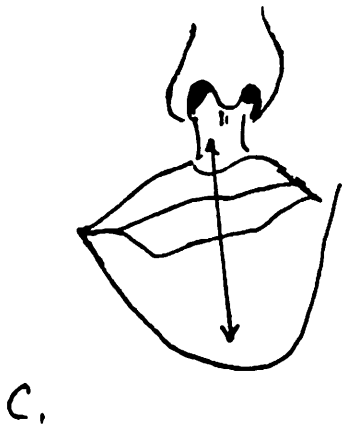
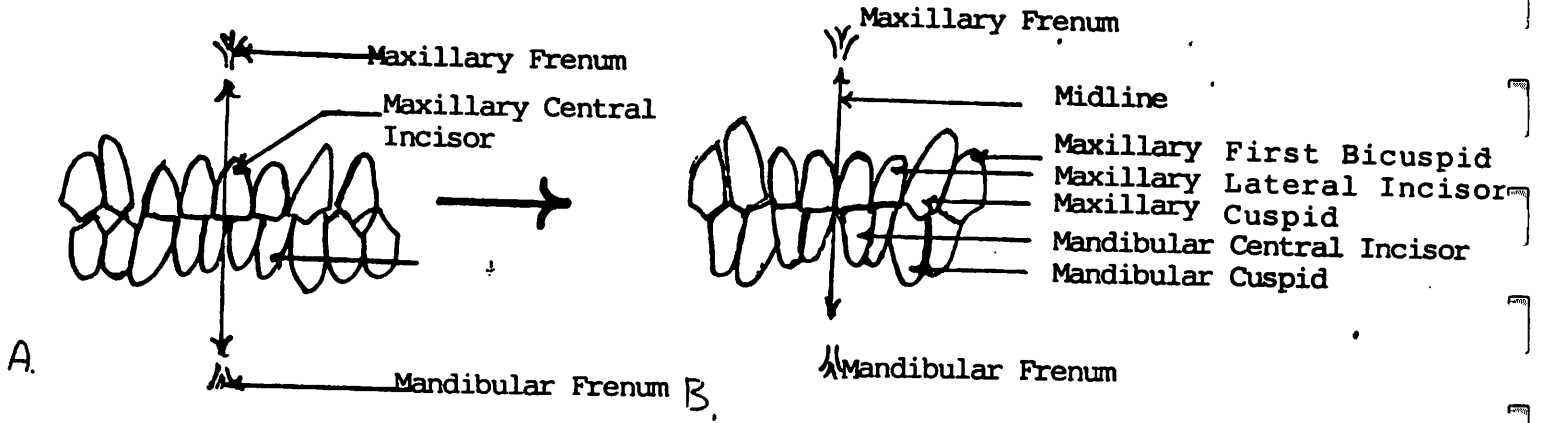
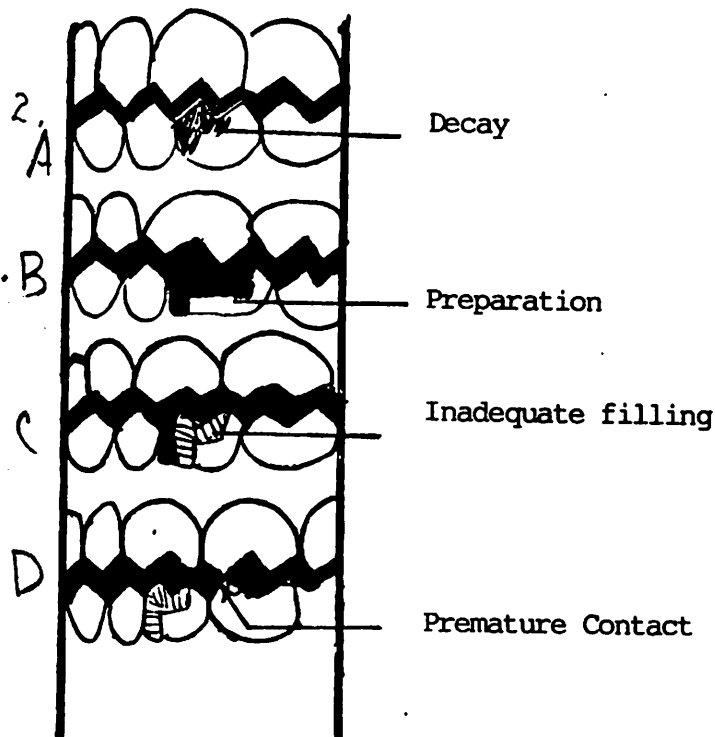


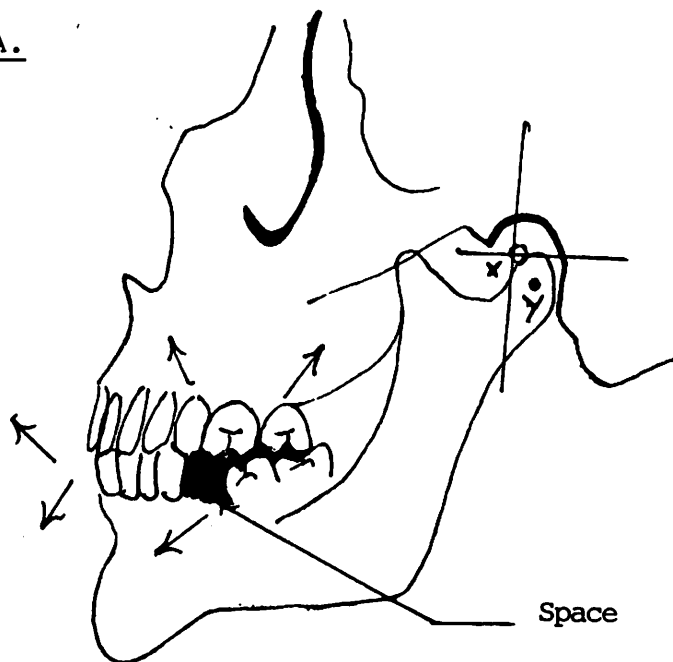
DIAGRAM 2.



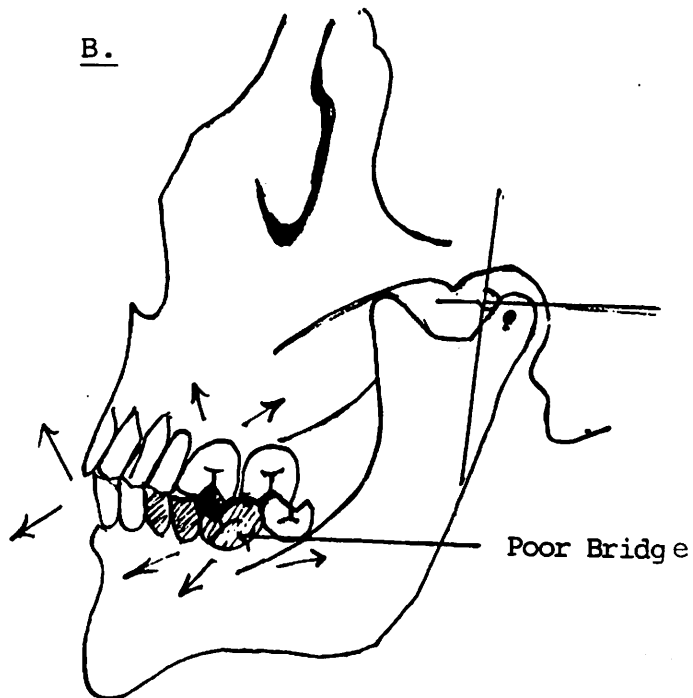
Imp. of Craniomandibular Alignment--Mestman
Page 7

Diagram 3

A.

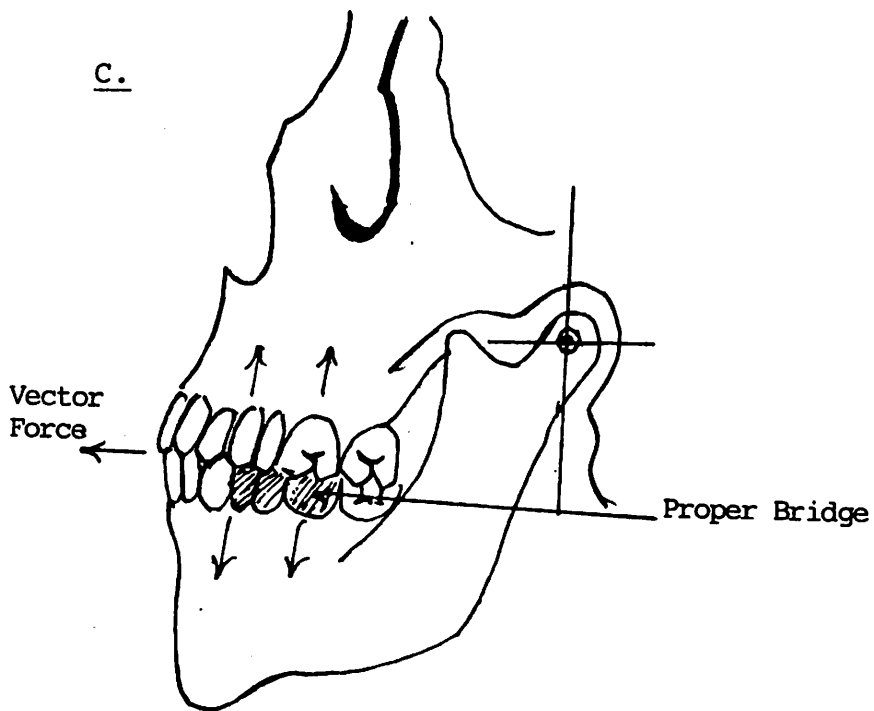


B.



TMJ

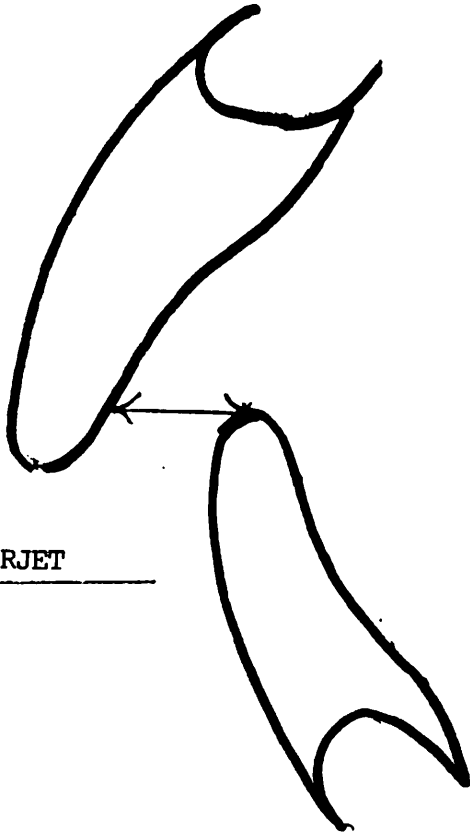
C.



CORRECTED

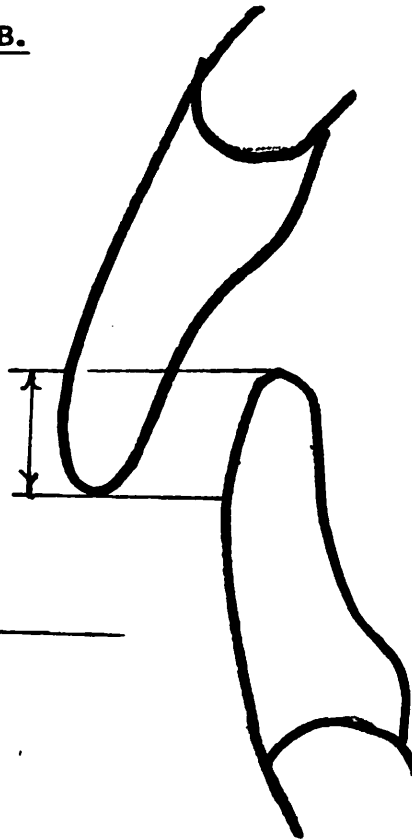
DIAGRAM 4.

A.



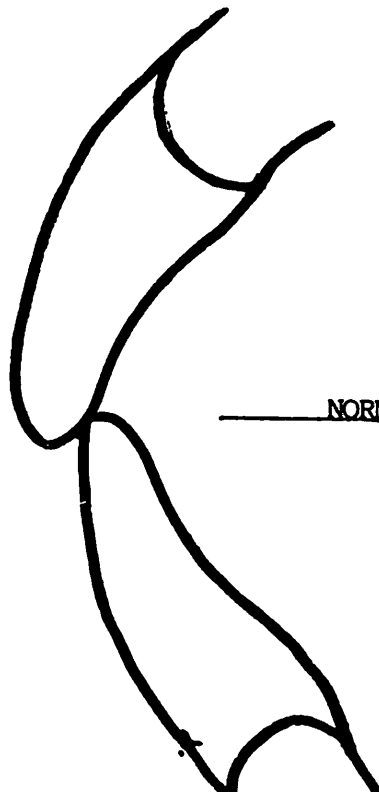
OVERJET

B.



OVERBITE

C.



NORMAL

Proprioceptors: New Methods of Analysis and Correction

by James L Otis, D.C.

Abstract

An overview is given describing new methods for evaluating and correcting Golgi tendon organ and muscle spindle cell dysfunction. Patterns of proprioceptor integration and adaptation are discussed.

Introduction

As chiropractors and applied kinesiologists, it is important that we understand the proprioceptive system of the body. We know the importance of balanced, integrated muscle functioning in maintaining optimal musculo-skeletal health. We know that muscles can become imbalanced in their functioning for many reasons, including stress of a physical, chemical and/or emotional nature. This paper outlines new methods of testing for proprioceptive dysfunction. It describes patterns of proprioceptive integration, and adaptive changes that occur in the proprioceptive system as a result of physical stressors. Future papers will discuss adaptations of the proprioceptive system to chemical stressors.

Golgi Tendon Organs

Current physiology textbooks describe the main function of the Golgi tendon organ as monitoring tension applied by the muscle through its tendon. As will be discussed below, another apparent function of the Golgi tendon organ is to monitor muscle length either by monitoring tension changes in the tendon or by other unknown mechanisms.

Golgi tendon organs rarely therapy localize when the muscle is near the midpoint of its range of motion. A much higher percentage of discovery occurs when the muscle is near one of the extremes of its range of motion, either shortened or lengthened. This occurs whether the muscle is actively or passively shortened or lengthened. The rare Golgi tendon organ that does therapy localize in a mid-range position will be negative to therapy localization when the muscle is near one end point of its range of motion.

Golgi tendon organs which therapy localize in a muscle shortened position will also therapy localize in a neutral or muscle lengthened position if the involved muscle is isometrically contracted. Similarly, Golgi tendon organs which therapy localize in a muscle lengthened position will also therapy localize in a neutral or muscle shortened position if the antagonist muscle is isometrically contracted.

Just as muscle length effects the therapy localization of Golgi tendon organs, so does muscle length influence the effectiveness of corrective stimulation of Golgi tendon organs. Golgi tendon organs which therapy localize in a muscle lengthened position can usually not be corrected in a muscle shortened position. Certain exceptions will be discussed next.

The speed of Golgi tendon organ stimulation is another factor which influences the effect of the stimulation. Stimulation of a Golgi tendon organ with a quick initial vector of force and a slow release of the pressure usually has opposite effects on functioning of the Golgi tendon organ than stimulation with slow initial pressure, and a quick rebound release of the

force. This is true whether the Golgi tendon organ is being stimulated for corrective purposes (one type of stimulation works; the other doesn't) or the Golgi tendon organ is being stimulated to experimentally produce proprioceptive dysfunction.

For the remainder of the paper, the method of stimulation will be assumed to be quick initial force with a slow, non-rebound release of pressure. Corrective stimulation for Golgi tendon organs that therapy localize in a lengthened position is best applied in a vector of force away from the muscle belly, while the muscle is in a lengthened position. Corrective stimulation for Golgi tendon organs that therapy localize in a muscle shortened position is best applied toward the muscle belly while the muscle is in a shortened position.

Muscle spindle cells

Current physiological understanding ascribes both phasic and tonic functions to the muscle spindle cells. Apparently the muscle spindle cell dysfunctions in only one of these functions at a time, often changing from phasic to tonic dysfunction, or vice-versa, as part of an adaptive mechanism to maintain proprioceptive integration between varied muscles of the body.

Muscle spindle cells that therapy localize when the muscle is at rest, (tonic therapy localization) will therapy localize only in a certain range of muscle length. Tonic muscle spindle cell therapy localization is abolished by lengthening or shortening the muscle, or it might only show up if the muscle

4

is in a lengthened or shortened position. This tonic therapy localization will persist no matter how long the muscle is held in the same position.

When the muscle spindle cell is dysfunctioning on a phasic basis, it will only therapy localize for four seconds after the muscle has changed lengths; either by lengthening or shortening, never both. The phasically dysfunctioning muscle spindle cell does not therapy localize in the clear in any position if the muscle has been in that position for longer than four seconds.

As with Golgi tendon organs, corrective efforts for muscle spindle cells are effective only within certain length ranges of the muscle. Tonically dysfunctioning muscle spindle cells are best corrected with the muscle in the same length in which the muscle spindle cells therapy localize.

Phasically dysfunctioning muscle spindle cells are best corrected in the position from which the muscle has just come when the muscle spindle cell therapy localizes. For example, if a muscle spindle cell therapy localizes for four seconds after the muscle goes from a shortened to a lengthened position, the muscle spindle cell is best corrected in the shortened position.

The relative speed of the initial and let up aspects of muscle spindle cell stimulation are important parameters of corrective efforts. For example, a muscle spindle cell stimulation which involves quick approximation of the tissue around the muscle spindle cell and a relatively slow let up of pressure, usually has an opposite effect on muscle spindle cell function than a stimulation of slow approximation and quick rebound release. This is true whether the muscle spindle cell is being stimulated for corrective purposes

(one type of stimulation works; the other doesn't) or the muscle spindle cell is being stimulated to experimentally produce proprioceptive dysfunction. For the remainder of this paper the method of stimulation will be assumed to quick initial force and a slow, non-rebound release of pressure. Usually muscle spindle cells which are corrected in a muscle lengthened position are corrected with approximation pressure, and muscle spindle cells which are corrected in a muscle shortened position are corrected with spreading pressure.

Patterns Of Proprioceptive Dysfunction And The Effects On Manual Muscle Testing

There are many combinations of proprioceptor dysfunction within and between muscles. Some of the most common patterns will be described below.

Generally if a Golgi tendon organ therapy localizes in any position, the muscle spindle cell will therapy localize phasically. If the Golgi tendon organ therapy localizes in a muscle shortened position, the muscle spindle cell usually therapy localizes phasically, after the muscle goes from a shorter to a longer position. Typically, this muscle is strong in the clear, (an apparent Golgi tendon organ influence), but temporarily tests weak immediately after it goes from a shortened to a lengthened position (an apparent muscle spindle cell influence). This has been described as a strain-counterstrain pattern by George Goodheart DC. On the other hand, if the Golgi tendon organ therapy localizes in a muscle lengthened position, the muscle spindle cell usually therapy localizes phasically after the muscle

goes from a longer to a shorter position. Typically this muscle tests weak in the clear (an apparent Golgi tendon organ influence), but temporarily tests strong after it goes from a longer to a shorter position (an apparent muscle spindle cell influence). If the muscle spindle cell therapy localizes tonically, the Golgi tendon organ does not therapy localize. Golgi tendon organs have not been observed to therapy localize phasically.

Patient Versus Doctor Initiated Muscle Testing

Doctor initiated and patient initiated muscle testing often yield opposite results (all other parameters of the testing situation remaining unchanged). This is true both when testing an indicator muscle in the process of therapy localizing a proprioceptor, and when testing a muscle directly. For example, some strain-counterstrain patterns only show up with patient initiated testing. In this case, the test indicator muscle exhibits a weakening response to therapy localization of Golgi tendon organs in the muscle shortened position only if the patient is allowed to initiate pressure in the indicator muscle test. Similarly, the dysfunctioning strain-counterstrain muscle shows a temporary weakening response after going from a shorter to a longer position only if the patient initiates the testing pressure. For the remainder of this paper the term "concentric dysfunction" will refer to muscle weakness evidenced by patient initiated testing, and "eccentric dysfunction" will refer to muscle weakness evidenced by doctor initiated testing. (Differences between patient and doctor initiated test procedures have been discussed by Walter Schmitt, DC). (1) Generally, the phase of muscle testing (doctor versus patient initiated) in which therapy localization of proprioceptors occurs is the same phase in which direct

muscle testing evidences dysfunction. Since many, if not most proprioceptors evidence dysfunction with only one type of testing, it is important to use both types of testing when investigating proprioceptive dysfunction. Corrective stimulation is the same whether dysfunction is evidenced by doctor or patient initiated testing.

Reactive Muscle Patterns

Muscles are linked by neurological circuits which function to coordinate movement of the various parts of the body. Proprioceptive dysfunction of one muscle often causes functional changes in linked muscles. This might be evidenced when the original dysfunctional muscle is resting, contracting, or immediately after it has been contracted. It is worthwhile to note that temporomandibular joint muscles are integrated through gait and reactive patterns with almost every muscle in the rest of the body. Typically, the muscles reacting between the temporomandibular joint and other areas of the body exhibit opposite muscle length characteristics, (one muscle's Golgi tendon organs therapy localize in a muscle lengthened position, and the other muscle's Golgi tendon organs therapy localize in a muscle shortened position) and the dysfunction shows up with opposite testing methods (doctor versus patient initiated testing). It is common to find a gait circuit in which contralateral arm and leg muscles evidence eccentric dysfunction and a related temporomandibular joint muscle evidences concentric dysfunction.

Usually corrective effort directed toward any dysfunctioning Golgi tendon organs within a circuit corrects dysfunction in other muscles of the circuit, including those of the temporomandibular joint, pelvis and shoulder girdle.

Corrective efforts directed to muscle spindle cells often do not have as far-reaching therapeutic effects in remote muscles of the circuit.

Proprioceptor Adaptation

Prolonged stimulation of one proprioceptor group leads to simultaneous adaptive changes, not only in the immediate proprioceptor group, but elsewhere in the body as well. Therapy localization and direct muscle testing afford wonderful methods of analyzing systemwide proprioceptor adaptation. Muscle spindle cells are observed to change between tonic and phasic dysfunction and both Golgi tendon organs and muscle spindle cells are observed to change between eccentric and concentric dysfunction.

The following is one illustration of proprioceptor adaptation to a prolonged postural position. In this example, the patient exhibits a positive therapy localization of the right psoas Golgi tendon organ in a muscle shortened position with doctor initiated testing. This person also exhibits a left pectoralis major clavicular muscle which is weak with eccentric contraction and strong with concentric contraction. When the right hip is flexed, then the pectoralis major clavicular becomes strong with eccentric contraction and weak with concentric contraction. This pattern remains constant for approximately five minutes until an adaptive change takes place in the Golgi tendon organs of the right hip. After five minutes, proprioceptive dysfunction of the psoas Golgi tendon organ is now evidenced with patient initiated (concentric) testing instead of doctor initiated testing. Now, while the hip is flexed, the pectoralis major clavicular evidences eccentric dysfunction instead of the previous concentric dysfunction and with the hip is extended, the pectoralis major clavicular

evidences concentric dysfunction instead of the previous eccentric dysfunction.

