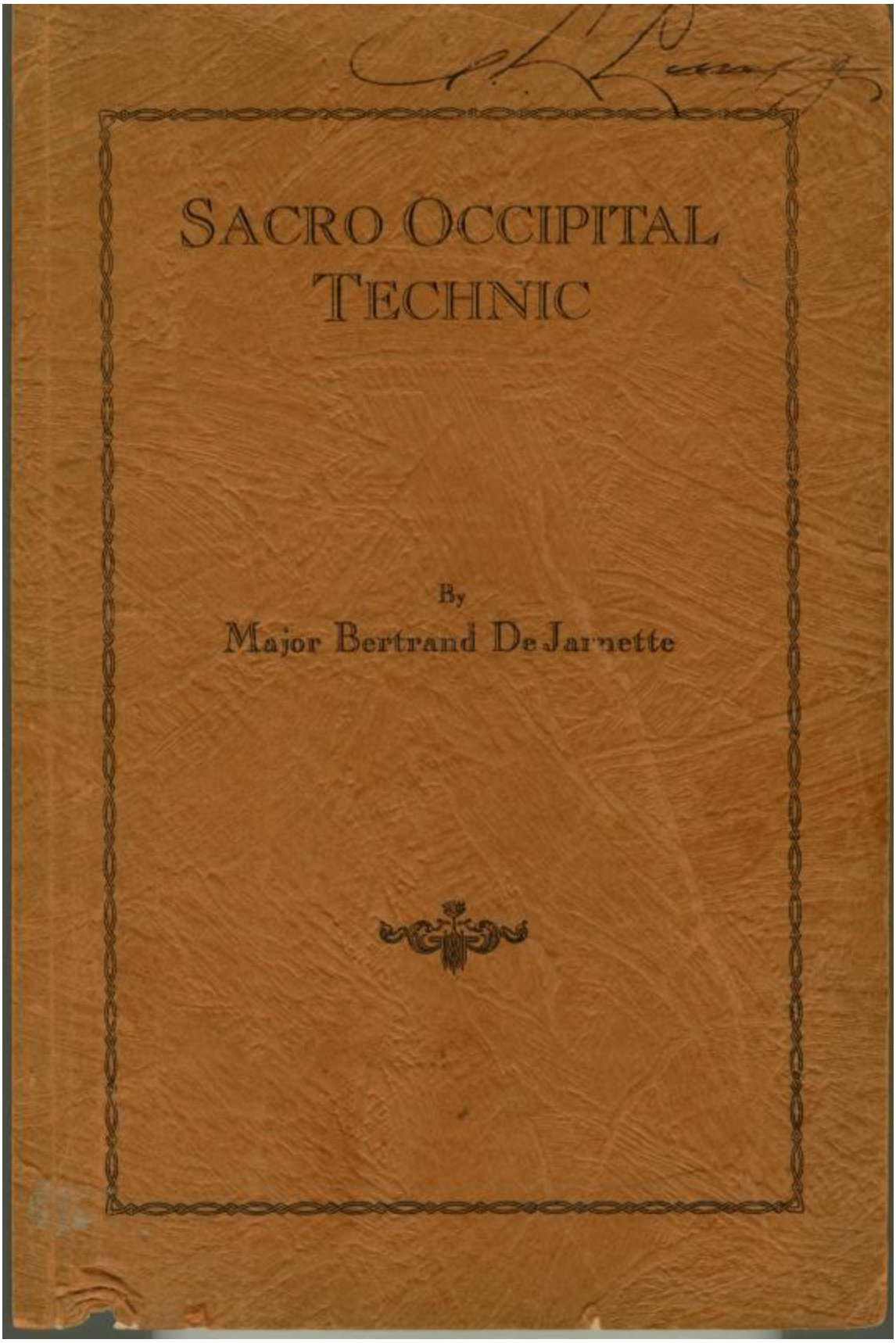

SACRO OCCIPITAL TECHNIC

By

Major Bertrand De Jarnette

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Sacro Occipital Technic

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Dedication

We gratefully dedicate this book to those hundreds of
Doctors of all Schools of healing who have so
faithfully aided us in our research work.,

INTRODUCTION

In the Sacro Occipital technic you will find that we have presented four separate technics.

VASOMOTOR LESION TECHNIC:

We have attempted to show the physiology and the pathology of the vasomotor lesion, its method action and the technic for its detection. We have attempted to explain and illustrate the technic for the vasomotor lesion correction.

BODY BALANCE TECHNIC:

We have used every precaution to fully illustrate and explain how the occiput is to be adjusted. Remember that the body balance technic is always used, if indicated, following the correction of the vasomotor lesion.

THE SPINAL NERVE LESION:

We have shown the technic detecting and localizing the spinal nerve lesion and the methods to normalize the spinal nerve lesion. The occiput is not adjusted following the spinal nerve technic, unless a body balance exists.