Another example of proprioceptive adaptation occurs when proprioceptors are experimentally stimulated so as to produce proprioceptive dysfunction. Stimulation of muscle spindle cells and/or Golgi tendon organs initially produces eccentric dysfunction. After five minutes of continual noxious stimulation, an adaptive change occurs, and dysfunction becomes concentric in nature. For example, if a muscle spindle cell is stimulated to cause muscle weakening, this weakening is evidenced with doctor initiated testing. The muscle tests weak with doctor initiated testing, the muscle spindle cell therapy localizes tonically with doctor initiated testing, and the Golgi tendon organs do not therapy localize under any conditions. After five minutes of continued manual muscle spindle cell stimulation, an adaptive change occurs. Now the muscle tests weak only with patient initiated testing. The muscle spindle cells therapy localize phasically with patient initiated testing, and the Golgi tendon organs therapy localize in a muscle shortened position with patient initiated testing.

As with muscle spindle cell stimulation, if Golgi tendon organs are stimulated to produce weakening, the resulting dysfunction is first evidenced with doctor initiated testing. The muscle tests weak with doctor initiated testing, the Golgi tendon organs therapy localize with doctor initiated testing and the muscle spindle cells do not therapy localize under any conditions. After five minutes of continual manual stimulation, adaptive changes occur and dysfunction is now evidenced with patient initiated testing. The muscle spindle cells now therapy localize phasically.

The two preceding examples illustrate changes that occur within a muscle. Parallel changes occur in remote muscles that share gait and/or reactive circuits. These remote muscles change from eccentric to concentric dysfunction, or vice versa, at the same moment that the local muscle makes its adaptation. Parameters of the remote muscle adaptation will be discussed in future papers.

Ligament Challenge

Ligaments contain proprioceptor elements which monitor the tension and/or length of the ligament. This has been discussed by George Goodheart DC, in relation to the ilio-lumbar ligament. (2)

Ligaments can be challenged by either approximating or distracting the two ends of the ligament (or the structures to which the ligament is attached). There is a difference between approximation and distraction challenges in that distraction challenge only becomes positive after a continual four second distraction. Approximation challenge is not time dependent and will show up with a brief application of force.

Challenging ligaments gives valuable information about the functioning of related parallel muscles. As discussed by Goodheart, approximation challenge of the ilio-lumbar ligament usually correlates with a strain-counterstrain pattern of the ipsilateral gluteus maximus muscle (the Golgi tendon organs of the gluteus maximus therapy localize in a muscle shortened position and the muscle spindle cells therapy localize phasically after the muscle goes from shorter to longer). On the other hand,

distraction challenge of the ileo-lumbar ligament usually correlates with a gluteus maximus muscle pattern of Golgi tendon organ therapy localization in a muscle lengthened position and a muscle spindle cell phasic therapy localization after the muscle goes from a longer to a shorter position.

Corrective efforts directed to the muscle proprioceptors usually clear the related ligament challenge. Golgi tendon organ correction often also corrects remote muscles and ligaments sharing the same circuit.

Temperomandibular Joint Ligaments

Challenge of the medial ligaments of the temperomandibular joint yield important information about temperomandibular joint function. Challenge of the sphenomandibular ligament, by either approximating or separating the greater wing of the sphenoid and the ramus of the mandible, yields information about the functioning of the internal pterygoid and/or external pterygoid muscles. The vector of positive ligament challenge will be parallel to the muscles involved. Challenge of the stylomandibular ligament by approximating or separating the mastoid portion of the temporal bone and the ramus of the mandible yields information about the functioning of the styloglossus and/or posterior digastric muscles. A convenient method of diagnosing styloglossus proprioceptive dysfunction is to have the patient therapy localize in the region of the styloid process of the temporal bone while she/he pushes the tongue against one side of the cheek and then the other, to lengthen or shorten the muscle. Correction is accomplished by stimulating the Golgi tendon organs while the tongue is held in the position that brings out therapy localization.

As a side note, Intraosseous challenge of the body of the mandible from the symphysis menti to the angle of the ramus (either compression or distraction challenge) parallels proprioceptive dysfunction of the anterior or posterior fibers of the genioglossus muscle. A convenient method of diagnosing genioglossus proprioceptive dysfunction is to have the patient therapy localize under the anterior portion and then under the posterior portion of the mandible (near the origin of genioglossus muscle) while he/she pushes the tongue forward or backward in the mouth. Correction is accomplished by stimulating that area which therapy localizes while the tongue is held in the position that brings out therapy localization.

Cranio-mandibular Challenge

Two handed cranio-mandibular challenges yield useful information about all of the major temporomandibular joint muscles. In addition to challenges previously discussed, challenge of the parietal bone and mandible yields information about the function of the temporalis muscle, and challenge of the zygomatic arch and mandible yields information about function of the masseter muscle. Challenging should be performed with both doctor and patient initiated testing, patient initiated testing being the most frequent method of discovery. Corrective attention to proprioceptive dysfunction (especially Golgi tendon organs) of the involved muscle will clear the cranio-mandibular challenge.

Summary: Clinical Applications

This understanding of proprioceptive dysfunction leads to simple, effective methods of identifying and treating muscle dysfunction. In particular, therapy localization of Golgi tendon organs in muscle shortened and muscle

lengthened positions is useful in uncovering muscle dysfunction which otherwise remains illusive. This is especially true of temporomandibular joint muscles, which, because of their small size, are difficult to test directly.

The proprioceptor system (together with central nervous system factors) mediates musculoskeletal responses to stressors of various types. It is this author's opinion that every time a muscle exhibits a change of muscle strength as a result of a local or remote challenge (physical, chemical or emotional) an observable change occurs in the functioning of one or more proprioceptor groups of that muscle. This change of proprioceptor function mediates the change of muscle strength.

This paper has described new methods of analyzing and correcting proprioceptor dysfunction. It has also discussed adaptative changes that occur between various parts of the proprioceptor system. It is hoped that this paper will provide useful clinical tools and ideas for further investigation and discussion.

REFERENCES

1. Schmitt, Walter H., Jr. "Muscle Testing As Functional Neurology: Differentiating Functional Upper Motorneuron And Functional Lower Motorneuron Problems," ICAK Collected Papers, January, 1986
2. Goodheart, George J Applied Kinesiology 1985 Research Manual Detroit: privately published, 1985

TONIC LABYRINTHINE REFLEXES IN THE WEIGHT BEARING POSITION

by Walter H. Schmitt, Jr., D.C.

ABSTRACT: Gamma 2 weakness patterns which appear in the upright (seated) position after all gamma 2 weaknesses have been corrected in the recumbent positions are related to tonic labyrinthine reflex (TLR) activity which becomes apparent only in the upright position. These gamma 2 weaknesses are abolished by placing the head in a position to activate an appropriate TLR muscular response. If the response to head position is the opposite of that predicted by TLR patterns, the hyoid must be corrected before proceeding. Correction of the TLR is based on challenge for vector and respiratory correction of a temporal bone fault, both of which must be performed in the upright position.

INTRODUCTION

The tonic labyrinthine reflexes (TLR) and the tonic neck reflexes (TNR) were the subject of a previous paper by this author.¹ In that paper, the functions of the TLR were related to the recumbent positions of the patient, that is, prone, supine, and side-lying positions.

Since the TLR are present in an infant at birth, the previous paper proposed that these basic reflex patterns should be investigated early in an examination and treatment procedure prior to checking and correcting any factors relating with upright posture such as righting reflexes, gait patterns, etc, especially since all other higher functions are built upon these basic TLR (and TNR) patterns.

Correction of the TLR and TNR with the patient in the recumbent position has been a useful tool, but since we are rarely dealing with infants in which these reflexes are primary, it is necessary to look at what occurs in the developed child and adult who must deal with gravity on a regular basis. However, since the TLR and TNR are fundamentally present in the recumbent position, they must be corrected in this position first, before continuing with the patient.

In a previous paper by this author entitled "The Psoas Sitting Test,"² the importance of testing muscles, such as the psoas, tensor fascia lata (TFL), rectus femoris and quadriceps, and adductors was related to the presence of structural faults in the weight-bearing position, particularly those of the spine and pelvis. These weight-bearing structural faults and the related muscle weaknesses were shown to be absent in the recumbent patient, and both muscle weakness and therapy localization would appear only when weight-bearing was introduced by having the patient assume the sitting position.

With the advent of gamma 1 testing and gamma 2 testing for identifying spinal and supraspinal sources of weakness, respectively, an entirely new perspective on weight-bearing problems has been achieved.³ Since gamma 2 (patient-started), concentric/isometric) testing is associated with problems arising at a supraspinal level, it was felt that it would be appropriate to re-evaluate our observations of weight-bearing

weaknesses in light of this new approach to muscle testing. The observations made in this paper are the first efforts at investigation of gamma 2 muscle weaknesses in the weight-bearing position.

WEIGHT-BEARING TESTING

Before we attempt any weight-bearing testing, whether it be gamma 1 or gamma 2 testing, it is necessary that all gamma 1 and gamma 2 faults which appear in the recumbent positions be corrected. This includes any recumbent TLR involvement. Upon having the patient sit upright on the treatment table, we formerly checked the major weight-bearing muscles of the lower limb to attempt to identify any hidden structural faults. We usually did not bother checking any upper extremity muscles which had shown previous weakness because we assumed (it turns out erroneously) that correction of any spinal faults which were related to weight-bearing would correct any upright recurrence of these upper limb muscles.

Upon testing for gamma 2 weakness of previously weak muscles in the sitting or upright position, we were shocked to observe that there were, in fact, a large number of patients who showed recurrence of gamma 2 weakness in the sitting position, as well as gamma 2 weakness of other muscles which were strong in recumbency. In addition, the gamma 2 weaknesses would still be present following correction of the weight-bearing spinal (i.e., gamma 1) fault.

REVIEW OF LABYRINTHINE ACTIVITY AND TLR PATTERNS

In an effort to identify the source of this upright gamma 2 weakness, we returned our attention to the TLRs. To review, the TLRs are stimulated by the position of the head in relation to gravity. The basic TLR patterns are summarized below:

<u>POSITION</u>	<u>MUSCLE RESPONSE</u>
Face up	Facilitates extensors- all limbs Inhibits flexors - all limbs
Face down	Facilitates flexors- all limbs Inhibits extensors- all limbs
Right ear down/left ear up	Facilitates right limb extensors Facilitates left limb flexors Inhibits right flexors & left extensors
Left ear down/right ear up	Facilitates right limb flexors Facilitates left limb extensors Inhibits right extensors & left flexors

The TLR arise from the utricles in the labyrinthine complex in the inner ear, imbedded in the petrous portion of the temporal bone. The plane of the utricles is more or less parallel to the base of the skull. The utricles are, therefore, placed more or less horizontally, but their anterior portion is curved in an upward, vertical direction. (See Figure 1a.)

The other parts of the labyrinthine complex are the saccules and the semicircular canals. The semicircular canals are concerned with angular acceleration (e.g., rotational movements) of the head. The utricles and saccules are concerned with the actual static position of the head

in relation to gravity. The orientation of the saccules is vertical, perpendicular to that of the utricles. (See Figure 1b.) The receptors of the utricles and saccules are the position recorders and are sometimes called the "static labyrinthine." The semicircular canals' receptors are "bidirectional angular accelerometers" and are sometimes called the "kinetic labyrinthine." The utricles and saccules are also sensitive to acceleration, but only to linear acceleration. In this paper, we are concerned with the static position of the head and therefore will not concern ourselves with the semicircular canals or the linear acceleration factors of the utricles and saccules.

The utricles are more sensitive to tilt of the head in the lateral (coronal) plane of the body. The saccules are primarily sensitive to changes in the antero-posterior (sagittal) plane. This can be observed by the anatomical orientation of these receptors as shown in Figures 1a and 1b. It is the utricles which are said to be the seat of the TLR, and so when investigating the TLR, we are going to be most interested in the "tilt" or lateral flexion position of the head where one ear is down, the other up. That is, in checking for TLR involvement, we are going to put the head of the seated or standing patient in a lateral tilt position, as best as possible approximating the one ear down/one ear up position. We may also check the upright patient in the face up or face down position.

SPATIAL ORIENTATION OF UTRICLES AND SACCULES

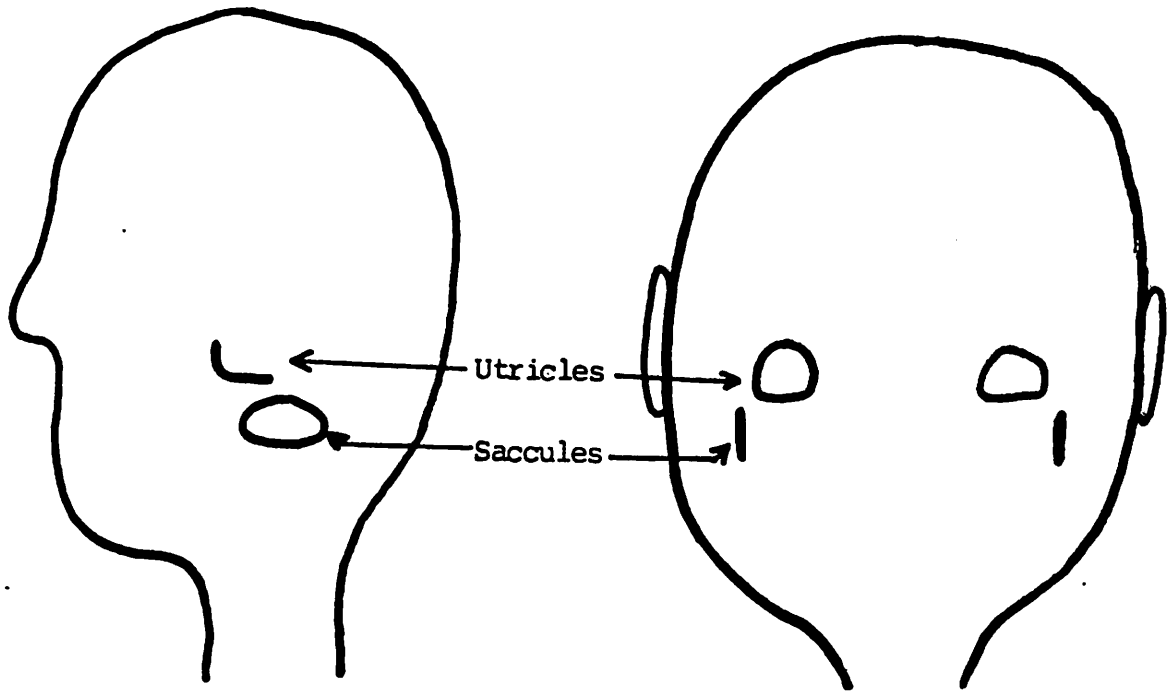


Figure 1a

Figure 1b

CLINICAL APPLICATION OF TLR IN THE UPRIGHT POSITION

When finding a muscle weakness in the upright position, it now becomes necessary to differentiate whether the weakness is of the gamma 1 or gamma 2 variety. Remembering that gamma 2 weakness is usually accompanied by gamma 1 weakness, we can test in the usual, doctor-started, gamma 1 fashion to identify a weight-bearing source of weakness. (It is this author's preference to check for weight-bearing faults in the seated position due to the increased stability of the patient in this position compared to standing. Of course, we eliminate the possibility of picking up foot, ankle, and knee problems in the sitting position, but we can screen for these with shock absorber technique or on standing at another time.

We now check all muscles which were weak in the recumbent position in the upright position, in addition to the psoas and other lower extremity muscles as we have in the past. When we find a muscle weakness in the traditional gamma 1 fashion, we immediately test in the patient-started manner to see if there is also a gamma 2 supraspinal source of weakness. Upon finding a gamma 2 weakness (having previously cleared all sources of gamma 2 weakness in the recumbent positions) we make the assumption that this supraspinal source of weakness now present must be associated with the upright posture. The two mechanisms of a supraspinal nature which may significantly alter their sensory input

from recumbent to upright are the visual pathways and the labyrinthine mechanism. We are presently investigating the relationship of the visual-labyrinthine interaction, but this investigation is not yet complete and will be reported in the future.

In an effort to identify if the upright source of supraspinal, gamma 2 weakness is originating in the labyrinthine mechanism, the gamma 2 weakness (and/or the gamma 1 weakness) is tested in the upright position, but with the head tilted in different positions: first: lateral flexion to the right, then to the left. This lateral bending is performed to put the head in as close to an "ear down and parallel to the ground" position as possible. We then test the patient with the head tilted as close to face down as possible, then with the head tilted back as close to face up as possible.

NORMAL AND SWITCHED TLR PATTERNS

The head position which abolishes the sitting gamma 2 weakness(es) should correlate exactly with those patterns of TLR listed above. That is, a gamma 2 weakness of the right latissimus dorsi (an extensor) should be abolished by a right ear down/left ear up position of the head, or possibly a face up position. Both of these positions will facilitate the right-sided extensor, latissimus dorsi.

Another example of this normal TLR pattern is in the case of a gamma 2 weakness of the psoas in the seated position. The right psoas, being a flexor, should be strengthened by a

TLR pattern where the head is either in the right ear up/
left ear down position or in the face down position.

It is important to recognize whether the pattern of
TLR activity fits with the expected pattern of strengthening.
If there is the opposite reaction to a head position from
what would be predicted, then there is a major form of a
switching present which must be corrected prior to making
a correction to normalize TLR feedback.

For example, if the right lat sitting weakness is
abolished by tilting the head to the left ear down/right ear
up position (the opposite from what would be expected), then
there is a switching problem present. Likewise, if a right
psoas sitting weakness is abolished by tilting the head to
the right ear down/left ear position, the switching pattern
must be corrected first before proceeding.

Correction of this type of switching pattern has been
related to identification and correction of a hyoid imbalance.
The hyoid is challenged in the sitting position and is usually
found to be in a laterality position (i.e., stylohyoid imbalance).
The hyoid challenge which creates weakness is maintained
while the source of hyoid problem is identified by T.L.ing
various factors until the hyoid challenge is negated. These
factors, which have been previously reviewed,⁵ are, in order
of occurrence: TMJ muscular fault, thymus involvement (T.L.
the angle of Louis on the sternum or place thymus tissue in
the mouth), a need for folic acid or a sphenoid tilt (naso-
sphenoid challenge). Rarely do we find that spindle cell

correction of the hyoid is appropriate therapy in the patients we see due to a very high rate of recurrence of hyoid imbalance, sometimes even a few moments later during treatment. After correction of the hyoid imbalance in these switching type patients, the gamma 2 muscle weakness in the seated position responds to the expected position of the head as predicted from normal TLR patterns.

CORRECTION OF UPRIGHT TLR INVOLVEMENT

When the gamma 2 (and gamma 1) muscle weakness is abolished in one of the TLR head positions, then we assume the potential for TLR involvement. Our findings are that cranial faults of the temporal bone are responsible for most of the upright TLR involvement we have observed. There is an occasional temporomandibular joint muscular fault which seems to affect the TLR through the temporal bone.

When we find that the appropriate head tilt right or left, or face up or face down, affects a gamma 2 weakness in the upright position, we T.L. to each temporal bone individually and retest for the gamma 2 (and/or gamma 1) weakness. The T.L. to the temporal bone is performed over the anterior part of the mastoid process and covering as much of the temporal bone in this region as the fingers can reach. If there is no positive T.L. to the temporal bone, then we T.L. to the TMJ in an effort to find the occasional involvement there. If the TMJ T.L. neutralizes the gamma 2 weakness, we check for and correct the TMJ in the standard fashion.

If the temporal bone T.L.s, then we apply the vector challenge method of Walther to identify and correct the problem.⁴ The most fascinating thing about the upright TLR fault is that there is absolutely no evidence of any cranial fault of the temporal bone in the recumbent position. The vector challenge which is present in the upright position is absent with the patient lying down. In addition, it appears that the correction in the direction of proper vector must be made in the upright position as well.

Proper correction of the TLR pattern neutralizes the gamma 2 weakness in the upright position, and may or may not correct the gamma 1 weaknesses present in this position. If gamma 1 weaknesses are still present, the appropriate procedures discussed in the previous "Psoas Sitting" paper are employed.

Occasionally, two gamma 2 muscle weaknesses are simultaneously present which are related to two entirely different TLR patterns. For example, sitting gamma 2 weaknesses of both the right lat (a right extensor) and the right psoas (a right flexor) may be present together and each respond to the predicted pattern of TLR head position. In this case, we find that one weakness responds to T.L. of one mastoid and the other weakness responds to T.L. of the other mastoid process. Upon challenging of the mastoid process for direction of vector correction, we usually find that each mastoid challenges more or less in the opposite direction from the other. Appropriate correction of each temporal bone fault results in correction of both gamma 2 sitting weakness patterns.

CONCLUSION

For 4 years, since the original presentation of the "Psoas Sitting" paper, I have been disturbed at the high rate of recurrence of weight-bearing faults, especially subluxations of the lumbar spine and hidden cervical disc problems which showed up only in this position. Identification of the gamma 2 weakness pattern in the upright position has been a great breakthrough in understanding the recurrence of these sitting (or standing) muscle weaknesses. Identification and correction of the gamma 2 upright weakness patterns has been a great aid in eliminating the recurrence of these faults by removing the supraspinal pattern of interference which probably initiated the recurrence of the weight-bearing subluxations in the first place.

It is felt that correlation of visual feedback with that of the TLR will give us an even greater ability to eliminate the recurrence of these faults, and as mentioned previously, these investigations are on-going.

REFERENCES

- 1.Schmitt, Walter H., Jr., Using Functional Neurology to Identify Patterns of Facilitation and Inhibition Arising From Tonic Neck Reflexes and Tonic Labyrinthine Reflexes. I.C.A.K. Collected Papers, January, 1986.
- 2.Schmitt, Walter H., Jr. The Psoas Sitting Test:Key to Hidden Lumbosacral Problems. Digest of Chiropractic Economics 26:2, September-October, 1983:p. 10.
- 3.Schmitt, Walter H., Jr. Muscle Testing as Functional Neurology - Differentiating Functional Upper Motorneuron and Functional Lower Motorneuron Problems. I.C.A.K. Collected Papers, January, 1986.
- 4.Walther, David S. Applied Kinesiology, Volume II. Pueblo, Colorado; privately published, 1983.
- 5.Schmitt, Walter H., Jr.,Hyoid Laterality and Spleen 21,K-27 Technique. I.C.A.K. Collected Papers, Winter, 1981.

SUMMARY OF CLINICAL PROCEDURE

1. Correct all gamma 1 and gamma 2 sources present in the recumbent position.
2. Test for recurrence of previously weak muscles in the seated (or standing) position.
3. Test for weakness of other weight-bearing muscles in the seated (or standing) position. (e.g., psoas, TFL, rectus femoris, adductors, etc.)
4. Check for gamma 1 versus gamma 2 weakness of these muscles.
5. Tilt head into lateral flexion right and left.
6. Tilt head forward (face down) and backward (face up).
- 7.(a) If tilting head in either 5. or 6. above causes strengthening of gamma 2 weaknesses as predicted by TLR patterns, T.L. each mastoid process individually and retest for gamma 2 response.
- 7.(b) If tilting the head as in 5. or 6. above causes strengthening of gamma 2 weaknesses in a pattern opposite of what would be predicted by TLR patterns, challenge for hyoid laterality and correct the hyoid imbalance (i.e., TMJ, thymus, folic acid, sphenoid tilt) before proceeding to 8.
8. Challenge mastoid process of positive T.L.ing temporal bone(s) for vector which causes greatest weakening of indicator muscle. Find the phase of respiration which neutralizes the vector challenge weakness. Correct appropriately.
9. Retest previous weak muscles for residual gamma 1 weakness. If present, T.L. lumbar spine, cervical spine, and/or pelvis. Challenge and correct subluxation as found.

MENINGEAL SUBLUXATION OVERVIEW

by

Sheldon Sinett, D.C., B.A., M.A.

ABSTRACT: An overview showing meningeal subluxation, including corrective procedures.

INTRODUCTION: The brain and spinal cord are enclosed by three membranes; an outer tough one called the dura, an inner more delicate membrane called the pia, and a middle layer called the arachnoid which is avascular. It separates from the dura by the sub-dural space, and from the pia by the sub-arachnoid space containing the cerebrospinal fluid. The meninges are firmly attached to the brain. It is also attached to the foramen magnum, and the 2nd and 3rd cervical segments. It then is free flowing until it gets to the second sacral segment where it is again attached. At the 2nd sacral segment the dura invest the filium terminale and is attached to the posterior portion of the 1st coccygeal segment. (1) Therefore, as you can see, anything affecting the cranial area or at the sacrum or coccyx can greatly interfere with the cranial-sacral motion. This would then interfere with the normal function and cause dural subluxation at the cranium or at any place in the spine.

PROCEDURE and CORRECTION

First, put a block at the ischium on one side and a block at the opposite glenoid and see if a strong muscle weakens. This should be done while the patient is supine. The weakness at the side of the glenoid indicates that a meningeal subluxation is present, and that the patient has to take a longer step on that side. (2) If blocking in the supine position does not show weakness, use brain function to see if weakness will occur. If weakness occurs our procedure is to clear out the pelvis, which is usually a Cat. I or a walking Cat. II. We also use the new procedure on the ilio-lumbar ligament if necessary.

As you are probably aware, Dr. Goodheart stated that he uses a tapeless measure to measure the spine between E.O.P. and the last coccygeal segment. There should not be more than 1/2" diff-

erence while sitting, standing, or lying. Any difference indicates a meningeal subluxation.

The correction is a coccygeal lift (cephalic). Hold the contact approximately one minute and see if a previously sore anterior neck muscle is no longer painful to palpation. (3)

Check if there is a strain counterstrain to the external pterygoid or internal pterygoid muscles. You are aware that the pterygoid muscles attach to the pterygoid plate of the sphenoid. Any imbalance to these muscles will cause interference with the normal function of the meninges.

T.L. both TMJ with one hand. Pulling caudal and with teeth together, see if the muscle weakens. If so, that indicates a strain counterstrain to the pterygoid. Palpate the side that caused the weakness to see which is the sorest. At the sorest point, hold your index finger as you bring the patient's neck into flexion to see if the sore area is alleviated. At the point of cervical flexion that alleviates soreness, hold the neck in that position as you hold contact on the pterygoid and let the patient take a deep breath and hold. Hold this contact until the soreness in the pterygoids leaves and then slowly return the neck to the normal position. (4)

Check if upper cervical fixation is present. You will find a fix if there is a weak gluteus maximus muscle on both sides. Correct by standard applied kinesiology procedures. (5)

CONCLUSION: By correcting the meningeal subluxation the benefits and results that your patients will receive is remarkable.

REFERENCES

- (1) Gray's Anatomy, 27th edition, Pub. Lea & Fibinger
- (2) Goodheart, George J., Applied Kinesiology 1983 Workshop Manual, Privately published.
- (3) Goodheart, George J., Applied Kinesiology 1985 Workshop Manual, Privately published.
- (4) Goodheart, George J., Applied Kinesiology 1984 Workshop Manual, Privately published.
- (5) Goodheart, George J., Tape #64.

LOW BACK PAIN AND DEPRESSION

A RETROSPECTIVE STUDY OF 129 CASES

BY

JOHN F. THIE, D.C.

A retrospective study of 129 consecutive cases in our clinic revealed only 7 patient, or 5.5%, who had an entrance complaint of both low back pain and depression.

There were 49 cases, or 38%, who had low back pain and 14 cases, or 11% that had depression.

In a retrospective study of patient entrance histories of 129 cases entering the Thie Chiropractic Clinic in Pasadena, the following data was collected from the history forms which were filled out by the patients on their initial visit to our clinic.

The data had four possibilities. The patient instructions were to fill in every blank with a 1 for never had this complaint; 2 for previously had this complaint and 3 for currently suffering from this complaint. The fourth possibility was for the patient to not fill in the blank.

In the depression category, 66 or 51% stated that they had never suffered from depression as a symptom. 25, or 19% stated that they had previously suffered from this symptom. Only 14 or 11% of the patients stated that they were currently suffering from depression. There were 24 left blank by this group of 129 patients or 19%.

In the low back problem category, 24 or 19% stated that they had never suffered from a low back problem. There were 42, or 32% who said that they previously suffered with low back problems. The current complaint of having low back problems was found in 49, or 38% of the histories. 14, or 11% did not fill out this part of the history form.

When this study was started, I was wondering if there was a correlation between depression and low back problems. From these statistics that only 7 patients or 5.5% of the patient population had both a current complaint of depression and low back problems.

It is hoped that other members of the college will collect data regarding the numbers and types of entrance complaints that patients present so that we can understand our patient populations regarding their entrance complaints.

THE GRADING OF INTERVERTEBRAL DISC LESIONS

B.E. VICKERY, D.C.

ABSTRACT: Applied Kinesiology has identified a disc lesion that is not identified by previous diagnostic methods. Therefore, we suggest the following classifications of disc lesions.

INTRODUCTION

Spinal pain has been labeled "85% guess work"⁽¹⁾ by the world's leading orthopedic surgeons. With the use of CAT Scan and Applied Kinesiological tests for IV-disc lesions, it has become clear that most on-going and persistent spinal pain is caused by IV-disc cartilage lesions, with or without subluxations. It is necessary to re-classify disc lesions according to these findings and remove the mystery as to the cause of most spinal pains.

DISCUSSION

My initial paper⁽²⁾ on disc lesions with CAT Scan followup stated: "we chiropractic physicians who practice AK have the finest most sensitive tool for the diagnosis and treatment of herniated and bulging discs yet developed!" This statement is still true. Since that time, we have continued accumulating files on CAT Scan (83), and can now clarify IV-disc lesions.

Using the triple disc challenge for injury -- opening, closing and spinous laterality as the standard -- we found 25 cases (CAT Scan) with no visible change in the shape of the disc, and 58 of which did show changes from slight bulges to complete herniation.

Applying the theorem "things equal to the same thing are equal to each other" brought us to the conclusion that disc lesions should be called "lesions" because by definition: "a lesion is any

pathological or traumatic discontinuity of tissue"⁽³⁾. Selectively, "degenerative lesions -- one which is caused by or is characterized by degeneration."; "histological lesion, microscopic lesion, minute lesion --one that is discoverable only by the microscope"; versus "gross lesion -- a lesion that is visible to the naked eye."

Grading of Disc Lesions

By incorporating these elements; the small to large lesions; the uniform results of Applied Kinesiological challenge⁽⁴⁾ to all stages of degeneration; CAT Scan verification; the knowledge that the disc has rich nerve enervation⁽⁵⁾; and the observation that almost all cases respond to proper treatment; we suggest the following classifications:

1. Grade 1 Disc Lesion - Internal Disc Nerve Irritation

The disc is outwardly normal (CAT, myelogram). The disc, however, on challenge, weakens a strong muscle. This is the most common disc lesion which remains undiscovered by previous methods of investigation! Clinically, patient has varying degrees of pain. The nerve root (paraspinal) area is tender to deep palpation. This is the beginning of degeneration. According to Boyd⁽⁶⁾ "The lesions may develop in any of the three constituents, i.e. 1. the nucleus ..., 2. the annulus...}the cartilage plate." May often be neutralized with gentle adjustment.

2. Grade 2 Disc Lesion - Internal Disc Irritation and External Ligaments

Positive CAT evidence of bulge. Patient may be antalgic. Need more treatment -- typical spinal adjustment may be very harmful at this stage!

3. Grade 3 - Herniated or Prolapsed Disc (Nerve & Spinal Impingement)

CAT Scan, Myelogram grossly visible. Patient may be antalgic. Posterior displacement of nucleus into the spinal canal. Rest, and time (up to six to seven months) are needed for successful treatment. Definitely no adjustment of "subluxations" until healing is well underway. This can be catastrophic! (7)

SUMMARY

Applied Kinesiology again makes the invisible, visible and has taken the mystery out of back pain. By the identification and proper treatment of the grade 1 disc lesion, the major source of spinal pain is isolated and identified. The pain generated in these early lesions is primarily discogenic, while in the 2nd and 3rd grade lesions, ligament stretch and nerve tissue impingement become the dominant factors. Factors such as arthritis, neuromuscular trigger points can be treated simultaneously. Incidences of tumors and neoplasms are estimated to be under 1% in our experience.

Furthermore, since the majority of afflicted persons also show altered chemistry and are often repeaters, it is an opportunity to modify these nutritional factors to prevent further degeneration.

References:

- (1) CBS News 1985
- (2) Vickery, Brice E. "Traumatized Intervertebral Disc: Applied Kinesiological Diagnosis-Treatment with Routine CAT Scan Evaluation". ICAK Collected Papers, Winter 1983

References (cont'd)

- (3) The American Illustrated Medical Dictionary
W.A. Newman Dorland, M.D. Saunders, 1948 edition
- (4) Walther, David S., Applied Kinesiology, "The Advanced Approach In Chiropractic", Systems D.C., Pueblo, Colorado 1976
- (5) Cox Lumbar Spine Symposium information - January 1986
- (6) "Textbook of Pathology", William Boyd, M.D.
1948 - Lea & Febiger, Philadelphia page: 1002
- (7) Orthopaedics Principles and Their Application
Samuel L. Turek, M.D. Lippincott page: 1335

A SPECIFIC NUTRITIONAL GUIDE AND SOME APPLIED KINESIOLOGY
SUGGESTIONS FOR PATIENTS' SIGNS AND SYMPTOMS

by

Dr. C. Lance West, D.C., D.I.C.A.K.

ABSTRACT

During the years of attending and videotaping Dr. George Goodheart's seminars, listening to his monthly research tapes, and checking personally with Dr. Goodheart about specific patient problems and their nutritional needs, the following nutritional and general information have been collected.

No amount of praise could adequately thank Dr. Goodheart for his valuable research and generous sharing of his vast knowledge and expertise. This paper represents the accumulation of some of the information which he has contributed to our profession and specifically to the International College of Applied Kinesiology.

The information in this paper is from Dr. George Goodheart's research manuals, lectures, seminars, research tapes, and conversations with him. There are some exceptions, as specifically noted, in the paper; for example, Dr. Wright's Book of Nutritional Therapy, Jonathan V. Wright, M.D., with specific page references from which the information was obtained.

The information has been arranged alphabetically so it can be transferred to individual cards to form a card file to which you might add specific items or ideas as they appear. You would then have all this information at your finger tips for quick reference.

ABSTRACT (continued)

I hope this paper will be a source of really valuable assistance in your daily practice when you need specific information relating to your patients' needs.

In preparing this article, I am greatly indebted to Dr. Tom Kalis, D.C. of Allen Park, Michigan for his valuable assistance in helping me collect this information.

I am also greatly indebted to my secretary, Mrs. Dorothy Mann, for the many weeks she worked on the computer to arrange, edit, type, and prepare this paper for publication.

TABLE OF CONTENTS

	<u>Page No.</u>
Absorption	1
Acidosis	1
Acne	2
Acromioclavicular Joint	3
Adrenals	3
Adrenals - Physiology of the Adrenal Cortex	4
Aerobic Muscle Testing	6
Anaerobic Muscle Testing	7
Alkalosis	7
Allergies - Alkaline	8
Allergies - Endocrine	8
Allergies - Food	9
Aluminum	10
Amenorrhea	11
Anemic	11
Antacids	12
Antibiotics	12
Anti-Inflammatories	13
Antiviral	13
Arms	13
Arthritis	13
Arthritis - Osteo	14
Arthritis - Rheumatoid	15
Belching	16
Bile	17

TABLE OF CONTENTS (continued)

	<u>Page No.</u>
Blepharospasm	17
Blisters	17
Blood	17
Blood Information	18
Blood Pressure	18
Blood Vessels	18
Body Odor	19
Breasts	19
Bronchitis	20
Bruising	20
Burns	20
Bursitis	20
Calcium	21
Calluses	21
Calves	21
Canker Sores	21
Carpal Tunnel Syndrome	21
Cataracts	22
Chlorophyll Capsules	22
Cholecystitis (Gallbladder)	22
Cholesterol	23
Colds	23
Colitis	23
Colitis (Dr. Wright's Book of Nutritional Therapy)	24
Colitis - Ulcerative	24

TABLE OF CONTENTS (continued)

	<u>Page No.</u>
Constipation	24
Contraceptives - Oral	25
Cortisone	25
Costo-Cartilage	25
Cough	26
Cramps	26
Crying	26
Cystitis	27
Dandruff	27
Dandruff (Dr. Wright's Book of Nutritional Therapy)	27
Deodorants	28
Depression	28
Diabetes	28
Diabetes Mellitus	28
Diarrhea	28
Diet	29
Diet - Allergies	29
Diet - Cancer	30
Diet - Degenerative Arthritis	30
Diet - Diabetes	30
Diet - Hypertension	31
Diet - Kidney Stones	31
Diet - Old People	31
Diet - Older Women	32

TABLE OF CONTENTS (continued)

	<u>Page No.</u>
Diet - Optimum	33
Diet - Pregnancy	34
Diet - Small Person	34
Diet - Women	35
Digitalis	36
Dilanton	36
Disc	36
Diseases - Degenerative	37
Diuretics	37
Dreams	37
Dysmenorrhea	37
Ears	38
Ears - Infections	39
Eczema	39
Eczema (Dr. Wright's Book of Nutritional Therapy)	39
Edema	40
Elbow	40
Enemas	40
Energy	40
Enuresis	41
Epilepsy	41
Epistaxis (Nosebleeds)	41
Essential Fatty Acids	41
Extremities	42

TABLE OF CONTENTS (continued)

	<u>Page No.</u>
Eyes	42
Eyes - Infection	43
Fascial Flush	43
Fat Absorption	44
Fatigue - Chronic	44
Feet	44
Fever	45
Fingers	45
Fixations - Vertebral	46
Flatulence	46
Flatulence (Dr. Wright's Book of Nutritional Therapy)	46
Foot Levelers	47
Free Radicals	47
Gait	47
Gallstones	48
Ganglion	48
Glaucoma	48
Gout	48
Hair	48
Head	49
Headache	49
Headache - Migraine	50
Health Principles	50
Heartburn	51

TABLE OF CONTENTS (continued)

	<u>Page No.</u>
Heart Problems	51
Heel Lift	51
Hematoma	51
Hemorrhoids	52
Hepatitis	52
Hernia	53
Herpes	53
Hiccups	53
Hot Flashes	54
Hydrochloric Acid	54
Hypoglycemia	54
Ileocecal Valve	55
Imbrication	56
Infections - Child	56
Infections - General Recommendations	57
Influenza	57
Insomnia	58
Intermittent Claudication	58
Intestinal Gas	59
Iodine	59
Iron	60
Itching	60
Juices	61
Kidneys - Infection	61

TABLE OF CONTENTS (continued)

	<u>Page No.</u>
Kidneys - Nephroptosis	62
Kidneys - Stones	62
Kidneys - Stones (Dr. Wright's Book of Nutritional Therapy)	63
Knee	63
Lactic Acid Yeast	64
Lactobacillus Acidophilus	64
Laxatives	64
Learning Disability	65
Ligaments	65
Ligament - Interlink	65
Liver	66
Lumbar	66
Lymph	66
Magnesium	67
Memory	67
Menorrhagia	67
Menstrual Period - General	68
Menstrual Period (Dr. Wright's Book of Nutritional Therapy)	69
Metabolism - Fat	69
Metrorrhagia (Bleeding Between Menstrual Periods)	69
Milk	69
Mineral Oil	70
Miscarriages	70
Mouth - Dry	70

TABLE OF CONTENTS (continued)

	<u>Page No.</u>
Mucus	71
Muscles	71
Muscle Testing	71
Myxedema	72
Nails	72
Nervousness	72
Neuroceptors	72
Neurologic Disorganization	73
Niacin Versus Niacinamide	73
Night Blindness	74
Nightmares	74
Nightshade	74
Nose	74
Nutrition	75
Obesity	75
Osteoporosis	75
Pain	76
Palm	76
Pancreas	76
Parotid Gland	77
Pectoralis Minor	77
Perspiration	77
pH	77
Phosphorous	78

TABLE OF CONTENTS (continued)

	<u>Page No.</u>
Polyuria	78
Premenstrual Syndrome (PMS)	79
Prostate	79
Prostate Problems	80
Pruritus Ani	81
Quadriceps	81
Sacroiliac Subluxation	81
Salivation	81
Scalenus Anticus Syndrome	82
Schizophrenia	82
Sexually-Related Problems	82
Shin Splints	82
Shoulder Elevation	83
Sinus Problems	83
Skin	84
Sleep	84
Soybeans	84
Stiffness	85
Stools	85
Success Syndrome	85
Sunburn	85
Supplements	86
Switching	86
Tachycardia	87

TABLE OF CONTENTS (continued)

	<u>Page No.</u>
Taste	87
Teas - Herbal	87
Teeth (Pain)	88
Tensor Fascia Lata (TFL)	88
Throat	88
Thymus Gland	88
Thyroid - General Information	89
Thyroid (Hypo)	90
Tinnitus	91
TMJ	91
Tongue	92
Trace Minerals	92
Tranquilizers	92
Trigger Points	92
Ulcers	93
Urea	93
Urinary Infections	94
Urinary Problems	94
Urinary Testing	94
Uterine Fibroids	95
Vagina	95
Varicose Veins	95
Vertigo	96
Visceroptosis (Dropped Viscera)	96

TABLE OF CONTENTS (continued)

	<u>Page No.</u>
Vitamin A	96
Vitamin B	97
Vitamin B12	98
Vitamin C	98
Vitamin D	98
Vitamin E	99
Vitamin F	99
Vitamin G (Complex)	99
Vitamin K	100
Vitamin P	101
Warts	101
Water	101
Water Balance	102
Weight	102
Whiplash	102
Yawning	102
Yeast Infections	102
Yeast Infections (Dr. Wright's Book of Nutritional Therapy)	103
Zinc	104
References	105

ABSORPTION

- Signs and Symptoms: Chronic gas, low-grade diarrhea, undigested food in the bowel movements, etc.
- Use hair analysis (see section on Hair).
- Usually means a lack of stomach acid (hypochlorhydria). Take Betaine HCl or Glutamic HCl to increase the acid in the stomach. If the stomach feels bad or patient has heartburn, worse gas, pain, or any other symptoms, stop the HCl. Use 5-60 grains of HCl, depending upon the individual.
- Another possible solution is a lack of pancreatic digestive enzymes; try these. There aren't any side effects except for allergies; however, allergies are also related to a lack of stomach acid.
- If patient has poor absorption, he will have a history of health problems. Patient will have difficulty in digesting carbohydrates, fats, and protein.
- Side Notes:
1. Don't ever take Betaine HCl or Glutamic HCl with anti-inflammatory drugs (i.e., Aspirin, Indocin, Butazolidin, or Cortisone). They increase the chances of ulcers.
 2. You can tell if the absorption is O.K. by the relief of signs and symptoms.
 3. You can use the hair analysis every six months.

ACIDOSIS

--Signs and Symptoms:

1. Shortness of breath.
2. Frequent sighing.
3. Irregular respiration.
4. Breathlessness.

ACIDOSIS (continued)

- | | |
|------------------------------|--------------------------------|
| 5. Tendency to be irritable. | 10. Restlessness with signs of |
| 6. Tachycardia. | dehydration (i.e., dry mouth, |
| 7. Photophobia. | decrease in urine and |
| 8. Dysphagia. | sweating, and dry, hard |
| 9. Insomnia. | stools). |
- Nutrition:
1. Calcium Lactate - pH 6.0 - 7.0 - 3 tablets daily.
- pH 5.0 - 6.0 - 6 tablets daily.
 2. Alkaline minerals.
 3. Leafy vegetables.
 4. Vitamin A Complex. It regulates the pH.
 5. Restricted sodium can cause acidosis.
- Check upper cervicals.
- Check the dorsals.
- Check the liver.
- Check the pelvis.
- Can be caused by diabetes.

ACNE

- Skin problems.
- Thymus and thyroid problems (Endocrine problems).
- Test for weak scalene muscles - use B6. B6 will make them strong. Use B6 cream locally.

ACNE (continued)

- Allergy to foods, especially a food they like. Using muscle testing, check the foods they eat.
- Check need for zinc.

ACROMIOCLAVICULAR JOINT

How to Fix: Tape the arm and shoulder (sticky sides together). Any time you have pain in the injured shoulder, move the good shoulder back. This automatically forces the injured shoulder to come together.

ADRENALS

- Use green beans and zucchini for adrenal problems (natural source of sodium); sodium is needed for the adrenals.
- With Sartorius, Gracilis, and Posterior Tibial weakness, if adrenal material doesn't improve strength, try choline and/or lecithin - 3-12 tablets daily.
- Physical findings with Hypoadrenia:
 1. Ragland effect - change in blood pressure.
 2. Paradoxical pupillary dilation.
 3. Rogoff sign.
 4. Increased sound over pulmonary area.
 5. Weak adrenal muscles.
- Nutrition: Use adrenal gland nutrition, pantothenic acid, and chromium.

ADRENALS - PHYSIOLOGY OF THE ADRENAL CORTEX

The hormones of the adrenal cortex influence the biochemical behavior of most, if not all, tissues of the body. They affect electrolyte and water balance; the metabolism of carbohydrates, protein, and fat; androgenic function; pigment metabolism; lymphoid morphology; the responsiveness of connective tissue; host resistance; and adaptation to stress. If the adrenal cortices are destroyed or removed and adequate replacement therapy is not supplied, profound physiologic changes ensue and death occurs.

The signs and symptoms associated with adrenocortical inadequacy include anorexia and GI dysfunction, weight loss, dehydration, hypotension, hypoglycemic episodes, weakness and easy fatigability, dizziness and syncopal attacks, increasing pigmentation, nervous irritability, and a striking decrease in resistance to all forms of stress. A prominent feature of adrenocortical deficiency is the inability to retain salt and to maintain normal water and electrolyte balance. Excessive loss of sodium and chloride is associated with negative water balance and susceptibility to water intoxication. Plasma sodium and plasma chloride are decreased and plasma potassium is increased. Disturbances in carbohydrate metabolism include impaired gluconeogenesis and increased oxidation of glucose; consequently, liver glycogen is depleted and the fasting blood sugar is usually decreased.

Indications: Adrenal Cortex Extract is indicated in the treatment of patients with chronic primary adrenocortical deficiency (Addison's Disease) and

ADRENALS - PHYSIOLOGY OF THE ADRENAL CORTEX (continued)

secondary adrenocortical insufficiency induced by (1) adrenal surgery, (2) adrenal vascular accidents, (3) overwhelming systemic infection (e.g., Waterhouse-Friderichsen Syndrome), or (4) the combination of a usually non-critical stress (such as anesthesia, surgery, infections, or trauma) and inadequate adrenocortical reserve. Because of the multiple physiologic actions of the adrenocortical hormones and their essentiality for maintenance of normal adaptation to stress, Adrenal Cortex Extract may be of value in various conditions. In Addison's Disease, a satisfactory response to Adrenal Cortex Extract is evidenced by cessation of nausea and vomiting, increased appetite with weight gain, increase in energy, relief of asthenia and fatigue, elevation of blood pressure to normal, and decrease in nervous irritability. Maintenance therapy with Adrenal Cortex Extract should be adequate to prevent crisis as well as to sustain a good clinical response and should, therefore, be intensified during periods of intercurrent stress.