THE SACRO OCCIPITAL TECHNIC:

This part of the technic is brief, but fully explained and illustrated. The Sacro Occipital technic is used in conjunction with technic for the spinal nerve lesion and is used when pain exists and then only.

In studying this book of technic, start at the very first page study each part. Do not pass up any part of the technic, until you understand its part in this therapy. Do not glance at an illustration and think you have mastered it. We believe you will agree that we presented technical data that will require a bit of study and diligent practice, but the time you use in study and practice will well repay you in results secured.

This book clearly differentiates between the chronic vasomotor lesion and the acute spinal nerve lesion. Bear this differentiation in mind all times.

Resolve today to become a better spinal therapist for the tomorrows that are to come.

THE HUMAN MACHINE

In presenting this technic to you, we shall consider that the human body is a very delicately adjusted machine. We shall presume that it is self regulatory, but like all machines, it is subject to mal adjustments. We shall not look at the body as a machine that must have new parts added or old parts subtracted, but as a unit that will function perfectly when all parts are properly adjusted.

The body is self selective, it has the power of subtracting from the Earth's materials things that are of value as foods. It has the power to repell from the body those things of the Earth that are harmful, but it has the power of selecting and repelling only while in proper adjustment.

A patient has an affinity for certain plant pollens and under no consideration can stand the contact of these pollens against its parts, but when proper mechanical adjustment is resumed, the body will tolerate these pollens without effort. Certain foods are seemingly very harmful to certain people and will make them deathly sick if eaten, but if proper mechanical adjustment is restored, these foods become beneficial and well tolerated. We can not say that this food is one man's meat and another man's poison, because if the man who considers the food good becomes unadjusted it will be poison to him and the one to whom it is poison, if mechanically readjusted to perfection will consider that particular food, as meat well tolerated,

If a patient has a severe gastritis and certain foods are for the present harmful, withhold those foods until adjustment is made, and they will become beneficial to that man's body.

Disease can not and will not manifest itself in the body unless that body has some maladjustment. Life shall go on well past the point of three score and ten providing proper mechanical adjustment is maintained.

The Human body has an inherent ability to maintain normal adjustment, but this inherent ability is often destroyed or hindered in its normal processes by the mishandling of the body by either patient or Doctor.

The body lives by stimuli. Normal stimuli is normal adjustment. Abnormal stimuli is abnormal adjustment, disease, death.

Care of the Human Machine

Care of the Human machine demands consideration of many factors, but perhaps the most vital is careful consideration of maintaining or restoring normal nerve impulses.

THE VASOMOTOR NERVES: Circulation feeds the body, cleans it, heats it, and heals it. The heart is the circulatory regulator and is itself governed by the nervous systems. It beats because of two factors, NEUROGENIC or nerve energy, MYOGENIC or muscle energy. Nerves cause the flow of blood, this causes muscle heat, expansion and contraction. The nerve impulse excited the heart to contraction, regulates its speed, but the myogenic energy maintains it in operation by heat functions. The heart forces blood into the lungs and into the aorta. The Vasomotor nerves cause the blood to circulate throughout the body. The Vasomotor nerves regulate the caliber of all blood vessels. Causes normal dilation in one

part or normal constriction in another part. When activity in a muscle starts dilation is supreme, when function gets under way, constriction increases and the greater the function of a muscle the greater is constriction. If this did not take place the muscle would fill with blood and all of its capillaries would rupture by engorgement.

Being that the body lives by stimuli and that nerve impulses are the sources of stimuli, it is evident that the Vasomotor nerves must perform a very important function in maintaining health, for by their deeds shall the body be known as being either healthy or sick.

Coarse forces are nowhere found in evidence in the Human body. Every function is the result of fine forces and it is this one thing that we, as spinal therapists, must devote no little thought to. If the fine forces rule Nature and the human body, is it not possible that coarse forces will not and can not be tolerated? Is not a crude adjustment or manipulation an expression of a coarse element of force? Is not a quick or a well defined adjustment or manipulation expressive of the finer things of force? One hundred men using axes can not fell a tree in one ten thousands the time that one bolt of lightning can. One scientifically applied adjustive force is the equivalent of 1000 ill defined, crudely applied adjustive forces.

The vasomotor nerves respond to two degrees of stimuli, inhibitive or stimulative. Stimulative force causes constriction, because it excites the vasomotor nerves, inhibitive force causes dilation because it inhibits the constrictors and lets the dilators reign supreme. If we have a patient suffering from excessive vasodilation, would it be wise to apply more dilative forces to the body? Would it not be better to apply stimulative or constrictive forces to the body? If we have a body suffering from the effects of constriction, would it be wise to apply more constrictive forces? If we have a case of high blood pressure, would it be wise to apply stimulative forces to cause further constriction? Would it not be better to inhibit the constrictive force and allow dilation to take place? If we have a patient that is suffering from very low blood pressure, would it be wise to apply dilative forces and further increase' the low blood pressure?