Support:

- | | |
|---------------------|--------------------|
| 1. Vitamin C | 6. PABA |
| 2. B Complex | 7. Minerals |
| 3. Pantothenic Acid | 8. Adrenal Gland |
| 4. Vitamins A and D | 9. Pituitary Gland |
| 5. Vitamin E | 10. Tyrosine |

ADRENALS - PHYSIOLOGY OF THE ADRENAL CORTEX (continued)

Zucchini Vegetable Soup is a good source of organic sodium.

1 can or frozen package of french green beans

1 cup chopped celery with leaves

1 medium zucchini - quartered

1 cup tomato juice

1 cup water

2 tablespoons honey

1 teaspoon paprika

2 tablespoons dehydrated onion flakes

Pepper to taste

Combine and simmer until tender - about one hour. Serve hot or cold.

Foods high in organic sodium are zucchini, squash, green beans, and celery.

AEROBIC MUSCLE TESTING

--Nutrition: Iron.

--Red and/or dark muscles.

--With oxygen for long distance, endurance type.

--Burn fat - slow twitch - postural muscles.

--Slower testing than anaerobic testing - 1 test per second.

--Exercise - 80% of their maximum pulse! 12-15 minutes - 4 times a week.

(General rule: $180 - \text{patient's age} = \text{maximum aerobic pulse.}$)

ANAEROBIC MUSCLE TESTING

- Needs pantothenic acid and long NL work.
- White and/or light muscles.
- Without oxygen - for short distance, speed type.
- Upper body muscles - fast twitch.
- Quick and short tests (faster than aerobic) - 3 tests per second.
- These muscles burn glucose.

ALKALOSIS

--Signs and Symptoms:

- | | |
|--|--|
| 1. Slow pulse. | 7. Burning, crawling, and itching-
type sensations. |
| 2. Night cramps. | 8. Rapid blood clotting time. |
| 3. Stiffness of joints. | 9. Patient feels worse after
eating. |
| 4. Night cough. | 10. Abnormally high hematocrit. |
| 5. Circulatory disturbances. | |
| 6. Dryness of skin with
thickening. | |

--Nutrition:

1. Phosphorous - Phosfood - 10 drops in a glass of water, 3 times a day.
2. Acid minerals.
3. Non-citrus acids (i.e., cider vinegar).
4. Phosphorous and potassium.
5. Cider vinegar is a dilute solution of potassium.
6. Consider Vitamin A Complex. It regulates the pH.
7. HCl supplementation.

ALKALOSIS (continued)

- Check upper cervicals.
- Check the dorsals.
- Check the liver.
- Guanidine is the most alkaline substance known.

ALLERGIES - ALKALINE

- If patient is alkaline, acidify the large intestine by taking an apple cider vinegar enema - 1 to 3 tablespoons to a quart of water.
- Fix cranial faults - temporal bulge - parietal descent.
- No citrus fruits or juices. Limit other fruits and juices.
- Eat more natural grains and yogurt.
- No refined sugar; or keep to a minimum.
- Check Bilateral Pectoralis Major Clavicular.
- Use Betaine HCl, Cal-Amo, and Phosfood.

ALLERGIES - ENDOCRINE

- Sartorius, gracilis, gastrocnemius muscles.
- Look for posterior ilium (Category II).
- Nutrition: Adrenal extract, Vitamin C, sea salt, Drenamin (more complete support than Drenatrophin). No refined sugars.

ALLERGIES - FOOD

--Signs and Symptoms: itching, asthma, hives, eczema, arthritis, bursitis, low back pain, and anything else!

--Anything that comes in a bag, box, or can or if it is dried, fried, or laying on its side is dead food. Take patient off the above and then give them a food intake form. Have patient record all food eaten. Take them off any food they eat three or more times a week; later, reintroduce it.

--Take food out of diet for a week and then put it back every fourth day. If you don't, the patient will develop a sensitivity to something else.

--Use a rotation diet.

--Pulse will increase with food allergies. Pulse testing takes time.

--Skin testing for food allergies is useless!

--Blood test RAST is very good but not foolproof. The test exposes the blood to allergens.

--Give up to 400 mcg. of selenium.

--Give Antronex - 2 tablets - 3 times a day.

--AK Testing:

<u>Muscles</u>	<u>Organ</u>
Bilateral Pectoralis Major Clavicular	Stomach
Pectoralis Major Sternal	Liver
Latissimus Dorsi	Pancreas
Infraspinatus	Thymus
Rectus Femoris	Small Intestine
Sartorius	Adrenal

ALLERGIES - FOOD (continued)

--Side Notes: Check any chronic muscle that is weak. In a bad allergy, all muscles will be weak. In an allergic-type patient, check Histadine on tongue - all muscles will weaken. Then place Antronex on tongue, and all muscles will become stronger.

--Big Offenders - Foods:

1. Coffee, colas, chocolate, and black tea.
2. Nightshade family of foods cause joint pain and arthritis. These foods are tomatoes, green peppers, egg white, potatoes, tobacco, and paprika.
3. Dairy products: cheese, milk, and eggs. Patient may react to one kind of dairy product, but not another.
4. Spices.
5. Salt.
6. Mayonnaise (kind and type may have an effect).
7. Meat (check different kinds).
8. Bread.
9. Grains.
10. Sugar in any form.

ALUMINUM

Stainless steel pots and pans are much healthier than aluminum, but the steel people can't say that legally. Aluminum removes the phosphorous from the phospholipid sheath that protects cells.

AMENORRHEA

- Fix lumbar and sacral areas.
- S-1 joint problems.
- Normal body fat - 22%. If below that, they need the fat of endocrine production.
- Expose skin to sunlight or full spectrum light as much as you can.
- Failure of maturation of the graafian follicle which would be due to the reluctance of the anterior pituitary gland to elaborate follicle stimulating hormone.
 1. Severe emotional stress.
 2. Cranial lesion.
 3. Chronic illness - endocrine depletion.
 4. Very poor nutrition - protein deficiency.
 5. Major structural faults.
 6. Pituitary drive technique, pineal, light therapy. When the lights are on, the pineals are on. When you turn off the lights, the pineals turn off. May also be a TMJ problem.
 7. Fluid retention - use B6. Estrogen inhibits B6 dependent enzymes.
- Athletic Amenorrhea (specifically runners) tends to have a decreased level of estrogen resulting in a Ca problem and should increase Ca levels to 1,500 mg. per day (same as postmenopausal females).

ANEMIC

Often, these patients don't need iron; they need to acidify their often alkaline gastrointestinal tract - use Lactic Acid Yeast.

ANTACIDS

- Interfere with vitamin and mineral absorption.
- Supplement with Vitamin B1 - 10-20 mg.
- Take calcium and phosphorus.

ANTIBIOTICS

- They kill unwanted and wanted germs. Some of the wanted germs don't always return on their own.
- A common, recurring problem for women is the vaginal yeast infection. This usually occurs after antibiotic therapy which kills all of the unwanted germs but also kills the wanted germs, and then the yeast or other germs take over the vaginal area and cause trouble. See "Yeast Infections" section for more information.
- They also kill off normal intestinal bacteria. This causes diarrhea, especially in children. Problems that occur are decreased synthesis of Vitamin K and decreased utilization of Ca, Na, Folic Acid, and Vitamin B12. Patients can avoid this by taking Lactobacillus Acidophilus every day they are on antibiotics (or eat homemade, unsweetened plain yogurt), and continue taking it for a week to ten days after the antibiotic therapy has stopped.
- If diarrhea develops after their use, use Zymex.
- After their use, use acidophilus, buttermilk, or plain yogurt enemas.

ANTI-INFLAMMATORIES

Dr. Wright's Book of Nutritional Therapy, J.V. Wright, M.D., Page 369.

"Aspirin, Butazolidin, and Indocin are usually used for arthritis, bursitis, tendonitis, and rheumatism problems. If patient is on any of these, use B Complex and 1-2 grams of Vitamin C per meal."

ANTIVIRAL

Use Selenium.

ARMS

- If arms feel heavy, check deltoid. Also, check PMS (liver) and PMC (stomach).
- If arms feel like lead (very heavy), check the infraspinatus.
- Armpits: sweaty - don't perspire enough other places. Use a lemon on your skin. Take a pint of hot drink with lemon, and soak in a hot bath with lemon (also, wrap the body in a plastic sheet to increase general perspiration).

ARTHRITIS

- Liver problem - check Betacol.
- Arthritics have very sluggish livers.
- Arthritics usually are constipated, caused by Guanidine (the most alkaline substance known) in the liver which creates an alkaline body, which causes the blood to be alkaline, which causes Ca decrease, which causes

ARTHRITIS (continued)

calcification. Therefore, the treatment should be:

1. Acidify the body.
2. Detoxify the body.
3. Get rid of the constipation.

--Don't use mineral oil because it is indigestible and Vitamin A is soluble in it. Vitamin A cannot be reclaimed and Vitamin A tends to protect against arthritis.

--Needs B6.

--Precipitated Ca in the bone-arthritic-phosphorous deficiency.

--Use Vitamin C as a preventative and cure!

--Allergic arthritis. This is an allergy which manifests itself with arthritis signs and symptoms.

--Degenerative arthritis - don't use milk.

ARTHRITIS - OSTEO

--Use Ammonium Chloride - Betaine HCl.

--Osteoarthritis patient with calcium deposits.

--There is more Ammonium Chloride in Cal-Amo than in Betaine HCl.

--Use OSTARPLEX for stiffness and swelling of the joints. It contains 30% Betacol, 30% Phosfood, 20% Ostrophin, 10% Cal-Amo, and 10% Complex G.

ARTHRITIS - RHEUMATOID

--Diet: Don't eat any citrus fruits or high carbohydrate foods (i.e., natural or refined dates, figs, honey, etc.)

--Eat: Fresh vegetables and fruits (most desirable are bananas and potatoes). Raw potato juice is excellent. Whole grain cereal is good. As much as possible, proteins should be from fish and fowl. Yogurt is excellent when constipation is a problem.

--Nutrition:

1. Betacol - joint pain, rheumatic swelling, inflammation. Take 1 - 3 times a day.
2. Thymex - rheumatoid, inflammatory condition. Take 1 - 3 times a day.
3. Drenamin - allergy. Take 3 times a day for 3 days; then 6 to 9 times a day thereafter.
4. Arginex - liver and kidney. Take 6 times a day; then 1 to 3 times a day.
5. Use Calcium Lactate.
6. Use Rumaplex - contains Ca, B, protomorphogen, and protein. Ingredients: 20% Cyroplex, 10% Ostrophin, 8 1/3% Calcium Lactate (fortified), 16% Arginex, 10% Calcifood, 8 1/3% Brewer's Yeast, 16 2/3% Betacol, and 10% Prost-X.
7. Check Nutrimere. This is a whole protein product.

--Product Bulletin:

1. Ferrofood - take 1 - 3 times a day.
2. Cyruta (inflammatory condition) - take 1 - 2 times a day.
3. Ostogen Wafers - take 1 - 4 times a day.

ARTHRITIS - RHEUMATOID (continued)

4. Thymex - rheumatoid inflammation - take 1 - 3 times a day.
5. Drenatrophin - joint inflammation - take 1 - 3 times a day.
6. Ostrophin - take 1 - 4 times a day.

BELCHING

--Signs and Symptoms:

1. Lack of Betaine HCl.
2. Hiatal hernia.
3. Vasomotor disturbance.

--Blood pressure: (1) less than 120, (2) 120-140, and (3) more than 140.

--Put pressure at side of right D5, both sides of D10, and both sides of L2.

--For (1) and (2) blood pressure: take this as the standard blood pressure. Run your fingers down the TP; use cold on areas that are red, and hot on white areas; or use a hard adjustment. For (3) pressure, use heat only.

--Less than 120 blood pressure: cool red spots or use a hard adjustment. Heat white spots.

--120-140 blood pressure: same as above.

--More than 140 blood pressure: use only heat.

BILE

- Can be thinned with A-F Betafood.
- Betaine increases metabolism of some bacteria. Don't give to a patient with an infection (respiratory, etc.).
- Bile salts dosage (with heavy meal): 1 the first day, 2 the second day, and 3 the third day.
- Bile salts thicken thin mucus.

BLEPHAROSPASM

- Patient usually has a problem with occiput posterior.
- Use PRYT (pitch, roll, yaw, and tilt technic).
- Give chelated trace minerals.
- Comes and goes.
- Electron poisoning EBA (e-Poise - new from Standard Process Labs).

BLISTERS

Very small on the palm of the hand - use bile salts.

BLOOD

- Copper and iron are needed together (a balance).
- Lack of Folic Acid creates problems.
- Use Vitamin B12 and Folic Acid. When giving B12, use Folic Acid with it to prevent possible Pernicious Anemia.

BLOOD INFORMATION

The ratio of phosphorous to calcium is 4 to 10.

BLOOD PRESSURE

- High Blood Pressure Symptoms: flushed complexion, headache, overweight, high cholesterol, and high triglycerides.
- High diastolic - look to the kidneys. The prostate could be putting pressure on the bladder; this pressure is forcing the urine back into the kidneys. Decrease salt consumption to zero.
- Run your fingers down the sides of the spine and look for red and white areas. Cool the red areas and heat the white areas.
- Ragland Test - blood pressure goes up 20-30 points - usually indicates a highly-excited state.
- Use garlic to decrease blood pressure. It decreases dizziness, headaches, and lowers serum cholesterol.
- Elevated systolic/diastolic - consider Antronex. Give patient 2 tablets; wait 10 minutes and take the blood pressure again. If it has decreased, the cause is partly due to a congested liver.
- Low blood pressure - use Vitamin B.

BLOOD VESSELS

Dr. Wright's Book of Nutritional Therapy, J. V. Wright, M.D., Page 330.

"To increase elasticity, try magnesium."

BODY ODOR

Dr. Wright's Book of Nutritional Therapy, J. V. Wright, M.D., Pages 328-331.

--"Needs Calcium Lactate and Magnesium Chloride (especially magnesium) for 3-4 weeks.

--If magnesium doesn't work, try zinc."

BREASTS

--Lumpy - fibrocystic disease. This is a lumpy breast without cancer.

--One-half of all women have lumpy breasts.

--Lumps:

1. Fibroadenomas - smooth, round, solid, and freely movable (like a marble). They should be removed. They won't go away. They increase in size during pregnancy and lactation.
2. Pseudolumps - distinct in a lumpy breast and change in size with menstrual cycle. They are sore and tender in women in their thirties.
3. Cysts - fluid-filled sacs. They are painful and appear overnight; are common in women in their forties; are benign; and can be treated (drained) with a needle by their M.D. or D.O.
4. Cancer - hard and usually not tender; are movable or fixed in post-menopausal women; and need a biopsy.

--With lumps, stop caffeine consumption for a month or two. Expect a reduction in the size and/or fewer lumps. This is an allergic response.

BRONCHITIS

Shortness of breath - usually D1 left, TP to left inferior, SP to right.

BRUISING

Use Chlorophyll Complex, Bioflavonoids, Cyruta Plus, Vitamin C, and Vitamin K.

BURNS

--Use chlorophyll ointment and wheat germ oil (an antioxidant).

--Put burn under cold water as soon as possible.

BURSITIS

--Needs HCl in the tissues. Use Cal-Amo - 1 every hour.*

--This is a spot, a hot spot. Very, very sensitive; not a general shoulder ache. Needs to be acidified. Use ACP&E - 6 per day. Limit the motion; use cervical collar; needs taping.

--Check the liver, adrenals, and kidneys.

--Bursitis can occur in the spinal area as well.

*Too much Cal Amo will cause diarrhea, a burning sensation in the throat, or yawning (Acidosis).

CALCIUM

- Phosphorus/Calcium - 4 to 10 daily.
- Patient who is nervous and jumpy needs calcium.
- With a deficiency, patient gets infections and colds easily. Use Calcium Lactate.

CALLUSES

Dr. Wright's Book of Nutritional Therapy, J. V. Wright, M.D., Pages 287-293.

"Very heavy calluses on the feet or any part of the body (i.e., elbows, hands, etc.) - consider using Vitamin A."

CALVES

- If you squeeze the calf and it is tender, patient needs Vitamin B.
- Check for possible Hidden Cervical Disc.

CANKER SORES

- Use Calcium Lactate and Complex F.
- Test for B6 need.

CARPAL TUNNEL SYNDROME

- Use Ostogen and B6.
- After mechanical correction, use a wrist support.

CATARACTS

--Use B4 and B Complex.

--Precipitated Ca in the eyes - phosphorous deficiency.

CHLOROPHYLL CAPSULES

Dr. Wright's Book of Nutritional Therapy, J. V. Wright, M.D., Page 329.

"They are a good source of magnesium and potassium."

CHOLECYSTITIS (GALLBLADDER)

--Check with Murphy's Sign.

--Thin the bile with Iodine and A-F Betafood.

--Acute:

1. Stop all food.
2. Drink a lot of hot water (as hot as you can stand it). This dilutes the bile.
3. Use a cold pack over the gallbladder.
4. Enemas - repeat several (acid) to clean out the gut (one quart water and juice of one-half lemon).

--Chronic (with or without stones):

1. A-F Betafood.
2. Bile salts to promote function.
3. Olive oil and lemon juice in equal amounts.
4. Zymex for change in bowel flora.

CHOLESTEROL

Dr. Wright's Book of Nutritional Therapy, J. V. Wright, M.D., Page 330.

"Try magnesium to decrease cholesterol."

COLDS

- Take Calcium Lactate and Vitamin C so the cold won't take hold.
- Check need for A-C Complex.
- Don't drink citrus juices. They make the gut alkaline; you want to acidify it. Use Ascorbic Acid and Betaine HCl.

COLITIS

- Emergency measure: mono-diet - one food per meal, then use a rotation diet (every 4 days).
- Use chlorophyll for local irritation.
- Latonex (from drug store - needs to be refrigerated). Can be used orally and rectally.
- Selenium - patient may show a need for this.
- Look for an allergy problem.
- Use Vitamins A, D, and B Complex.
- Restore pH and intestinal flora.
- Check: lumbar, pelvis, pituitary gland, adrenal gland, and electrolyte support.

COLITIS

Dr. Wright's Book of Nutritional Therapy, J. V. Wright, M.D., Pages 92-93.

- "Increase bran. Use 2 rounded tablespoons on breakfast cereal.
- Replace white flour with whole grain flour.
- Take a dose of lactobacillus acidophilus per day (liquid or capsule).
- No sugar.
- Use whole animal intestinal substance."

COLITIS - ULCERATIVE

For relief from pain, use 1 teaspoon of Anti-Gastrin product in warm water and drink it. If it tastes bad, use some honey in it. Expect quick results.

CONSTIPATION

- Stretching the buccal membrane often will increase peristaltic action.
- Upon rising, drink 8 ounces of cold water.
- Increase physical activity; walk a mile daily.
- Sluggish thyroid.
- Sluggish liver and gallbladder. May need some bile salts.
- For chronic constipation, use Lactic Acid Yeast. Disodium Phosphate.
- Needs dietary fiber - raw, whole vegetables. Put through food chopper and eat them. The food chopper is important.
- Needs digestive enzymes and/or HCl and/or Zinc.
- May need Essential Fatty Acids.
- Dilated colon - needs Vitamin B.

CONSTIPATION (continued)

- Patient seldom needs a laxative. A laxative leads to depleted bile - leads to inadequate absorption of fats - burns sugars - decreased sugars - craves sweets - decreased roughage (unrefined CHO) - laxatives.
- Emotional - if you have to go, go! Get into a regular habit.

CONTRACEPTIVES - ORAL

- Signs and Symptoms: Mood swings, depression, sleeplessness, complexion problems, dry or flaky skin, fluid retention, hair loss, "lifeless" hair.
- Supplements to use: B6, a high potency B Complex, and multiple minerals.

CORTISONE

Dr. Wright's Book of Nutritional Therapy, J. V. Wright, M.D., Pages 369-370.

- "Side Effects: gastrointestinal ulceration, delayed wound healing, hypertension, and suppression of natural immunity.
- If patient is on Cortisone, use the following supplementation: Vitamin A - 50,000 I.U. a day; Vitamin E - 100-200 I.U. a day; and Chelated Zinc - 50-100 mg. a day (Zinc stimulates enzymes involved in wound healing).
- Long-term use can cause osteoporosis; therefore, add Calcium - 800-1200 mg. a day, and Vitamin D to utilize the calcium."

COSTO-CARTILAGE

If there is tenderness, give Iodine; it works like a miracle.

COUGH

Dry Cough: D1, therapy localize and challenge - usually left TP to left and superior and SP to right.

CRAMPS

--Calf muscles at night - give iodine and calcium.

--Calf muscles, anytime - give sodium and calcium.

--Hamstrings - need calcium and HCl.

--Leg - restless leg:

1. Vitamin E and Selenium.

2. Check lingual C; then C.

--Leg, stomach, etc.:

1. Give calcium (needs acid media) and magnesium.

2. Cramps accompanied by a body odor - use Calcium Lactate and Magnesium Chloride.

3. In one foot - give phosphorus.

4. Complex E-2 is good for all cramps but best for heart cramps. It works within 10 minutes. For speedier relief, have patient chew Complex E-2 and Complex G (vasodilator).

--Avoid tea, coffee, and chocolate.

CRYING

--Needs iodine and/or Complex G.

--Chlorine in water will kick out iodine.

CRYING (continued)

- Riboflavin and niacin deficiency.
- Check parotid gland.
- Use Iodex - rub it into the root of the neck.
- Check manganese and calcium.

CYSTITIS

- See "Urinary Infection" section.
- See book "Cystitis" by A. Klinmartin.
- Check need for Vitamin A.
- Check for allergies.

DANDRUFF

- Check for allergies.
- Stop frequent hair washing; brush instead.
- Give Vitamins A, B6, Complex F, E, and Selenium.

DANDRUFF

Dr. Wright's Book of Nutritional Therapy, J. V. Wright, M.D., Page 29.

- "Give Essential Fatty Acids, Zinc, and Vitamin B.
- No sugar."

DEODORANTS

Some deodorants have aluminum in them. This penetrates the skin and destroys the phospholipid material which protects the nerve cells. The muscles are short-circuited and the person stops perspiring. As soon as the person builds more protective phospholipids around the cells, he starts perspiring again.

DEPRESSION

Check need for Tryptophan and B12.

DIABETES

--Use Pritikin Diet.

--Use Chromium.

DIABETES MELLITUS

One of the first symptoms is numbness in the fingers and toes.

DIARRHEA

--Chronic, low grade - may be an absorption problem. Fix the small intestine.

--HCl and Thymex are excellent for stopping diarrhea even if it has been in existence for years.

--Use Lactic Acid Yeast.

DIET

Dr. Wright's Book of Nutritional Therapy, J. V. Wright, M.D., Pages 400-433.

- "Men need more Vitamin C than women (2 grams a day for men and 1 gram a day for women).
- Men have more heart attacks than women.
- Animal meat eaters have more heart attacks than vegetable eaters.
- Eat onions and garlic. They are anti-heart attack diet foods.
- Don't drink milk. It increases the chances for heart attacks.
- Take Lecithin - 1 tablespoon a day; Vitamin E - 400 I.U. a day; Essential Fatty Acids - 1 tablespoon a day of either safflower oil, sunflower oil, wheat germ oil, linseed oil, or corn oil; and Vitamin C.
- For the prostate - give Zinc and Essential Fatty Acids. Pumpkin and sunflower seeds are a good source of both. Eat seafood, liver, and mushrooms or take 20-30 mg. of Chelated Zinc daily.
- Side Note: always take Vitamin E with Essential Fatty Acids."

DIET - ALLERGIES

Take Vitamin C to body tolerance doses; B6 (50 mg.) helps to avoid kidney stones; pantothenic acid (1 1/2 grams plus) (best source in food is leafy vegetables); and B Complex (50-200 mg.).

DIET - CANCER

Dr. Wright's Book of Nutritional Therapy, J. V. Wright, M.D., Pages 425-426.

- "Include nuts in your diet (peanuts are a legume, not a nut) along with millet, berries, fruit, three or four peach/apricot kernels daily, lentils, chick peas, and beans.
- Need a high fiber diet. There is a lower rate of cancer in vegetarians.
- Don't eat foods with synthetic chemicals, flavors, colors, or preservatives.
- Take the following supplements daily: Vitamin C (1-3 grams or more), Vitamin E (400-800 I.U.), B Complex (10-20 mg.), and Vitamin A (has anti-tumor activity - 20,000 I.U.)."

DIET - DEGENERATIVE ARTHRITIS

Dr. Wright's Book of Nutritional Therapy, J. V. Wright, M.D., Pages 426-428.

- "Avoid the nightshade family of foods (tomatoes, potatoes, peppers, eggplant, and tobacco).
- Eat foods rich in B vitamins and also take Vitamin B Complex (20-50 mg.).
- Take Vitamin C (1-3 grams) and a good source of calcium and magnesium.
- Look for an allergy problem."

DIET - DIABETES

- Eliminate refined sugars and processed foods.
- Take brewer's yeast and eat liver for chromium. If you take chromium tablets, you will need 1,000 mcg. or 1 mg.

DIET - HYPERTENSION

- Cut down on salt. Eliminate bacon, ham, cottage cheese, most other cheeses, lunch meats, olives, pickles, and sausage. Most important is eliminating the salt shaker.
- Increase foods with potassium (fresh fruits, vegetables, and fruit juices).
- Supplemental foods: brewer's yeast, wheat germ, blackstrap molasses, and sunflower seeds.
- Don't drink softened water.
- Eat more vegetables than red meat.
- Try to control and change the sodium/potassium ratio.

DIET - KIDNEY STONES

Dr. Wright's Book of Nutritional Therapy, J. V. Wright, M.D., Page 425.

- "Take Magnesium - 50 mg.; B6 - 10 mg.; and Vitamin A - 20,000 I.U. They are better than a low calcium diet.
- Magnesium is found in nuts, seeds, and whole grains.
- B6 is found in liver, nuts, seeds, beans, lentils, brewer's yeast, and wheat germ.
- Vitamin A - a good source is deep green and yellow vegetables."

DIET - OLD PEOPLE

Dr. Wright's Book of Nutritional Therapy, J. V. Wright, M.D., Pages 420-423.

- "B Vitamins - especially Niacin, B12, Folic Acid, and Choline - 50 mg. tablet - 2 times a day.

DIET - OLD PEOPLE (continued)

- Side Note: Niacinamide doesn't give a vascular flush like niacin does!
- Choline - may be anti-senility vitamin. Lecithin is a good source - 1 tablespoon a day.
- Vitamin B12 injections decrease chronic tiredness and increase mental alertness. Patient should learn how to inject himself (cheaper).
- Folic Acid injections - 2-4 mg. per month.
- Vitamin C - body tolerance level.
- Vitamin E - 800 I.U. - don't take if you have hypertension. Use 200 I.U. maximum for rheumatic heart disease.
- Protect from osteoporosis and prostate problems.
- Concentrate on vitamin-rich foods first; then supplements.
- Alfalfa and kelp are excellent sources of minerals (watch the salt in kelp if patient is hypertensive).
- Brewer's yeast is a good source of B vitamins and other nutrients.
- Wheat germ, desiccated liver, and rice polishings are good sources of concentrated nutrients.
- Eyes - need Vitamin A - 50,000 I.U., and Zinc - 50 mg."

DIET - OLDER WOMEN

Supplement diet with calcium. It decreases the chances of Osteoporosis and Osteomalacia.

DIET - OPTIMUM

Dr. Wright's Book of Nutritional Therapy, J. V. Wright, M.D., Pages 428-433.

1. "Highest nutrient foods are nuts, seeds, beans, and whole grains. They have all the nutrients for growth.
2. Fresh, raw vegetables. Eat a wide variety without chemicals or wash them thoroughly.
3. Fruit and berries. Eat a wide variety without chemicals or wash them thoroughly.
4. Good water.
5. Seafood. Eat a wide variety. Put shellfish at the bottom of the list.
6. Eggs.
7. Chicken, turkey, and rabbit.
8. Milk, pork, and beef. Milk should be kept at a minimum; pork and beef should be at the bottom of the list.

Items 1-4 are the best. The number represents the acceptability. If it is difficult to comply with the above recommendations, try to stay as close as possible.

DON'T EAT FOODS WITH: synthetic food chemicals, artificial flavors, colors, preservatives, sugar (refined), white flour, or other highly processed foods."

DIET - PREGNANCY

Dr. Wright's Book of Nutritional Therapy, J. V. Wright, M.D., Pages 412-416.

--"Prepare the body before pregnancy just like you would prepare for a garden--you prepare the soil. Doesn't human life deserve the same? Prepare ahead of time.

--Don't take drugs (including aspirin) when pregnant. The fetus is very susceptible to chemicals and may be affected by them for a lifetime.

--Calcium - 1 1/2 to 2 grams a day especially in the latter part of pregnancy; Chelated Iron - 50-100 mg. a day; Folic Acid - 1 mg. a day and also get some from green leafy vegetables, lima beans, salmon, and brewer's yeast.

--For nausea and vomiting - take B6 - 25-200 mg. a day or more. Sometimes, Vitamin K is good for nausea and vomiting.

--A good multivitamin and mineral supplement is always wise during pregnancy.

--Nursing mothers need a high-quality protein diet, 2 grams of calcium daily, and no more than 10 mg. of B6 (too much B6 will stop lactation). Nurse as long as you can--30 months is not too long!"

DIET - SMALL PERSON

Dr. Wright's Book of Nutritional Therapy, J. V. Wright, M.D., Pages 418-420.

--"Vitamin A - 10,000 I.U.; Vitamin D - 400 I.U.; multiple vitamins and minerals; Vitamin C - 10 mg. per pound and more when ill or until diarrhea starts; Vitamin E - 50 I.U. for small children and 200 I.U. for older children.

DIET - SMALL PERSON (continued)

--Look for white spots on fingernails. Give Chelated Zinc - 30-50 mg. a day.

Stop when white spots disappear.

--If a child doesn't eat a lot of dairy products, give 500 mg. of calcium."

DIET - WOMEN

Dr. Wright's Book of Nutritional Therapy, J. V. Wright, M.D., Pages 407-412.

--"Try to eat like a primitive man (i.e., natural, fresh, raw foods).

--Need more iron during the menstrual years.

--Special needs: foods containing iron such as liver, organ meats, meats in general, fish, beans and other legumes (lentils, peas, chick peas), potatoes, dried fruits, blackstrap molasses, and wheat germ. Iron will absorb better with animal rather than plant food. Iron foods and Vitamin C (combination) will double the absorption. Good for anemia (best way to determine need is with a blood count). Iron - 30-50 mg. a day of chelated or ferrous gluconate is right for most women.

--Do not take Vitamin E, Vitamin A, or Essential Fatty Acids with iron.

Separate them by 3-4 hours.

--B6 and B Complex for menstrual problems/hormone problems. Eat whole grains, nuts, seeds, beans, lentils, liver, organ meats, wheat germ, and brewer's yeast.

--Good sources of calcium are milk, cheese, and other dairy products. Other sources are deep green leafy vegetables (especially beet tops, dandelion greens, swiss chard, kale, parsley, turnip greens, and watercress); soybean

DIET - WOMEN (continued)

products; salmon; and sardines. Take a calcium supplement balanced with magnesium.

--Sugar - NONE - it is refined and lacks nutrients. It also uses up the B vitamins.

--Take these supplements: Iron, Calcium, B vitamins, Vitamin E (400 I.U. - without iron), and Vitamin C (1-2 grams)."

DIGITALIS

--Found in the Foxglove plant.

--Supplement diet with foods rich in potassium: bananas, orange juice, other fruit juices, and fresh green vegetables.

--Give Vitamin C - 2 to 3 grams a day.

DILANTON

--If used long enough, it will cause: (1) convulsions, and (2) a deficiency of Folic Acid.

--Used to control pain. Take patient off Dilanton and put them on Folic Acid.

--Will interfere with Vitamin B12 and Folic Acid absorption.

DISC

--For disc problems, take 2 to 3 grams of Vitamin C.

--Use A-C Carbamide to dehydrate a swollen disc.

--Use manganese to strengthen disc capsule and ligaments.

DISEASES - DEGENERATIVE

--Use Super-EFF.

--Avoid using products containing aluminum. It destroys the phospholipids which protect nerve cells. There is aluminum in deodorants which destroys the protective sheath around the cells.

DIURETICS

If a patient must take diuretics, use the following diet: foods rich in potassium (raw vegetables, fruits, and nuts); magnesium (nuts, whole grains, and greens); B Complex (wheat germ, liver, and beans); and Vitamin C (fruits, melons, and peppers). These foods should be eaten daily. If patient takes diuretics because of menstrual problems, use B6 (50-100 mg. a day).

DREAMS

--For nightmares, use AC Carbamide (a diuretic). There could be a kidney function problem. Check for psoas weakness.

--Check for NH₄ (ammonia) by smelling.

--No dreams - patient needs Vitamin B6.

DYSMENORRHEA

--After you adjust everything, give zinc for back pain and magnesium for front pain.

--Use a diffusible calcium for about a week before menses.

DYSMENORRHEA (continued)

--Failure to produce progesterone:

1. Needs available Ca, may be assisted with HCl, and Vitamins F and D.
2. Needs adequate supplies of protein and iron.
3. Needs pituitary and thyroid support.
4. Could need cranial corrections.
5. Structure (typically sacrum).
6. Toxic elimination - look for source.

--There are five possible causes:

1. Ca metabolism - use Calcium Lactate - 1 every hour or 1 every 15 minutes until pain stops.
2. Spinal and pelvic subluxations - adjust.
3. Visceroptosis - dropped uterus. Use uterine lift technic.
4. Ileocecal Valve Syndrome.
5. Endocrine and hormonal imbalances - check for adrenal/thyroid and/or estrogen/progesterone imbalances. Use ovary, uterus, and pituitary supplements. Check liver, large intestine, Vitamin B levels, etc.

EARS

--Check the upper trapezius and lower trapezius muscles.

--Nutrition: Vitamins F, G, and C.

EARS - INFECTIONS

- Upper cervical structure.
- Cranial.
- Allergies.
- NL drainage for ears including throat.
- Use of specific hot and cold packs on ears and throat.
- Finger drainage of throat lymphatics.
- Use dry or moist heat locally - for pain relief only.

ECZEMA

- Allergy - usually in the bowel - caused by dairy products.
- HCl production is low; poor calcium absorption.
 1. Glandular support - adrenal, pituitary, etc.
 2. Use Unsaturated Fatty Acids, and B6.

ECZEMA

Dr. Wright's Book of Nutritional Therapy, J. V. Wright, M.D., Pages 32-43.

"For the type that appears in front of the elbows, behind the knees, sides of the fingers in the "web" space, palms of the hands, wrists, forearms, further down the legs, and behind the ears, give the following nutrition:

- Chelated zinc - 50 mg. - 3 times a day.
- Vitamin C - 1 gram - 2 times a day.
- Cod liver oil - 1 tablespoon a day.
- Vegetable oil (soy, safflower, sunflower, etc.) - 1 tablespoon a day.
- Pancreatic enzymes - 2 tablets per meal."

EDEMA

Check the liver.

ELBOW

Tennis elbow: wrist extensor, supinator, extensor carpi radilai, extensor ulnaris. Also, check adductors - therapy localize elbow against opposite knee, fix least sensitive - push hyoid to side treated at the same time.

ENEMAS

- Coffee - 1 quart water plus 1 cup coffee - for liver problem.
- Acid cleansing - 1 quart water plus 1/2 lemon - as an acidifier and detergent.
- Salt - 1 quart water plus 2 teaspoons salt - for mucus.
- Water - for hydration.
- Apple cider vinegar - 1 teaspoon to 1 quart water - to acidify the bowel.
- Lemon - for cleansing.
- Chamomile tea - 1 cup tea to 1 quart water - to detoxify.
- SIDE NOTE: PREPARATION SHOULD BE IN STAINLESS STEEL OR GLASS CONTAINER ONLY! NEVER USE ALUMINUM CONTAINER! THEY ARE TOXIC!

ENERGY

Check occiput, diaphragm, ileocecal valve, and dorsal lumbar fixation.

ENURESIS

- Low back mechanics - trapezius and diaphragm.
- Relates to allergies - dairy products.
- Other possible factors: Calcium and B Complex deficiency, cranial, and emotional.
- Check thyroid, PMC, etc. - treat to stimulate thyroid.

EPILEPSY

- Occipital lesion - check B&E technic.
- Cranial extension.
- Allergy - hypoglycemia - always the ileocecal valve.

EPISTAXIS (NOSEBLEEDS)

- Allergies - give Vitamins A and C.
- Check need for Vitamin P (Cyruta Plus has more Vitamin P).
- Check blood pressure.
- Eat green vegetables for Vitamin K. Deep green are best (spinach, cabbage, turnip greens, broccoli, etc.).
- Use Chlorophyll Complex (a natural source) - fat soluble.

ESSENTIAL FATTY ACIDS

- Good source is safflower oil - 1 teaspoon a day.
- Linolenic Acid cannot be produced by the body. It restores growth and prevents dermatitis.

ESSENTIAL FATTY ACIDS (continued)

--Best sources of essential fatty acids are seeds and nuts from which the vegetable oils are derived (sunflower, safflower, soy, and sesame are only a few). Be careful that seeds, nuts, or their oils are not exposed to the air because this will make them rancid.

EXTREMITIES

--Burning and swelling of feet accompanying hot weather - use thiamine.

--Cold hands and feet - faulty protein metabolism.

1. Treat liver and thyroid.

2. Check cranial.

3. Check hydration.

--Sweaty hands and feet - failure of proper kidney elimination.

1. Problem usually in the pituitary and hypothalamus.

2. Check cranial.

3. Hydrate patient regardless of symptoms. Check tongue for moist condition.

EYES

--Blurred vision, accommodation, sensation of "sand", redness of palms of hands, veins showing on chest and abdomen - use Complex G and consider Organic Minerals.

--Blood shot eyes - generally need Complex G.

EYES (continued)

- Heavy liddedness - check for protein deficiency.
- Night blindness - use Vitamin A.
- Disorders - use Vitamin A-C Complex and/or A-C-P Complex.
- Use IPLEX.
- Color blindness is a trace mineral deficiency.
- Use Oculotrophin (don't use if inflammation is present).
- Brilliant, blinding flashes of light across the visual field - give bile salts.
- Check the quadriceps and upper trapezius.

EYES - INFECTION

- Check upper cervical structure.
- Correlate with liver congestion and treat.
- Use Vitamins A and E.
- Use Boric Acid or Sodium Bicarbonate as an eye wash - 1 teaspoon to 1 cup of water (usually requires bicarbonate).

FASCIAL FLUSH

- When needed, test a strong muscle. Then stretch the same muscle. Now test it again. It will test weak. Therefore, patient needs fascial flush work. Iron the muscle out--any direction--just iron it out.
- Don't rolf every muscle; only those that need it.
- Check the stomach and liver.
- Nutrition: use 15 mcg. of B12 and Folic Acid.

FAT ABSORPTION

For poor fat absorption, use Beta Carotene (Vitamin A).

FATIGUE - CHRONIC

Diaphragm:

- Hold breath (should be less than 40 seconds).
- Lead toxicity.
- Psoas test.
- Therapy localize diaphragm.
- Snider test (blowing out a match).

In the morning, look for a tender spot on the sternum and use strain-counter-strain (spot is around the fourth rib).

- Check PMS - strong.
- Cross arms (anterior).
- Use strain-counterstrain.
- Good for adrenal-type patient.

In order to have energy and prevent fatigue, the pancreas, liver, and adrenals all must function well together.

FEET

- Sweaty and odors - kidney problem. Patient needs more water!
- While standing, three-quarters of weight should be on the heels.
- Cracked heels - thyroid problem. Patient needs Complex F and Iodine.

FEET (continued)

--Toes - numbness of toes and fingers usually is the first sign of Diabetes Mellitus. Numbness could also come from Carpal or Tarsal Tunnel Syndrome.

FEVER

- Fever is a symptom and is not an enemy, but a friend. Therefore, the use of drugs in infections to bring the fever down has unexpected disadvantages.
- The temperature of a small infant may decrease seven degrees during a cold bath. A crying spell may increase it two or three degrees.
- The pulse increases by ten for each one degree of temperature.
- There are three types of fever: (1) continuous - elevated all during the day; (2) intermittent - daily fluctuations (two degrees or more); and (3) remittent - normal, then up, then normal for days.
- Adaptive - from work, climate, hormones, etc.
- Pyrogenic - from disease.

FINGERS

- Snapping fingers - Tenosynovitis - tendon with "ball" on it and it won't slide easily. Give B6 - 150 mg. a day for 1 1/2 months and eat pecans.
- Numbness and stiffness in the morning - usually C7 - therapy localize and challenge TP and SP (usually SP to right and TP to left).

FIXATIONS - VERTEBRAL

- Use Octacosanal which is found in Wheat Germ Oil - three perles a day. This is especially indicated with fixation throughout the spine and pelvis.
- If there are chronic fixations even with using Chlorophyll Complex, look to the cranials.

FLATULENCE

- Fix the Tensor Fascia Lata. Use Cyro-Yeast or Lactic Acid Yeast, Zymex, and Betaine HCl for intestinal bacteria balance.
- Use Cyrofood tablets and/or powder (powder is crude form of Cyroplex and one-third Calcifood).
- Use A-F Betafood - usually for liver and gallbladder.
- Use Betacol.
- Use Anti-Gastrin.
- Use Cholacol II for detoxification of the colon. Foul-smelling stools is a sign that colon is toxic.
- Use Zymex II.
- Use Zypan - HCl with pancreatic enzymes.

FLATULENCE

Dr. Wright's Book of Nutritional Therapy, J. V. Wright, M.D., Pages 290-291.

- "Chronic gas may be an absorption problem.
- Use pancreatic digestive enzymes - two or three tablets with each meal."

FOOT LEVELERS

- Scaphoid pads are almost as good.
- Good for prevention if you are on your feet a lot.

FREE RADICALS

- To neutralize free radicals, use Taurine, Cysteine, Methionine, Magnesium, B12, Folic Acid, and B6.
- Free radical quenchers: Niacinamide, Selenium, Essential Fatty Acids, Vitamin E, Vitamin C, Bioflavonoids, and Super Oxide Dismutase (SOD).

GAIT

- Can be tested in a supine position - dorsiflex and plantar flex - the foot.
- Correct (sometimes) by correcting fixations that are found - with eyes into distortion.
- Nutrition: Use EBA and/or trace minerals.
- Gait Point:
 1. Recurrent switching problems.
 2. Walking.
 3. Running.
 - a. You should consider 1, 2, and 3 in gait problems.
 - b. Anterior muscles flexors - lateral muscles abductor.
 - c. If you find more than one, look for a foot problem.
 - d. The points to be rubbed can be palpated.
 - e. Major source of incoming information.
 - f. Use an Acu-Aid on these points.

GALLSTONES

- To dissolve, cook the green leaves of the red beet. Then either eat the green leaves or mix 50% of the beet juice with 50% tomato juice. Drink one-half glass per meal for 48 hours. All symptoms will be relieved.
- Too much of the above juice will act as a poison because of the Oxalic Acid (impairs Ca assimilation).
- Gallstones are cholesterol.
- You can also use a little olive oil, but the beet juice is best.

GANGLION

Try B6.

GLAUCOMA

Check AC Carbamide product.

GOUT

- Check Arginex (good for high levels of uric acid).
- Avoid protein.
- Use Folic Acid and B12.

HAIR

- Premature loss - look at the thyroid function.
- Analysis - the minerals usually reported are Ca, Mg, Fe, Cu, Zn, Chromium,

HAIR (continued)

and Manganese. If five out of these minerals are low, suspect poor absorption.

HEAD

--If head perspires, use Vitamin D - 400 units, 2 to 3 times a day.

--If head is red, there is a liver problem - needs bile salts.

HEADACHE

Temporal Area - hypotonicity of temporal muscles:

--Pain on top of head - uterine or prostate.

--Pain worse in morning - liver and thyroid.

--Pain in morning - check need for Cyruta (Standard Process Labs).

--Pain and pressure behind eyes - pituitary swelling.

--Pain on one side of head - gallbladder.

--Switching from one side to the other side - gallbladder, pancreas, allergy.

--Pain at back of head - toxic headache related to liver, kidneys, bowels.

--Pain covering entire head - muscular strain. Use strain-counterstrain technic.

--If patient gets headaches when reading, have patient read, test muscle, then read backwards, and then test muscle. Could indicate switching.

HEADACHE - MIGRAINE

- Upper cervicals.
- Allergies - usually affecting the pancreas, liver, gallbladder, and small intestine.
- Parietal Descent Technic - other cranials as indicated.
- Avoid the following foods: wheat, oranges, eggs, tea, coffee, chocolate, milk, beef, corn, cane sugar, and yeast.

HEALTH PRINCIPLES

Dr. Wright's Book of Nutritional Therapy, J. V. Wright, M.D., Pages 356-365.

- "All of our food should be whole, unrefined, and cooked as little as possible.
- Avoid all synthetics in the diet.
- Beware of possible adverse reactions to even wholesome, natural food.
- Diet supplementation is always necessary for good health:
 1. A high-quality multiple vitamin and mineral supplement.
 2. Additional Ascorbic Acid.
 3. Additional Vitamin E.
- Get enough exercise, regularly, to stay fit.
- Recognize stresses in your life; don't ignore them. Find a way to eliminate them or adjust to them.
- See your Chiropractic Physician for regular checkups."

HEARTBURN

- Use Anti-Gastrin Powder. Mix 1 teaspoon of powder with warm water and drink. Patient will feel the difference immediately! If it tastes bad, use a little honey in it.
- Consider Phosfood Liquid. If this increases the burning sensation in the stomach, this may mean that the patient has an ulcer.

HEART PROBLEMS

- Irregular heartbeat - use B vitamins (B1 and B4).
- Fibrillation - use B vitamins.
- Bundle Branch Block - use B vitamins.
- Low blood pressure - use B vitamins.
- Potassium and magnesium - occasionally effective in precordial and post-cardial tap technic.

HEEL LIFT

To evaluate correctly, evaluate after the patient has stood on the heel lift for 30 seconds.

HEMATOMA

For a very bad hematoma, use pancreatic enzymes for four or five days (no longer than that because they can affect the Folic Acid levels). Cells can't heal without Folic Acid.

HEMORRHOIDS

--Portal system congestion; lymphatic congestion.

1. Hypothyroid, liver sluggish.
2. Pelvic mechanics.
3. Trigger point releases on anterior apex of Coccyx.

--Drink six to eight glasses of water per day.

--Check need for Collinsonia, and A-F Betafood.

--Check need for A-C-P Complex.

--Check need for Vitamin K.

HEPATITIS

Dr. Wright's Book of Nutritional Therapy, J. V. Wright, M.D., Pages 252-263.