If a patient has sciatica and the blood vessels are in a state of constriction, would it be wise to apply an adjustive force to the area involved that would cause further constriction? Would it not be better to apply an adjustive force that would cause dilation and thereby relieve the circulatory embarrassment?

It is fundamentally necessary that you be enabled to know whether your patient's circulatory apparatus is in a state of dilation or constriction. You can not hope to produce results if you apply to your patient a force that will aggravate, instead of relieve, the embarrassed member that is in trouble.

Many Doctors use bath cabinets and routine massage for every patient. This, we believe, is a very unsound policy, for where massage or a hot bath would be indicated for a constricted case, it would be exactly contraindicated in a case suffering from the effects of dilation, for all of you know that heat and massage produce dilation and engorgement of tissues. This law is infinite and can not be made to vary one iota. Many Doctors claim to use nothing but specific adjusting. A case that would require a specific adjustment would be a case where the object is to produce stimulation and a case where stimulation of the constrictors would be contraindicated of course would be made worse by receiving a specific adjustment.

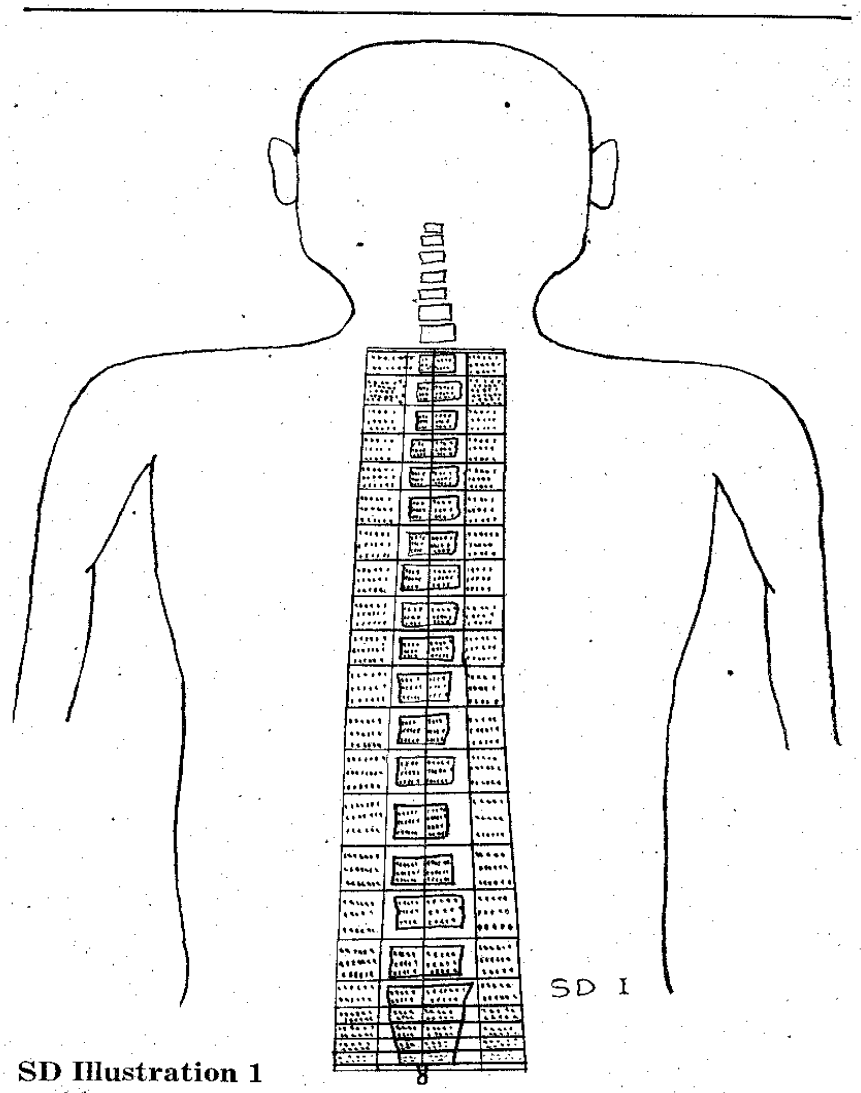
The few remarks that we have interspersed regarding the Vasomotor nerves are written as a warning. No matter how carefully you apply the Sacro Occipital technic, if you misuse the vasomotors you will be defeated.

SPINAL DIAGNOSIS

This chapter is not written to take the place of our Brochure on Spinal Diagnosis, but to further remind you of the importance of this subject.

Spinal diagnosis as contained in this chapter shall deal exclusively with the Vasomotor Spinal areas and their reactions to manual examination and therapy.