--"Signs and Symptoms: swollen lymph glands, slight tenderness in the stomach area between the ribs, slightly enlarged liver, skin and eyes turn yellow, brown urine, and whitish diarrhea.

--For family prevention, get a gamma globulin injection.

--Give 25-50 grams of Vitamin C (Na Ascorbate) intravenously - 3 to 5 times.

Side Effects: It acts as a chelating agent and removes Ca and other minerals from the bloodstream; therefore, IVs should have Ca in the solution. IV treatment is safe as long as Ca is included in the solution.

--Take as much Vitamin C, orally, as possible.

--Keep everything used for the patient separate (i.e., eating utensils, bathroom, etc.)."

HERNIA

- Fix abdominals O and I, SC, GTO, and Fascia. Neurological factor, stretch weakness, B12.
- Release Pectineus (entire muscle is usually short).
- Stimulation of muscle around hernia.
- Use Complex F - a low dose - often.

HERPES

- Check need for HCl.
- Check adrenals.
- Adjust area in the lesion; look for rib lesion (on forced inspiration).
- Herpes Simplex: Give Ca, Complex F, Essential Fatty Acids, HCl, and Lysine.
- Herpes Simplex II: use Wheat Germ oil and Zinc.
- Herpes Zoster: Use B Complex, B12, celery juice (large amounts - two quarts a day).
- Check strain-counterstrain in local area.
- Check acupuncture meridians.
- Glycerine - might work but Ca is better.
- Limit Vitamin D.

HICCUPS

- Look for ligament-interlink. Knead between the xiphoid process or the coccyx - a general diaphragmatic problem.
- Use a Uvula lift.

HOT FLASHES

- Vitamin F, especially during menopause. Use Complex F - 3 times a day for 3 weeks.
- Use Bioflavonoids - 100 mg. - 3 tablets - 4 times a day.
- Use Adrenal and Iodine.

HYDROCHLORIC ACID

- If you have to use hydrochloric acid for more than six months, check need for zinc.
- Hydrochloride Products:
 1. Cal-Amo - used to acidify patients.
 2. Phosfood - used to acidify patients.
 3. Betaine Hydrochloride - used to help digest protein and acidify patients.
 4. Cal-Amo is the primary acidifying product.

HYPOGLYCEMIA

- Signs and Symptoms: Unexplained tiredness, shakiness, foggy mind, extreme forgetfulness, depression, fits of anger, crying spells, headaches, mental confusion, and the desire to eat between meals.
- Primary hypoglycemia thought to be an insulin secreting tumor.
- Secondary hypoglycemia is what you hear about most of the time.
- Stimulants for hypoglycemia are: sugar, coffee, tobacco, colas, and alcohol. These should be avoided.

HYPOGLYCEMIA (continued)

--Diet: High protein, low carbohydrate, with B vitamins, Vitamins C and E. Eliminate all refined sugars and carbohydrates, all artificial colors, flavors, and preservatives. Patient needs zinc, calcium, and manganese.

ILEOCECAL VALVE

--Causes:

1. Upper cervical subluxation.
2. Diaphragmatic hernia.
3. Intestinal intoxication.

--Therapy localize liver.

--Check kidneys.

--Smell breath of patient (lungs).

--Therapy localize entire bowel (rectum).

--Check hyperpsoas.

--Acidify the patient.

--Opened - may need acid and Chlorophyll Complex.

--Closed - may need acid and calcium.

--Needs a proper pH; therefore, a high dose of Vitamin C will close it very tight causing a closed situation.

--With acute problem, take a lemon enema every day for as long as two weeks.

Then, introduce good flora (lactobacillus acidophilus).

--Trick: with a closed ICV, have patient push back with abdomen, then release the pressure and really open it.

IMBRICATION

--Shingle-like overlapping; something is jamming; a nagging, constant pain in the area where it exists.

--Predisposed by weak abdominals, hamstrings, etc.

--Can happen anywhere in the spine.

--Can be seen on an oblique film - Hadley's S Curve.

Challenge

1. Pull leg (hands above knee) down (foot between doctor's knees).
2. Check for a strong muscle becoming weak.

Correction

1. A very sharp thrust caudally with block just above the imbrication.

SIDE NOTE: DON'T DO IT WITH A DISC PROBLEM.

INFECTIONS - CHILD

Dr. Wright's Book of Nutritional Therapy, J. V. Wright, M.D., Pages 70-79.

"Recurrent Infection Recommendations:

1. No sugar (in or on anything). Honey is O.K.
2. No white flour. All breads and cereal products should be whole grain.
3. Avoid refined foods. Foods should be whole, natural, and fresh.
4. Supplements: Vitamin C (500 mg. with each meal and more when child is ill); Vitamin B Complex (should contain 10-20 mg. of each B vitamin - 1 with each meal); Vitamins A and D (10,000 I.U. of A and 400 I.U. of D - take 3 times a day); Zinc (chelated - 25 mg. a day); and Thymus (1 tablet 3 times a day)."

INFECTIONS - GENERAL RECOMMENDATIONS

--Fast.

--Allow only water and juices.

--Liberal use of enemas:

1. Lemon enema for cleansing.
2. Apple cider vinegar.
3. Coffee for liver detoxification.

--Acidify the system - usually with Vitamin C to diarrhea limit.

--Take a hot bath with lemon in it to induce sweating and fever. Rub the cut surface of a lemon all over the skin and immediately take a hot bath, followed by getting into bed and sweating.

--Localized use of contrast packs - hot, cold - over a specific area of infection.

--Treat the infection specifically.

--Check need for A-C Complex (for colds, infections, etc.).

--Infection Products:

1. Vitamin A-C Complex.
2. Vitamin A-C-P Complex.
3. Vitamin C Complex.
4. Calcium Lactate.
5. Potassium Bicarbonate.
6. Thymex.

INFLUENZA

--Take high amounts of Vitamin C to diarrhea limit to acidify the body.

INFLUENZA (continued)

- Acidify the small intestine with HCl.
- Spleen - persistent, recurring low-grade fever. Use glandular extract to strengthen system.
- Liver - high fever - hydrate patient. Be very strict with diet.
- Any of the above may have a specific need for thymus or adrenal support.
- Use one bottle of citrate of magnesia - early - regardless of diarrhea.

INSOMNIA

- Use Ca tablets - chew them just before you fall asleep.
- If patient can't get to sleep, use Ca and Tryptophan (Ca Lactate, Ca Orotate, Glycerol Phosphate).
- Think sleep!
- If patient always wakes up at the same time every night, check for a meridian problem; but usually it's a B Complex problem.
- Decrease motion.
- Don't eat meat before going to bed.

INTERMITTENT CLAUDICATION

- Patient can't walk more than a block without stopping. Therapy localize and challenge L1 and L4 - usually SP of L1 to right, TS to left. Usually the same for L4.
- Test the pulse at the ankle, behind the knee, at the hip, arms, and neck to determine if the flow of blood is "normal."

INTERMITTENT CLAUDICATION (continued)

- Can be caused by lack of a good blood supply.
- Supplements: Vitamin E (2,000 I.U. daily); Chelated Zinc (50 mg. - 3 times a day); Chromium (1 mg. - 2 times a day); Vitamin C (1,000 mg. - 3 times a day - increase a gram daily until diarrhea); Ca Pangamate (50 mg. - 3 times a day - may be called B15 or Pangamic Acid).

INTESTINAL GAS

- Gas forming microorganisms can only exist in an alkaline gastrointestinal tract. The bowel should never be alkaline.
- Check need for Lactic Acid Yeast.
- Use Zypan. Dosage: first day - 3 with supper; second day - 3 with lunch and supper; third day - 3 with breakfast, lunch, and supper. Reduction should take place in the same order. Then stay on 2-3 tablets with supper.

IODINE

- Iodine should not be taken with iron. It should be separated by 12 hours.
- Thick and heavy secretions in the sinuses or other areas in the body (vagina, etc.) - give iodine.
- Iodine increases mucinase in patients with thick mucus.
- Check need for parotid gland substance.
- Too much or too little iodine is bad.
- Mollusk Extract is an excellent source of iodine and is somewhat antifungal.
- When the nose starts to run, back off.

IODINE (continued)

- Bile thickness needs iodine.
- Iodine is needed when secretions are too thick. Secretions will be thinned out with iodine.

IRON

- Iron should not be taken with iodine (separate from other supplements by 12 hours).
- Need for iron is determined by Bilateral Tensor Fascia Lata weakness.
- If nails are lined or if an infant's nails are turned up, give iron.
- Women need more iron during the menstrual years.

ITCHING

- Rectal itching is a sign that HCl is needed.
- Vaginal and skin itching - use HCl.
- Take apple cider vinegar bath.
- Use Vitamin F ointment for itching caused by exposure to the sun.
- Eyes (hay fever) - take 1,500 I.U. of Vitamin A every 15 minutes and give HCl.
- May need zinc.
- Take Complex F, Calcium Lactate, Thymex, A-C-P Complex, and Dermatrophin.

JUICES

- Carrot - helps eliminate mucus.
- Alfalfa - rich in chlorophyll. Should be mixed with carrot juice because it is too strong alone. Good food for excessive gas and sinuses (mucus buildup - i.e., bronchial and asthmatic conditions including hay fever).
- Asparagus - contains large amounts of asparagine. Good as a diuretic when combined with carrot juice. It is also good for glandular and kidney problems.
- Beet - very powerful if taken alone. Take no more than two or three ounces with carrot juice, two times a day. Good for building the blood and cleansing the liver. Good for PMS and menopause.
- Carrot, beet, and coconut juice combination - good as a cleanser of the kidneys and gallbladder.
- Carrot, beet, and cucumber juice combination - very good as a cleanser and healer of the gallbladder, liver, kidneys, prostate and sex glands. Hot water and lemon juice is also good for these conditions.
- Cabbage - contains chlorine, sulfur, and iodine. The chlorine and sulfur cause cleansing of the mucus in the stomach and small intestine (must be raw cabbage juice without salt). It will form lots of gas if the small intestine is toxic.

KIDNEYS - INFECTION

--General:

1. Urine too alkaline - acidify.
2. Pelvic mechanics - lumbar, sacrum, or coccyx.

KIDNEYS - INFECTION (continued)

3. Bowel congestion (possible allergy). Diet too high in sugar.
4. Needs adrenal support - Albaplex (high dose).
5. Use Arginex for detoxification of kidneys.

--Acute Phase:

1. Use Vitamins A and C - hourly.
2. Use juice of 1/2 lemon and 1 teaspoon of baking soda in 8 ounces of water - 2 times a day.
3. Stop all protein foods.
4. Use unsweetened cranberry juice - 2 glasses daily.
5. Increase water intake, and take Albaplex (high dose).

KIDNEYS - NEPHROPTOSIS

--Psoas weakness equals occiput subluxation equals SCM imbalance equals strain-counterstrain.

--Side posture technique for kidney lift; leg pendulum technique.

KIDNEYS - STONES

--Stones are usually sulfate.

--Usually the problem is that the urine is too alkaline (usually due to an alkaline diet); rarely is it too acid. Put patient on an acid ash diet (foods).

--Use orthophosphoric acid - 30-90 drops per day.

--Give Vitamins A, C, and E.

KIDNEYS - STONES (continued)

- Use Vitamin A from Standard Process Labs because it is made from beef kidney lipids.
- Precipitated CA in the kidneys - phosphorous deficiency.
- For pain, use a towel dipped in cold water and place it over the painful area.

KIDNEYS - STONES

Dr. Wright's Book of Nutritional Therapy, J. V. Wright, M.D., Page 268.

- "Take magnesium for calcium oxalate stones (it makes calcium oxalate more soluble).
- 1. Chelated magnesium - 100 mg. - 2 times a day or magnesium oxide - 100 mg. - 3 times a day.
- 2. B6 - 50 mg. - 2 times a day.
- 3. No more than 2 to 3 grams of Vitamin C daily.
- 4. Eliminate high oxalate foods from diet especially spinach and rhubarb.
- 5. Calcium limitation not necessary after a few weeks."

KNEE

- Check for problems with: Sartorius, Tensor Fascia Lata, Quadriceps, Gracilis, Adductors, Hamstrings, and Gastrocnemius.
- Runners Knee: check Knee Extensors, Rectus Femoris, and Quadriceps. Patella Bursitis.

LACTIC ACID YEAST

Signs and Symptoms: Constipation (hard, dry stools), weight loss, foul-smelling stools, body and breath odors, gas, and diarrhea.

--Produces lactic acid by fermentation of sugars and starches, thereby inhibiting the growth of toxic bacteria in the alimentary system.

--Acts to correct persistent alkaline stools--the major cause of chronic constipation. Patient may have to use it indefinitely.

--Very good for failure to gain weight.

--Will ferment any carbohydrate.

--Acts to acidify the large intestine.

LACTOBACILLUS ACIDOPHILUS

--Good to use with antibiotics. Use three times a day during the time patient is taking antibiotics and for a week to ten days after.

--Lactinex tablets (may be able to purchase this from a drugstore) - 3 to 4 tablets with meals during the time patient is taking antibiotics and for a week to 10 days after.

--Try to get refrigerated lactobacillus acidophilus.

--A good source is Ultradophilus from Linblads, Inc.

LAXATIVES

Don't ever use them. Use bran instead!

LEARNING DISABILITY

- Program: (1) put children on a "good" diet; and (2) take children off the medication (usually a stimulant).
- Switching: (1) Ocular lock - reading problems - do eyes work together; (2) therapy localize K27 - palmar and dorsal surfaces; and (3) therapy localize cross K27 - check gait, cranial. Check B6 and niacinamide. Consider Cross Crawl exercise.
- Check limbic - therapy localize bridge of nose. If muscle weakens, tap the nasal area bilaterally for 60 seconds. Recheck. Check for limbic subluxation at C7 - 1st rib. Adjust as needed. May also be subluxation at T12 - 12th rib.

LIGAMENTS

To tighten ligaments, use manganese for poor functioning ligaments (all of them). Success syndrome: (a) more adrenal stimulation than normal, (b) all five factors, (c) heavy dose of adrenal - six a day, and (d) zucchini every day increases sodium.

LIGAMENT - INTERLINK

- Sacroiliac joints - sternal costal joints.
- Xyphoid - coccyx and sphenoid bone.
- General test for: any strong muscle (start with SCM). Therapy localize: knee, elbow; and knee and elbow. Push hyoid bone to the left or right while they are therapy localizing the knee and elbow. Now whichever side,

LIGAMENT - INTERLINK (continued)

left or right, makes the muscle strong again, that's the side you treat with intermittent stimulation - 30-40 seconds and holding the hyoid in that direction (the one that made it strong); or, which one point is least tender (treat that side with the intermittent pressure for 30-40 seconds).

--Nutrition: use Complex G (contains riboflavin and niacin) and SOD (super oxide dismutase).

LIVER

--Sluggish - there are two types:

1. If fat gives the patient stress - give A-F Betafood.
2. If patient has arthritis and a bloated liver - give Betacol.

--Check need for Vitamin B, C Complex, Amino Acids, and Complex G.

LUMBAR

Low back pain:

1. Deep muscular massage (with elbow) in Sacrospinalis muscle.
2. Thrust SP A-P from both sides using lumbar roll.
3. Exercises - pressure with hand on knees, with knees crossed.

LYMPH

--Lymph is actually blood plasma which escaped from the blood vessels by hydrostatic pressure (lymph vessel pressure is very low).

LYMPH (continued)

- Inactive patients should have massage and/or manipulation.
- Use Pectoralis Minor Technic (retrograde).
- Nutrition: Vitamin A Complex - 3 daily.

MAGNESIUM

Good for cardiovascular disease, angina pectoris, lowering cholesterol levels, increasing blood vessel elasticity, irregular heart beat, balancing potassium and sodium, and body odor.

MEMORY

- Poor memory - use RNA.
- A quick change in memory - look at the Supraspinatus muscle.

MENORRHAGIA

- It is profuse bleeding at the time of menses which is a sequel of excess estrogen without the counter-balancing presence of progesterone.
 1. Failure of estrogen breakdown by liver.
 2. Toxic system producing secondary toxic elimination by way of the uterus.
 3. Allergies, bowel congestion, and structural problems.
- Put cold towel over abdomen.
- Give massive doses of Vitamin E - 1 every 15 minutes (for excessive bleeding).

MENORRHAGIA (continued)

--Needs Vitamin E, Calcium, and Vitamin B. Vitamin B is a must (natural and high frequency dose).

MENSTRUAL PERIOD - GENERAL

--Menstrual flow:

1. Light: Hypothyroid - check for anemia. Excessive progesterone - deficiency of estrogen.
2. Heavy: Progesterone deficiency - excessive estrogen. Take OVEX from Standard Process Labs.
3. Irregular: On the 14th, 15th, 16th, and 17th nights of cycle, keep a small wattage light on at night.

--Weakness and fatigue with period: patient is anemic and also needs adrenal support.

--Cramping: use uterine lift for immediate relief. Take Calcium Orotate. May need zinc if cramps are in the back and magnesium if cramps are in the front. Check Ileocecal Valve.

--Headache: therapy localize and challenge L4 and C4. Usually L4 left TP to superior and SP to left inferior. Use same procedure for C4 (sometimes reversed).

MENSTRUAL PERIOD

Dr. Wright's Book of Nutritional Therapy, J. V. Wright, M.D., Page 6.

"Use B6. Dermatologists say it helps acne before the menses - used internally and externally. It also helps depression."

METABOLISM - FAT

- Products to help in the metabolism of fats: A-F Betafood, Cyrofood, and Choline.
- If a person burps immediately after eating a fatty meal, check the gall-bladder.
- If patient has gas several hours after meal accompanied by foul-smelling stools, use Cholacol II.

METRORRHAGIA (BLEEDING BETWEEN MENSTRUAL PERIODS)

- Bleeding between menstrual periods can be due to either ovulation or failure on the part of the Corpus Luteum to supply progesterone.
- Chronic Vitamin E deficiency.
- Give thiamine and iodine as needed and indicated.

MILK

- Cow's milk contains 300% more casein than human milk. It's the mucus-forming portion of milk.
- When you need milk, try to get raw goat's milk. It is best for humans. It

MILK (continued)

will not produce mucus; but it must not be heated above 118 degrees Fahrenheit and/or pasteurized.

--Best milk for humans is mother's milk; then goat's milk.

--Signs and symptoms of milk intolerance are excessive gas, then constipation, and/or a little diarrhea.

MINERAL OIL

--It is indigestible, but anything that is soluble in it (i.e., Vitamin A) cannot be reclaimed by the body. Therefore, eat a different oil which is not indigestible!

--Don't ever use it. It blocks absorption of Vitamins A, D, E, and K.

MISCARRIAGES

--If a miscarriage is threatened, give Vitamin E every hour; Octocosanol every hour.

--If patient has this problem, check thyroid function.

MOUTH - DRY

Patient needs alkaline ash minerals, especially potassium.

MUCUS

--Excess:

1. Give Ascorbic Acid. It dries out mucus.
2. Increase organic iodine - 1/2 tablet daily until problem is gone.
3. Give Zymex II for upper respiratory mucus.

--If mucus is too thick, give iodine.

MUSCLES

--When you stretch a muscle, it should get stronger.

--Aerobic - slow - red fibers.

--Anaerobic - fast - white fibers.

--If there is a weakness in the muscles, it indicates that the fascia is too short - needs fascial flush and 5 mg. of B12.

MUSCLE TESTING

--When muscle is ratchiting (vibrating when being tested), there is a major subluxation.

--When muscle is weak with repeated muscle testing, there are NL problems.

--When muscle is weak with repeated muscle testing, use the following nutrition:

1. Fast - give pantothenic acid for white muscle fibers.
2. Slow - give 18 mg. of iron for red muscle fibers. Give Ferrofood - 2 daily.

MYXEDEMA

This is a thyroid problem which is characterized by body swellings of the face and hands, slowing of the pulse rate, dryness and wrinkling of the skin, and reduction of the basal metabolic rate.

NAILS

- Nail biting - patient needs organic minerals.
- Soft nails - use calcium.
- Lined nails - use iron.
- Turned-up nails in infants - use iron.

NERVOUSNESS

- Check Brachioradialis - work the NL over the entire pectoralis muscle (very good results).
- Use C Complex to relax the nervous system.

NEUROCEPTORS

- Proprioceptors - muscles, joints, fascia, skin, equilibrium, etc.
- Chemoreceptors.
- Baroreceptors - pressure, carotid sinus.
- Thermoreceptors.
- Nociceptors.
- Electromagnetic - cones of eye, acupressure.

NEUROLOGIC DISORGANIZATION

- Gait - foot dysfunction.
- Check switching after walking.
- Check Cloacals.
- Check Cranials.

NIACIN VERSUS NIACINAMIDE

- Both are forms of B3.
- Niacin will dilate the blood vessels, causing a flush. Niacinamide will not.
- Niacin will lower serum cholesterol. Niacinamide will not or maybe just a small amount.
- Niacin will increase blood sugar (helpful in Hypoglycemia). Niacinamide will not or maybe just to a small degree.
- Use Niacin (500 mg. - 1 - 4 times a day - after eating food). If you use more and don't want the flushing, use Niacinamide; but the flush isn't so bad and maybe patient will feel better (especially true with an alcoholic).
- Prolonged use in megadose quantities results in nausea and will affect the liver.

NIGHT BLINDNESS

- Use Vitamin A (from fish liver oil). DO NOT use Vitamin A from Standard Process Labs because it is made from beef kidney lipids (good for kidney problems).
- Improve lymphatic drainage from the liver. This may remove the need for Vitamin A.

NIGHTMARES

- Liver toxicity.
- Excessive dreaming with a lot of action - use manganese.
- Usually kidney problem - give AC Carbamide.

NIGHTSHADE

- Foods in this family are tomatoes, potatoes, peppers, eggplant, and tobacco.
- The above foods contain Solanine (a toxin) which causes some people to have arthritis symptoms.

NOSE

- Runny - therapy localize and challenge SP and left transverse of C4 - usually C4 transverse on left, adjust to inferior SP (varies).
- Clogged - C5 SP usually to the right, TP to left.

NUTRITION

- A-C-P is good for urinary infections.
- AC Carbamide is very good for headaches. It is a detoxifier.
- Antronex is a natural antihistamine.
- A-F Betafood is good for the liver and gallbladder.
- Calcium is good for cramping.
- Vitamin D (400 units) with calcium is good for deep bone pain.
- Use Adrenal Gland Extract, Pantothenic Acid, and Vitamin C for adrenal gland support.
- Use Iodine for thick mucus.

OBESITY

Obesity is a DISEASE common only to man and domesticated animals that are fed mankind's food. Wild animals that eat naturally and domestic animals that are fed properly don't become obese. Obesity is not caused only by overeating. You know many fat people who are small eaters and many skinny people who are tremendous eaters. Obesity is caused by abnormal body metabolism which permits retention and storage of fats and fluids. In other words, it is further evidence of the faulty food habits of our civilization.

OSTEOPOROSIS

- Symptom: a persistent pain in the mid-back.
- In aged patients, use respiratory corrections when adjusting. Also, use X-rays to see the degree of Osteoporosis.

PAIN

--Use cold water (cold and wet is good) so the body sends more blood to the area. With heat, the body doesn't send blood to the area.

--Use very high doses of Calcium and Vitamin C.

--Use extra meridian pain control technique.

--Use Vitamin D for bone pain.

--Use DLPA (DL-Phenylalanine) for chronic pain and arthritis pain.

--Dimethylsulfoxide (DSMO):

1. Use 50% DSMO as the carrier, and 50% SOD and Catalayse (Dysmudrops from Nutri-Dyn). Apply externally to dramatically relieve pain. Paint it on the joints for acute pain (wrist, finger, knee). Do not use on a large area.
2. Tell the patient that DSMO causes bad breath (oyster smell).
3. DSMO used as a first aid will decrease pain by 70-90%.
4. Don't use it on a chronic problem.

PALM

If palm is red, check for a liver problem - needs bile salts.

PANCREAS

Good product for support is Pan-5-Plus from Nutri-Dyn.

PAROTID GLAND

- The secretions from these glands are important in the deiodination of food while it is still in the mouth. This will have an effect upon the thyroid.
Example: Weak Teres Minor - therapy localize to parotid and check the Teres Minor again. If it strengthens, give parotid tissue.
- First - chew parotid tissue; second - chew iodine; and third - eat your meal.
- Also, consider these glands when there is a testicular problem (i.e., hard, enlarged, damaged, sensitive, etc.).

PECTORALIS MINOR

Chronic weakness:

- Check reactivity.
- Check hyoid bone.
- Nutrition: Folic Acid, Thymus and/or Complex A.

PERSPIRATION

- Excessive perspiration: check need for kelp/organic iodine.
- Armpits: If there is a lot of sweat, rub lemon on the rest of the body.
Then, drink one pint of a hot lemon drink while sitting in a hot bath.

pH

- Normal oral pH is 6 = 5 - 6.7.
- Rectum pH - acid or neutral.

pH (continued)

--Caries free: adult - 7.6, child - 7.8.

--Mouth: adult - 7.6, child - 7.8. To increase pH, eat natural fats and oils.

--pH capsule: you swallow it and it will radio out the pH of the stomach. It is called Gastric Analysis by Radiotelemetry and is made by Telefunken in Germany. The pH is determined and then test solutions are ingested and the recorded changes are observed. Then another test solution is ingested, etc.

PHOSPHOROUS

--Use a phosphorous/calcium ratio of 4 to 10.

--If patient is without energy all the time, he needs phosphorus.

POLYURIA

With no signs of infection:

--Nephroptosis - see section on "Kidneys."

--Riboflavin deficiency - use Complex G.

--Bile salts elimination acting as irritants.

--Visceroptosis.

--Give Vitamin A - 1,500 I.U. every 1/2 hour.

--If only nocturnal - give natural thiamine (not synthetic).

PREMENSTRUAL SYNDROME (PMS)

- There are four types of PMS: 1-4 (the fourth is suicidal).
- Check the function of the liver.
- Look for sources of stress such as cranial, toxicity, and poor nutrition.
- Pituitary and adrenal functions are low.
- Can't handle refined carbohydrates.
- Check need for Zymex II and B6.
- Give B6 - 100 mg. - 4 times a day. Use for water retention, anxiety, nervousness, tension, and acne. For acne, use a cream with B6 in it. B6 is needed if patient is taking oral contraceptives.
- Don't give Complex F.
- Give thiamine (natural source) with Complex G - as needed.
- Estrogen inhibits many pyridoxine-dependent enzymes, particularly those that help to transform the amino acid tryptophan to niacin.

PROSTATE

Dr. Wright's Book of Nutritional Therapy, J. V. Wright, M.D., Pages 278-286.

--Enlargement:

1. Chelated Zinc - 50 mg. - 1 tablet, 3 times a day (check finger nails for white spots). The more alcohol consumed, the more zinc needed.
2. Essential Fatty Acid Capsules - 400 mg. - 1 capsule, 3 times a day - (reduces the size of the prostate).
3. Prostate Gland tablets - 2 tablets - 3 times a day.
4. Bee Pollen tablets - 3 a day. Bee pollen is used in Europe by naturopathic doctors.

PROSTATE (continued)

--Diet: no refined sugars, no white flour, eat mostly fresh foods, and increase the sources of zinc (i.e., pumpkin seeds and oysters).

PROSTATE PROBLEMS

Nutrition:

- Complex F - 6 a day for 3 days; 4 a day for 14 days; and 1 - 2 times a day thereafter.
- Organic Iodine - 3 a day.
- Prost-X - 1 - 3 times a day.
- Prostate - 1 - 3 times a day.
- Consider Pituitary, Adrenal, Thyroid, Calcium Lactate, Parotid, Complex F Perles, and Arginex.

From Product Bulletin:

- Complex F - night urination, dribbling, back pain, etc.
- Prost-X - pain of arthritis, stiff joints, sore muscles, dribbling, leg and back pain, decrease in libido, male climacteric, and aging processes. Take 1 - 3 times a day.
- Prostate Gland - nocturia, dribbling, low back pain, leg pains, fatigue, loss of libido, and constipation. Take 1 - 3 times a day.
- Iodine - prostate diseases.

Check the Thyroid: possibly a predisposing factor in prostate disease.

PRURITUS ANI

- HCl needed.
- Pancreatic Enzymes are needed for protein digestion.
- Parasites: rare - obtain by placing scotch tape on the anus. Use acid enemas. Eat figs, almonds, and walnuts.

QUADRICEPS

For rehabilitation, use a Pago Stick several times a week.

SACROILIAC SUBLUXATION

Foot Levelers, Inc.:

- Manipulation.
- Physiotherapy - massage - decreases muscle spasm.
- Immobilization:
 1. Use adhesive strapping or an orthopedic appliance.
 2. Wear the above for two weeks; then restrict activity for four weeks.
- Prognosis: Especially with a young patient, one or two visits will get them out of pain; however, it takes two to six weeks to reestablish balance and stability. If this route is not taken, it will lead to a "weak back."

SALIVATION

- Excess: needs more phosphorus.
- Dry: needs alkaline ash minerals (particularly potassium).

SCALENUS ANTICUS SYNDROME

Related hypertonic muscles to possible visceroptosis - parietal descent
technic, strain-counterstrain.

SCHIZOPHRENIA

--H.O.D. Test: Bell Therapeutic Supplier, Inc.

396 Rockaway Avenue

Valley Stream, New York 11581

Phone: 516-561-7665

--Switching problem.

SEXUALLY-RELATED PROBLEMS

--Pelvic muscles - weakness - use Vitamin E.

--Prostate - use zinc and associated trace minerals.

SHIN SPLINTS

--There two types of shin splints: anterior and posterior.

1. If patient jumps on his toes and gets pain, it is the anterior type.
2. If patient jumps on his heels and gets pain, it is the posterior type.

--Usually:

1. Anterior Tibia - use Vitamin B (athletes need Vitamin B because of excess sweating).
2. Lesser extent - the Peroneus muscles.
3. Posterior Tibia - do O-I and NL.

SHIN SPLINTS (continued)

To Fix:

- Use hard, heavy pressure on the GTO to correct the microevolution.
- Reset the GTO.
- Nutrition: use Vitamin B for anterior shin splints, and Adrenal for posterior shin splints.

SHOULDER ELEVATION

Look for Hyperglycemia or Hypoglycemia.

SINUS PROBLEMS

- Possible causes: cranial faults or nasal allergy.
- Thick and heavy sinus secretion - give iodine.
- Very thin secretion - patient needs better biliary function (use bile salts).
- Check or stop the use of milk.
- Nutrition (Standard Process Labs):
 1. Drenamin.
 2. Chlorophyll.
 3. Drenatrophin.

SKIN

--Dry: take 2 tablespoons of a high-grade vegetable oil daily. Check need for B6 and Vitamin E.

--Acne:

1. Check for thymus need.
2. Take B6 if it increases the strength of the Scalene muscles.
3. Test for food allergies.
4. See section on "Acne."

SLEEP

--Patient constantly falls asleep: needs Vitamin B and Complex G. Check the small intestine.

--A good source of B vitamins is a cake of yeast. Have patient eat one cake every day and then check to see how patient feels.

--People who yawn a lot while talking need Vitamin B and Complex G.

--To maintain sleep, use Tryptophan.

--Give Calcium.

SOYBEANS

--Soak for eight hours - using three or four different batches of clean water.

--To make soy milk, blend the above with some clean water.

STIFFNESS

- Morning joint stiffness: acidify the patient. Use Cal-Amo - 1 per hour - until they start to yawn and then cut back. Take them off citrus fruits.
- Muscle stiffness from exercise: use Calcium and Complex F.
- Check need for Phosfood.
- Give Lecithin.

STOOLS

- Bloody or black - could be ulcerative colitis.
- Bloody - could be hemorrhoids.
- Alkaline stool - needs bile and HCl.
- Clay-colored stool (acholic) - fat in stool - needs Cholacol.
- Light-colored stool - needs bile salts except when blockage has occurred (indicated by jaundice).

SUCCESS SYNDROME

- Therapy localize. Touch the S-I joints and the only muscle to go weak will be the Sartorius.
- To correct, use prolonged NL and NV work by doctor and patient.
- Eat zucchini soup once a day.

SUNBURN

- Use zinc oxide or a sunscreen.
- Use Complex F.

SUPPLEMENTS

- They are needed to correct nutritional deficiencies.
- Do not treat symptoms or conditions with supplements. If you alleviate a specific symptom or condition with a supplement, then it is considered a DRUG; and chiropractic physicians don't have a license for this!

SWITCHING

--When constantly switched, folic acid is needed.

--Where to start:

<u>Structure</u>	<u>Chemical</u>	<u>Mental</u>
Cranial	Electron Poisoning	Right-left brain
Gait	Neurotransmitter	Cross K27
PRYT	Choline, etc.	Learning disability
Feet		Emotional
Cloacals		
Proprioceptors		

--Cross therapy localize to K27.

--Cloacal Syndrome Technic:

1. Therapy localize labyrinthine reflex - medial to mastoid.
2. Neck right reflex - upper cervical - three fingers.
3. Postcloacal reflex - sacral - coccyx.
4. Visual righting reflex - supraorbital switch.
5. Anterior cloacal reflex.

--Find a weakness - muscle test - usually one side.

--Confirm with therapy localizing.

--Find respiration which abolishes weakness and adjust in proper direction on areas that therapy localize.

TACHYCARDIA

Blood sugar - use organic potassium.

TASTE

- Metallic - give iodine.
- Bitter - give bile salts.
- Can't taste foods - give zinc.
- Funny taste - check need for iodine and bile salts and question the thickness of the secretions. Give iodine for thick secretions and bile salts for thin secretions.

TEAS - HERBAL

- Peppermint - has a calming and strengthening effect on the nerves and is good for gas, indigestion, nausea, and flatulence. It is also a mild antiseptic.
- Chamomile - good for colds, throat infections, catarrhal conditions, and digestive problems. For a good night's sleep, drink one cup before bedtime. It has antitoxic properties and is good for enemas (1 cup of tea to 1 quart of water).
- Rosehips - excellent during a fast. It is rich in Vitamin C and bioflavonoids and increases healing. It is a beauty secret - helps keep collagen elastic and strong and helps to prevent wrinkles.
- Ginseng and Fo-Ti-Tieng - good for the brain, nerves, and glandular function. Revitalizes sex glands.

TEAS - HERBAL (continued)

- Sarsaparilla - aphrodisiac (contains testosterone and progesterone).
- KUFA formula: 1/2 teaspoon mint, 1/2 teaspoon basil, 1/8 teaspoon powdered ginger, 1/4 teaspoon licorice, and rose powder. It is good for mucus, especially in the morning with a sore throat. Drink a pot for breakfast and then drink 2-3 cups during the rest of the day. A change should be seen in 2 weeks.

TEETH (PAIN)

- Upper cervical mechanics (possible neurologic tooth).
- Use chlorophyll locally for gingivitis.

TENSOR FASCIA LATA (TFL)

- If bilateral weakness, check the lateral cuboid for subluxation.
- Also check the peroneus tertius and longus.
- If bilateral weakness, patient may be anemic.

THROAT

Lump in throat: needs potassium. Patient needs to become alkaline. Patient is acidic.

THYMUS GLAND

- General: The thymus gland is involved in antibody production. It seeds the lymphatic tissue which produces the antibodies. When you are exposed to a

THYMUS GLAND (continued)

bacteria, your thymus gland should immediately seed the lymphatic tissue to start the production of antibodies. It takes seven days to completely produce enough antibodies to destroy the bacteria. Thymus gland - seeds lymphatic tissue - produces antibodies - destroys protein.

--In an organ transplant, if the thymus gland is triggered off the above mechanism, it will destroy the "new organ."

--As people get older, the thymus gland gets smaller and we lose the ability to fight infection.

THYROID - GENERAL INFORMATION

--It's a regulator of body metabolism.

--It's a thermostat for the rate the body will use energy.

--Thyroid does not control the metabolic rate for the brain, retina, spleen, gonads, thymus, or lungs.

--Evaluations:

1. BMR - stay over night in a hospital. Then, in the morning, a mask is put over the face (nose and mouth) and patient lies completely still and is told to breathe normally.
2. Blood test, T3, T4, and T7 - good for pathological cases.
3. Best - take basal temperature (morning axillary temperature) for 30 days.

--Achilles tendon time - .330 seconds - "anything" faster denotes a hyperthyroid problem. Use Vitamin A and Thymus.

THYROID - GENERAL INFORMATION (continued)

- Consider using RNA for hypothyroid/hyperthyroid.
- Thyroid hormone has an effect on nutritional absorption.

THYROID (HYPO)

- Check need for Vitamin A, iodine, thyrosine (raw material for thyroid hormones), manganese, and B12.
- Menstrual cycle - more than 28 days denotes hypothyroid; less than 28 days denotes hyperthyroid.
- Look for carpal tunnel syndrome.
- Signs and Symptoms:
 1. Constipation.
 2. Premature hair loss.
 3. Miscarriages.
 4. Headaches and dizziness - worse in the morning and better at night.
 5. Short-windedness.
 6. Very emotional.
 7. Doesn't like to be watched.
 8. Low concentration and easily distracted.
 9. Memory loss.
 10. Apathy and/or laziness.
 11. Sudden change in personality.
 12. Depression and/or crying.
 13. Costal cartilage sensitivity.

THYROID (HYPO) (continued)

14. Thick, swollen tongue.
15. Lateral one-third of eyebrow missing.
16. Fatigue - worse in morning and better as the day goes on.
17. Feels better after exercise.
18. Easy to gain weight but difficult to lose.
19. Repeated infections.
20. Sensitivity to the cold in Autumn.
21. Cold extremities.
22. Skin problems: dry, chapped, flaky, cracking, and crevicing of the heels and/or hands. Use Thyroid and Complex F.
23. Nails - brittleness and softness. If soft, use calcium. If lined, use iron.

TINNITUS

Check for need for Cyruta.

TMJ

- Do appropriate TMJ technic on muscles, making sure the occiput is correct.
- Check temporomandibular ligament.
- Check with head back for therapy localizing.
- Manually challenge, NL as needed.

TONGUE

- If yellow - patient needs folic acid (fresh greens).
- If white - check small intestine (needs cooked food).

TRACE MINERALS

- If children lack trace minerals, they will eat dirt.
- If adults lack trace minerals, they will eat their own nails.

TRANQUILIZERS

Products from Standard Process Labs (in order of strength):

1. Orchex.
2. Min-Chex.
3. Min-Tran.

TRIGGER POINTS

- Push hard on them.
- Two types: Janet Travell and Lawrence Jones.
- Triggers a painful area.
- Travell - use hard pressure (iron out) or spray and stretch.
- Jones - extend or flex the spine - strain-counterstrain.
- Activity aggravates.
- With a Janet Travell trigger point, you stretch a muscle and it weakens.

TRIGGER POINTS (continued)

--With a Lawrence Jones trigger point, you maximize contractions and it weakens.

--Nutrition: use Vitamin B12.

ULCERS

--A person with ulcers lacks HCl and pepsin; therefore, they don't digest their food. The food sits and rots, creating gas and an organic acid which erodes his stomach. When protein rots, it putrifies and ferments carbohydrates. If the patient has HCl and pepsin in his stomach, then there is no rotting of food. Antacids give temporary relief, but make the situation worse than before. They neutralize both acids (digestion and rotting) and lead to stomach ulcers. The patient needs Zypan (for digestive support) and should stop taking antacids.

NOTE: Have the patient take the Zypan in the middle of the meal so the HCl (in Zypan) won't irritate the ulcer. If the patient can do this without experiencing pain, then give Comfrey-Pepsin E-3 along with Chlorophyll Perles (for healing) and Anti-Gastrin Powder (for pain).

--For relief of pain, use 1 teaspoon of Anti-Gastrin in warm water and drink it. If it tastes bad, use some honey in it. Expect quick results!

UREA

--To improve urea production, give Arginase.

--To improve urea production and for ligament strengthening, use manganese.

UREA (continued)

--To improve urea cycle function, give biotin, B6, magnesium, and aspartic acid.

URINARY INFECTIONS

--For urinary infections:

1. For acid urine - use Na Citrate (an alkali). Once a day for 2 or 3 days, drink 1/2 lemon and 1 teaspoon of baking soda in 8 ounces of water.
2. For alkaline urine - use cranberry juice or ascorbic acid.
3. With a bad infection, also have patient take Vitamin A (1,500 mg.) every 1/2 hour. Patient should feel better in 24 hours. If not, check for an absorption problem.

--To eliminate the infection, give Arginex.

--See section on "Cystitis."

URINARY PROBLEMS

--Check sacrospinalis muscles.

--Give A-C-P Complex.

--For nocturnal urination problem, give B Complex.

URINARY TESTING

--Best to use the first specimen in the morning, especially when testing for nitrite.

URINARY TESTING (continued)

- If you can't check the specimen within the first hour, refrigerate specimen and then test after it has been returned to room temperature.
- Fresh urine is the best for checking bilirubin and urobilinogen. These are very unstable when exposed to room temperature and light.
- The 24-hour collection test is for calcium, phosphorus, uric acid, magnesium, and oxalate.
- Specific gravity - 1.022 (water - 1.000).

UTERINE FIBROIDS

- Caused by toxic elimination through the uterus.
- Source of toxicity (allergy).
- Very chronic low back mechanics.
- Give Vitamin E.
- Give mammary tissue.

VAGINA

- Dryness - check need for Vitamin B, iodine, Complex F, and wheat germ.
- Normal bacteria in the vagina is called Doderlein's Bacillus.

VARICOSE VEINS

- Check for liver problem.
- Nutrition: use Collinsonia (Root).

VERTIGO

If patient lies on one side and not on the other, usually the right side produces vertigo. Therapy localize and challenge C4 SP left inferior.

VISCEROPTOSIS (DROPPED VISCERA)

- Fix abdominals - O-I, SC, GTO - neurological factors.
- Fix psoas - see section on "Kidneys - Nephroptosis."
- Reverse gravity and stimulate skin.
- Stimulate abdominal muscles electrically; and also by doing sitback exercises (isometric - three positions).

VITAMIN A

- Fat soluble - may need pancreatic enzymes for digestion.
- Use a mixed source - fish oil and beef.
- Vitamin A is double-bonded as is Vitamin D.
- Use for thick, heavy callusing.
- Use for sinus problems.
- Use it for night blindness - fix lymphatic drainage of the liver.
- Good sources are butter and carrots.
- Overdose signs and symptoms: headaches, deep bone pain, very dry skin, and hair loss.

VITAMIN B

- Improves nerve transmission (use Vitamin B from Standard Process Labs).
- Use for low blood pressure.
- Use for frequency of urination at night.
- Use for Bradycardia.
- Use for vasoconstriction muscles contraction.
- Use for heart murmur.
- Use for ringing headaches.
- Use for burning soles of feet and tender calves.
- Use for shin splints.
- Use for carbohydrate metabolism.
- Use for a person who is always yawning.
- Use for a person who has trouble with insects biting them.
- Use B4 for cataracts.
- B4 is an antiparalysis factor.
- If patient has a B deficiency, they have a tendency to be acid.
- To activate B6, use zinc, magnesium, and phosphorus.
- B vitamins are water and alcohol soluble.
- B vitamins are heat stable.
- If patient hops on one leg 10 times, then the other, the pulse should go up 40 beats. If it doesn't, give B vitamins.
- If patient has a low breath holding time, low pulse, and low temperature, give B vitamins.
- Nutrition: Eat a cake of yeast. It is a natural, total B Complex which includes Complex G. Good, cheap sources of B vitamins are cakes of yeast and Brewer's Yeast.

VITAMIN B12

Dr. Wright's Book of Nutritional Therapy, J. V. Wright, M.D., Page 56.

- "Injections are good for mental problems (possibility) - 100 mcg. - 2 times a week.
- With B12, take Folic Acid (1 mg. - 2 times a day or 5 mg. daily or more).
- Have patient learn how to give himself the injections."

VITAMIN C

- Use for urinary infections: with less than 7 pH, use a small dose; with more than 7 pH, use a large dose.
- Use Vitamin C from Standard Process Labs. It contains all the necessary components to have a good Vitamin C. Use 5 mg. tablets.
- With Vitamin C, consider using Cyruta.
- It is associated with the psoas.
- Side Note: Animals who don't produce their own Vitamin C are: humans, gorillas, chimpanzees, monkeys, guinea pigs, an Indian fruit-eating bat, certain shrimp, and maybe the Coho Salmon.

VITAMIN D

- It is double-bonded, as is Vitamin A.
- It puts calcium in the blood.
- Good for a patient who sweats around the head but not much on the rest of the body.
- Good for bone pain.

VITAMIN E

- There are many different sources; each source giving different results.
- Any green plant is a source of Vitamin E--with green peas as the "best" source. Use the pods to make soup.
- Muscle test to determine which source of Vitamin E is needed.
- For musculoskeletal disorders, use a dry form.
- Use Vitamin E when using Vitamin A. Vitamin E helps to prevent the oxidation of Vitamin A.
- Vitamin E is an antioxidant.
- For allergies, use Vitamin E with 400 mcg. of selenium.

VITAMIN F

- Puts calcium into the tissues (from the blood).
- Good sources are sesame seed oil and olive oil. Keep oil cold after opening and out of the sunlight.
- Take Complex F for several days before getting out in the sun; then take one every hour while out in the sun.

VITAMIN G (COMPLEX)

- Not alcohol soluble; only water soluble.
- Not heat stable.
- Starts the urinary stream (relaxes the sphincter muscle).

VITAMIN G (COMPLEX) (continued)

- Patient needs Complex G if he can hear his heart while lying in bed, has quick cramping, has eye twitches, sighs a lot, and cannot take a deep breath.
- Good for Tachycardia - vasodilator muscle relaxer.
- Good if eye sight gets blurry - loss of some vision (print disappears).
- Good if patient has cracks at the corners of the mouth.
- Good for the pulse rate.
- Good for ligament interlink.
- Good if patient tends to be alkaline.
- Good for fat metabolism.
- Tends to acidify.
- Increases polarity of RBC, WBC, and blood vessel walls and platelets.
- People who have trouble "getting" their breath need Complex G.

VITAMIN K

Dr. Wright's Book of Nutritional Therapy, J. V. Wright, M.D., Pages 307-308.

- "Best source is from fresh, green leafy vegetables, especially deep green vegetables (i.e., spinach, cabbage, turnip greens, and broccoli).
- Vitamin K is fat soluble."

VITAMIN P

- Has some flavonols in it.
- Good for capillary fragility.
- Good for nosebleeds and easy bruising.
- Use Cyruta Plus from Standard Process Labs.

WARTS

- Use all organic trace minerals.
- Look for Teres Major weakness.

WATER

- Evaluate need for water. Rub your finger on the tongue. If it slides easily, there is no problem. If tongue is like sandpaper, the patient needs to drink more water.
- Drink water, not fluids! Water is water and other fluids are considered food.
- Drink spring water (Mountain Valley bottled water).
- Good water: spring or natural well water. Avoid chlorinated, fluoridated, or distilled water.
- Distilled water has no minerals present. It acts like a vacuum in the body. The body throws minerals at this vacuum in an attempt to fill it up; therefore, distilled water depletes your body of minerals - BAD! It causes disturbances in the ratio of the WBC.

WATER BALANCE

Check the liver.

WEIGHT

If patient can't gain weight, check need for Lactic Acid Yeast.

WHIPLASH

Check the Suprahyoid and Infrahyoid muscles.

YAWNING

A person who is always yawning needs B vitamins.

YEAST INFECTIONS

Fungal Organisms:

--Caused by the use of common drugs such as Nystatin (brand names - Nilstat and Nycostatin).

--Yeast infections cause muscle weakness: PMS - liver, TFL - colon, and iliacus (ICV related). These muscles will gain strength with Antronex or Thymus (Standard Process Labs), Biotin (Nutri-Dyn), or Imu-Stem (Wildwood Botanics) placed on the tongue.

--Stay away from yeast products, sugar, refined carbohydrates, mushrooms, aged cheeses, beer, fruit juices, and dried fruit.

--Biotin inhibits candida albicans growth.

YEAST INFECTIONS (continued)

- Use Antronex for candida albicans.
- Use thymus, small intestine tissue, and trace minerals for candida albicans.
- Use molybdenum for candida albicans.

YEAST INFECTIONS

Dr. Wright's Book of Nutritional Therapy, J. V. Wright, M.D., Pages 381-382.

"Take 2-3 tablespoons of lactobacillus acidophilus for 7-10 days, or take 3 or 4 Lactinex tablets with each meal. Normal vaginal bacteria is Doderlein Acidophilus (not available).

1. Make anti-yeast medication using 1/2 cup of plain yogurt with a tablespoon of lactobacillus acidophilus.
2. Insert 2 teaspoons of this mixture into the vagina each night. (This mixture should be refrigerated when not being used.) Do this for 5 nights in a row. Always douche with vinegar and water in the morning.
Side Note: Wait to do this until after the menses. Douche is to remove the messy material and also to acidify the vagina (inhibits the yeast and promotes the growth of lactobacillus acidophilus). Yogurt adds a little stickiness to lactobacillus acidophilus, promotes the growth of good bacteria, and is soothing. Use a tampon on a syringe for insertion into the vagina.
3. Use Ultradophilus for vaginal disturbance. Use 1/2 to 1 teaspoon to 1 ounce of water. Place mixture in the vagina with a vaginal syringe. Retain for 8-12 hours using a tampon. Remove tampon and douche. Repeat this procedure for several days."

ZINC

--Look for white spots on fingernails, body odor, and eczema. Patient needs 50 mg. of zinc - 3 times a day.

--Zinc absorption is related to adequate pancreatic enzymes.

--If zinc is reported as being high (hair mineral test), it probably isn't.

Run a 24-hour urine collection test and then if it tests high, it is high.

--With a long usage of zinc, check on the calcium levels. Zinc suppresses calcium.

REFERENCES

1. Seminars, Lectures, Annual Research Manuals, Monthly Research Tapes by Dr. George Goodheart, D.C., 20567 Mack Avenue, Grosse Point Woods, MI 48236.
2. Dr. Wright's Book of Nutritional Therapy, Jonathan V. Wright, M.D., Rodale Press, Emmaus, Pennsylvania, 1979.

Induction of Neurovascular Response

A. J. Woodson, D.C.

Abstract: The neurovascular reflex is used in Applied Kinesiology¹ to assist in muscle balancing through restoration of normal vascularity to the associated muscles and organs. These reflex points therapy localize when involved. Normally, a directional tugging of the tissue at the reflex point results in a pulsation which can be felt in the fingertips. Elicitation of this pulsation is not always necessary to demonstrate a result; however, it is considered desirable. The strength of the perceived pulsation varies with the approximation of the perfect combination of contact dynamics. It has been the experience of the author that a similar pulsation can be elicited from common neurovascular points on the skull by directionally influencing the upper cervical spine, as well as other vertebral levels and areas of the body. This procedure has typically resulted in enhanced patient relaxation, pain relief, and positive muscular response.

While holding the neurovascular point at Lambda with my left hand in an effort to improve overall patient response, my right hand has tended to come to rest on the patient's neck, generally for convenience. Wondering if I could enhance the effect, I tried holding right thumb and forefinger on the Psoas/Illiacus neurovascular points simultaneously. I also tried holding the Mastoids bilaterally, the transverse of Atlas, the finger on Atlas and the thumb on the Mastoid...every combination I could think of. All with no particular result. The left hand was still the focus of the procedure; I was trying to elicit the neurovascular response in the standard way.

In one particular case, after working with what I knew to be a dural torque problem, I set about to do some func-

(2)

tional enhancement with the neurovasculars. I remembered the two tennis balls taped together which Dr. Goodheart advocated as a way for patients to de-torque themselves at home. I decided to change the focus of the neurovascular approach by making my left hand passive instead of active as I was contacting the NV point. Sitting, facing the left side of the table with the patient prone, I began to apply various combinations of pressure to effect cervical extension, rotation, lateral flexion...whatever it took to "de-torque" the cervical spine, which is what I thought this would do. For some reason it seemed likely that the neurovascular point would respond. When I found the right combination of direction and pressure, the familiar pulsation began at the NV point under my fingers. By varying the direction and intensity of my contact in the spine, I could bring the pulsation to a maximum, or I could eliminate it altogether with the opposite vectors. The patient thanked me when he got up and remarked that he felt much more relaxed; his pain had eased considerably.

I was delighted to experience this phenomenon, especially in that it seemed to have a positive effect. I tried it on everybody I could, and it always "worked." I could always find a combination of pressure and direction that would evoke the neurovascular response. Generally, everybody liked the feeling that went with it. Most responded during the procedure with relaxation. Their body position would change somewhat; the character of their breathing would change; afterwards they would say something like "Phew!" "Another minute of that and I would have been asleep" or "Could you feel me relax as you were doing that?"

In one case of what I call a "marathon headache," (she'd had it for ten days!), the patient got good response to everything I did, except that the headache was still there. She localized the pain at the left side of Axis, and I attempted to induce the neurovascular response with an upper cervical contact. This had little effect, much to my dismay. It then

(3)

occurred to me to try this same induction procedure on the Lovett brother, L4. With my left hand monitoring the neurovascular point on the cranium, I held contact at L4. I varied the direction and pressure until I felt a pulsation, and I made minor changes until I felt the strongest response. When I'd held that position for about a minute the headache was gone.

Now I had an answer for which I didn't have a question! I had assumed the induction response would be confined to the upper cervical vertebrae because of their dural attachments; that did not seem to be the case. I began to search for other areas which would give this same reaction. The lumbosacral articulations most frequently gave a good response, and often I was able to eliminate the pain that lingered after an adjustment--the pain I would usually send them home to put a cold compress on.

I found that it seemed to work best when the contact (wherever it was) was such that the patient could make repeated respiratory excursions from full inspiration to full expiration without loss of the pulsation. Sometimes a strong pulsation would be established in a relatively full expiration posture. The patient would be lying prone, my thumb pushing down on the transverse of L5. But the pulsation would markedly diminish as the patient began to take a deep breath. By changing the contact somewhat, we were always able to find a particular vector that would work through full respiratory excursion.

Because the response was dependable, I began to use this procedure systematically to reduce muscular tension prior to adjusting. Patients with acute pain appeared to let go of a "panic-type" tension, enabling further intervention. Occasionally I've seen that the patient's pain problem was gone after neurovascular induction alone. It contributed to post-adjusting relaxation, to get rid of that last little "catch," or to calm patients down after adjusting if they were the high-strung "You broke it!" type.

In another clinical situation, a patient demonstrated a positive Leg-Pull Test with therapy localization to the chondral

(4)

margins of ribs 7, 8 and 9. She felt distress in that area, and we checked for vertebral and costovertebral subluxations in that area of the spine. We fixed what we found and then did the Leg-Pull Test as before. Nothing had changed; the leg pulled down easily. On a hunch, I attempted to induce the neurovascular response using the anterior fontanelle this time, in that she was supine. I found a direction of tissue pull at the edge of the ribs that produced a strong pulsation, and held the contact briefly. I then instructed her to breathe through a few full excursions to make sure there was no interruption in the pulsation. This accomplished, the Leg-Pull Test was again attempted. This time the leg remained very strong. Afterwards, the patient's local discomfort was relieved as well as a sense of lumbar restriction she'd felt on that side.

This was intriguing. Dr. Bennett, who discovered the reflex areas on the skull which we refer to as the neurovascular reflexes, did not work with *only* those points. He also used reflexes on the trunk and the abdomen which he deemed to have similar effect. From what I can gather about the mechanics of his method from Ralph Martin's book,⁶ two contacts were necessary except when treating cranial centers. The second contact point was at the lower cervical aspect of the Upper Trapezius, for "visceral areas of the face," was adjacent to the first or second thoracic vertebra for "areas above the diaphragm," and was adjacent to the fifth or sixth thoracic vertebra for "areas below the diaphragm." A single contact sufficed when the area of concern was the cranium; the specific contact points for the brain existed only on the cranium.

Contacts were held with gentle pressure; the feedback was reduction of local tenderness, changes in the character of the patient's breathing, relaxation of body tension, initiation of peristaltic activity (visceral gurgling heard or sensed with the fingertips), or the presence of a pulsation under the fingertips. Dr. Bennett, in the transcription of his last lectures by Ralph Martin, D.C.,⁵ uses the phrase, "Bring a reflex into this point..." That is to say, cause a pulsation to begin at the de-

(5)

signated point. The reflex was not the *point*; it was what *happened* at the point.

In applying the neurovascular induction technique generally, in an effort to simply observe the ramifications of this approach, I would have the patient lie down prone on the Hi-Lo with the center piece unlocked to allow movement of the spine. Standing on the left side of the table, I would hold the NV point at Lambda with my left hand and apply pressure to the patient's spine with broad contacts of my open right hand. Beginning with the lower ribs on one side and then the other, I would move up the rib cage, first with pressure away from the spine, then with pressure toward the spine, sensing whatever response there was at the cranial point.

Some spots would react; some would not. Invariably though, a reaction would be elicited somewhere with the open hand, and then more specifically with the thumb narrowing the focus. In my experience, if a pulsation could be elicited with a pressure contact on the lower ribs on the right, for example, there would also be a reaction at the lumbosacral area on the opposite side. A patient who demonstrated a pattern of dural torque, such as a positive Leg-Pull Test, would react easily to pressure directed at the upper cervical spine. A patient who exhibited a pattern of upper cervical fixation, however, such as a positive Leg-Push Test, would respond more easily to pressure directed at the lower cervical spine.

These observations may help the curious practitioner find success in the initial application of this technique.

There are numerous methods which use focal pressure to accomplish various theorized therapeutic ends. The Receptor-Tonus work of Nimmo, the ischemic pressure trigger-point treatment presented by Travell² and popularized by Pruden,³ as well as the lesser known spinal pressure point contact used to relieve palpable abdominal "pulses" advocated by J. Cerney,⁴ all use similar techniques. Typically, digital pressure is applied to a particular spot for a variable length of time in the expectation of physiological change. Each technique has its own pro-

(6)

ponents, rationale, and methodology.

On the basis of the observed phenomenon reported here, it seems apparent that the body is not pressure sensitive *per se*; it is vector sensitive. The difference is that a vector has force and direction. The addition of a feedback monitor to these techniques, which have served practitioners skilled in their use and familiar with their vagaries and inconsistencies, would be helpful in reducing wasted effort.

My experience with this phenomenon parallels Bennett's: effective therapy produces immediate physiological changes; pain is relieved; patients feel better. Effective therapy is vectored therapy, and the determination of the proper vector is made much easier with immediate, sensitive, and patient-based feedback.

REFERENCES

- ¹Walther, David S., Applied Kinesiology, The Advanced Approach in Chiropractic, Systems DC, Pueblo, Colorado, 1976
- ²Travell, Janet G, and Simons, David G., Myofascial Pain and Dysfunction, Williams and Wilkins, Baltimore, Maryland, 1983
- ³Prudden, Bonnie, Pain Erasure, M. Evans and Co., New York, New York, 1980
- ⁴Cerney, J.V., Handbook of Unusual and Unorthodox Healing Methods, Parker Publishing Co., West Nyack, New York, 1976
- ⁵Martin, Ralph J., Dynamics of Correction of Abnormal Function, privately published, Sierra Madre, California, 1977
- ⁶Martin, Ralph J., The Practice of Correction of Abnormal Functions, privately published, Sierra Madre, California, 1983

The Leg-Push Test

A. J. Woodson, D. C.

Abstract: The Leg-Push Test is defined as a measure of the cooperative interaction of the Quadratus Lumborum and the Gluteus Maximus. Its relationship to both the Leg-Pull Test (described in a previous paper)¹ and the nutritional spectrum of the electron poisoning concept is explained. Some observations are included to help clarify the implicated issue of sympathetic/parasympathetic dominance. Therapeutic protocol, in cases where such testing is found positive, is suggested.

In putting a new label on what has been previously termed the Gluteus Maximus test, my goal is to simplify things. In order to make the Leg-Push Test a simplification, however, at first we have to complicate things somewhat. We have come to accept that spinal fixations tend to generate bilateral muscle weakness patterns. Since there is high correlation between certain spinal levels and certain pairs of muscles which show a weakness response during testing procedures standardized by Kendall and Kendall,² bilateral weakness of the Gluteus Maximus indicates upper cervical fixation.

Assuming no other positional involvements exist, it can be shown after the correction of an upper cervical fixation that the weakness response of this pair is eliminated. Therapy localization of the upper cervical vertebrae can likewise abolish the weakness response. Conversely, the weakness pattern of the Gluteus can be "hidden," and uncovered by various means. Commonly, hyperflexion or hyperextension of the neck will cause the initially strong pair to weaken in the expected way. This reinforces the concept that vertebral problems in the upper neck are implicated.

In dealing with patients from the standpoint of the Leg-Pull Test, (see Collected Papers, Winter 1985),¹ I have ob-

(2)

served that many patients who presented involvements of the lower cervical spine on initial examination, and who were treated appropriately and given the indicated nutritional support, would often return in a day or so, sometimes in a week or so, with changes in their symptoms that reflected the presence of an acute upper cervical fixation. Whereas before, the patient had had a strong Gluteus Maximus response, despite evocative testing procedures, EID, hyperflexion/extension etc., the patient now presented definite weakness response in the same test, done in the same way; this time it was totally in the clear.

Before I anticipated this problem, it was a source of frustration. I had seen this happen many times, long before I studied Applied Kinesiology and used muscle testing as part of my procedure. Patients flip-flopped between symptom patterns, usually more than once, because I had no nutritional approach to help stabilize the metabolic swings that accompany these physical phenomena. When I began to think in terms of the electron poisoning concept⁴ as a basis for nutritional intervention, I tried to apply it to these basic symptom polarities. I found those patients who presented a positive Leg-Pull Test (those who could not hold simultaneous contraction in the Popliteus and the Rectus Femoris) responded to nutrients which supported the thyroid side of the electron poisoning equation, i.e., desiccated thyroid, manganese, various liver supplements. Those patients who presented the classical bilaterally weak Gluteus Maximus responded to nutrients which supported the steroid side of the electron poisoning equation, i.e., desiccated adrenal, ovary, zinc. Both types of patients responded to electron poisoning supplementation, such as Electron Plus from Nutri-West.

I found if a patient presenting a positive Leg-Pull Test therapy localized the Gallbladder alarm points, it would abolish the weakness response. The test itself is a measure of the cooperative interaction between two muscles, and possibly two meridians. I looked at the Gluteus test from that stand-

(3)

point. In that it seemed to represent the other end of the nutritional spectrum, I supposed it could also have the same mechanics of interaction. I've seen cases where correcting an upper cervical fixation did not restore the strength of the Gluteus; sometimes one side would get strong, the other wouldn't. Aside from involvements at L5, and neurolymphatic congestion, the most common involvement was the Quadratus Lumborum. Fixing that would turn on the Gluteus.

What if the G.Max. test was testing the interactive cooperation between the Quadratus Lumborum and the Gluteus Maximus? As in the Leg-Pull Test, holding the alarm points of an involved acupuncture circuit should neutralize a positive test. I found that patients who had a bilaterally weak Gluteus Maximus, which strengthened with therapy localization to the upper cervical spine, indicating uncomplicated involvement, would also strengthen with therapy localization to the Large Intestine alarm points. I began to use the Leg-Push Test terminology to indicate its similarity to the Leg-Pull Test, but operating at the other end of the spectrum.

The ability of the body to compensate for problems on one side of the cellular energy equation causes, over a period of time, problems on both sides of the equation. There are patients who present a positive Leg-Push Test (what we've learned to think of as the G.Max.test) who strengthen when they therapy localize the *lower* cervical spine. Likewise, there are patients who present a positive Leg-Pull Test, which is normally neutralized by therapy localization to the lower cervical spine, who show tremendous response when they therapy localize the *upper* cervical spine. These exceptions appear to "prove the rule" in that they suggest the activity of the compensation mechanism of the body as a whole is based on the electron poisoning problems of the cell.

Patients who present a positive Leg-Push Test in the clear, that is, uncomplicated by prolonged adaptation response, generally present a history which suggests they are "burning the candle at both ends," so to speak. They are working two

(4)

jobs, getting a divorce, and taking care of a terminally ill family member all at the same time. They are taking no nutritional supplementation, admit to smoking two packs of cigarettes, as well as drinking two pots of coffee, or a six-pack of diet cola per day. They don't eat breakfast; many don't eat lunch either; they make it through the day on pastry, snacks, and candy. And they usually say, "I just can't understand why I have this damned headache!"

In his book The Neurodynamics of the Vertebral Subluxation,³ A.E. Homewood presents evidence to support the proposition that vagal overstimulation can be responsible for some involvements in the upper cervical area. The overlap in sensory nerve connections is well established throughout the spine; each posterior nerve root branches upon entry to the cord, ascending or descending one, two, and sometimes three neuromeres before terminating. Homewood maintains this same neurological overlap causes reflex involvement of the upper cervical level when there is hyperactivity of the Vagi, due to the proximity of the vagal nuclei and the first cervical nerves. I think there is a wealth of clinical evidence to support this view. In correlating *who* has the problem, and *what* he is doing to cause it, I would elect to say the patient presenting a positive Leg-Push Test is parasympathetic dominant, in contrast to the patient who presents a positive Leg-Pull Test who reacts as sympathetic dominant.

Hyperactivity of the Vagi is needed by these people to maintain balance in the midst of high stress situations and constant adrenal/ovarian overactivity. Many of these patients are using caffeine and nicotine in amounts far beyond the requirements for stimulation; they are probably deriving considerable sedation effects therefrom. In effect, they are like drivers with the throttle stuck in the "on" position; they can only control themselves with the brakes. These people tend to seek intervention when they can no longer maintain the frantic pace and are slipping down the long hill into the exhaustion phase of the General Adaptation Syndrome.

(5)

They come into the office with engines overheating and brakes smoking.

I rarely see what I've termed here an uncomplicated case. The longer the person has been putting up with his symptoms and riding the General Adaptation physiology, the more likely we are to see both a positive Leg-Push and Leg-Pull Test. The typical *complicated* case presents symptoms indicating difficulties at both spectral extremes. Occasionally, a successful nutritional challenge will immediately evoke the opposite problem. Finding a positive Leg-Push Test which responds excellently to dessicated ovary, for instance, can bring out a previously absent Leg-Pull Test. This, then, can be eliminated with something to support the thyroid side of the equation, commonly, thyroid itself. The more highly stressed the metabolism, the quicker this reaction takes place. Some patients do this flip-flop in two weeks, some in two days, some in the time it takes to flip over on the examination table.

It is this need to treat both ends of the metabolic spectrum simultaneously that can be overlooked in the effort to fully categorize a patient. Having diagnosed a patient as hypoadrenic on the basis of his postural hypotension, paradoxical pupillary reflexes, increased second heart sounds, elevated urinary chlorides, and Sartorius weakness, it seems a remote possibility that the successful resolution of the case may depend on the treatment given to the thyroid, or the thyroid side of the metabolic equation. The body doesn't lie, but it sometimes says, "I'm bending to the right because I'm bent to the left."

Having complicated the issue, I'm ready to suggest the Leg-Push Test is a simplification, at least in terminology. Actually, there are two tests to consider. The test position for the Gluteus Maximus that has the patient prone, the thigh extended on the trunk, and held as high as the patient can hold it, tests the cooperative interaction between the Quadratus Lumborum and the Gluteus Maximus. The same format with the thigh extended only moderately tests the Gluteus without the

(6)

anchoring requirement of the Quadratus. Some patients will break down at the most elevated position and then grab strength at the lower position, indicating separate involvements. I've seen that response a lot, but I didn't know what to call it. We could call it the "Quadratus Lumborum/Gluteus Maximus Cooperative Interaction Test." Instead, I call it the Leg-Push Test.

REFERENCES

- ¹ Woodson, Alan J., "The Leg-Pull Test" in The Collected Papers of the Members of the International College of Applied Kinesiology, ICAK, Shawnee Mission, Kansas, Winter 1985
- ² Kendall, Henry O., Kendall, Florence P., and Wadsworth, Gladys E., Muscles, Testing and Function, 2nd Ed., Williams and Wilkins, Baltimore, Maryland, 1971
- ³ Homewood, A.E., The Neurodynamics of the Vertebral Subluxation, privately published, 1963
- ⁴ Goodheart, George J., Applied Kinesiology 1983 Workshop Procedure Manual, privately published, Detroit, Michigan, 1983

****INDEX****

- Acupuncture Points, 91
- Applied Kinesiology, 1, 13, 59, 171,
209, 283
- Applied Mechanics, 91
- Body-Typing, 19
- Candida Albicans, 171
- Cervical Injuries, 101
- Clavicle Subluxation, 177
- Depression, 275
- Diet Planning, 19
- Doctor Therapy Localization, 195
- Dyslexia, 131, 149
- Ferreri Neural Organization, 59
- Five Element, 55
- Food Allergy, 127
- Gall Bladder Meridian, 181
- German Electro-acupuncture, 1, 13
- Hair Samples, 217
- Heilpraktiker, 205
- Hydrochloric Acid Deficiency, 181
- Intervertebral Disc Lesions, 279
- Kinesi-Arc System, 37
- L.D. Technique, 149
- Learning Difficulties, 59
- Learning Disabilities, 131
- Lips Apart, 127
- Lips Together, 127
- Low Back Pain, 213, 275
- Magnets, 47
- Malingering, 101
- Meningeal Subluxation, 271
- Meridian Spinal Adjusting, 67
- Metabolic Individuality, 19
- Muscle Balance, 73
- Muscle Testing, 127
- Musculoskeletal Forces, 37
- Neurovascular Response, 401
- New Patient, 187
- Non-Kinetic Physiological, 187
- Nutritional Guide, 283
- Nutritional Supplements, 13
- Nutritional Testing, 1
- Parasites, 155
- Patient Orientation, 201
- Prepelvic Tap, 159
- Proprioceptors, 243
- Rectus Femoris Dysfunction, 177
- Reiki, 209
- Seven Conditions, 73
- Sheng Cycle, 55
- Sore Throat, 161
- Source and Luo Points, 55
- Specific Gait Patterns, 43
- Statistical, 183
- Stress and Disease, 113
- Stress Fractures in Runners, 217
- Structural Lesions, 43
- Technique Variations, 107
- Therapy Localization, 91, 195
- Tonic Labyrinthine Reflexes, 257
- Tonsillitis, 161
- Universal Sacral Fault, 123
- Weight Bearing Position, 257