When you place your hands upon the spinal column, whether for purpose of examination or therapy, you affect in some manner the vasomotor spinal areas and it is for you to know just what effect that you are going to produce, otherwise you shall eternally be causing conflicting reactions. If it is your therapeutic aim to produce a given reaction in a segment of the cord, and you unknowingly produce in that segment some other reaction, you can not expect the pathology you are dealing with to respond entirely to your satisfaction.



SD Illustration 1

This is an illustration of the compensatory spinal muscle, spinal cord cell circulation. The spinal muscles that are ennervated by the posterior internal division of the spinal nerves lay three inches laterally to the spinal column, from the first dorsal to the coccyx.

We now call your attention to SD plate Number 1.

This plate is a schematic drawing of the spinal muscle, spinal cord, compensating Vasomotor centers.

The spinal muscles that are ennervated by the posterior internal division of the spinal nerves, play a very important part in health, because by their compensating action they maintain a normal cell activity within the segments of the spinal cord, and if the segments of the spinal cord are correctly balanced, the brain cells are also correctly balanced we have what is known as normal cell activity and health.

The spinal muscles that are ennervated by the posterior internal division of the spinal nerves, lay three inches laterally to the vertebrael bodies, and are found from the first dorsal to the coccyx. These muscles contain within themselves cells that have both a blood and nerve compensating relationship with compensating cells in the segment of the cord. It is in these compensating cells that we have the origin of the bulbs of the vasomotor nervous system and the same posterior internal division of the spinal nerves that ennervate these spinal muscle cells, also ennervate the internal viscera of the body and all the skin surfaces of the body, so if compensation is disturbed here, we have disturbances of cell function both in the viscera that are ennervated and the visceral compensating skin areas. All abdominal, pelvic and thoracic viscera have skin surfaces that compensate with themselves. The lungs can be either made hypremic or anemic by applying certain therapeutic agents over the chest wall. The abdominal viscera can be made hypremic or anemic by applications over their compensating skin areas. This same effect can be produced by applying these agents over the spinal vasomotor areas, showing a definite and positive relation ship between visceral and skin areas and vasomotor and skin areas. Heavy massage of the skin area over the kidneys will cause the skin to become actively hypremic and will drain the blood from the kidneys to a certain extent, but if the vasomotor nerves that supply the kidneys are given off from an hypremic cord cell, this massage will be extremely beneficial, but if the opposite. is in effect, the massage will at first be, beneficial, later to cause an adverse reaction and further increase the hypremia of the pathological kidney, for the same posterior nerves enervates the skin and muscles of the back that ennervate by vasomotor influence the blood vessels of the kidneys and that explains why massage can be beneficial or very detrimental, all depending upon the state of the compensation blood factor between spinal muscle cells and cord cells at the time of applying the massage.

You will please note in SD charts 1 that we show a much heavier cell function in dorsal segment two, than in dorsal segment one. This is because dorsal segment two is particularly responsible for controlling the circulation to all parts of the head and face, as well as the neck. Dorsal segment 2 also supplies vasomotor impulses to the cardiac muscle and you will find that practically every chronic patient will at some time show a lesion of the second dorsal segment.

The spinal muscle segments correspond to the spinal cord segments and as such spinal muscle segment eleven will correspond to spinal cord segment eleven. All positions are gotten by measuring laterally from the tips of the spinous processes and no consideration is made for spinal nerve emissions as to segmental position.

SPINAL MUSCLE, SPINAL CORD CELLS

We now refer you to charts SD 2, SD 3, and SD 4,

Illustration SD 2 is the compensating relationship between the spinal muscle cells that are ennervated by the posterior internal division of the spinal nerves and the cells of the spinal segment. You will notice that both cord cell and muscle cell are of the same diameter. This is a muchly exaggerated illustration of the diameter of the cell, for we ask you to remember that each cell, containing as it does thousands of minute cell bundles, is still so very minute

that a microscope is necessary to analyze its structure. When both cord cell and muscle cell is of the same diameter, we have equal circulatory compensation, hence we have cell health. It is fundamentally necessary for bodily health that we have equal circulatory balance between the cells of the cord and spinal muscles, for only by equal circulation can we have normal food supply and normal evacuation of debris. If stagnation is set up by unequal circulation, we can not expect either a normal food supply to be present nor can we expect debris to be carried away, hence we have cell deaths in greater quantities than we have cell births. It is sound fundamental physiology to expect Nature in her infinite wisdom to provide some means of equalizing spinal cell circulation, and this spinal muscle, spinal cord circulation is the definite answer to this physiological thought.

The cells that go to make up the viscera and the muscles of the body and the skin overlying all these structures depends upon the same source of nerve energy for maintaining health as does the cells of the spinal muscles, hence if we have a healthy function of the spinal muscles in their compensating relationship with the spinal cord cells, we have a normal body functioning in its fullest measure.

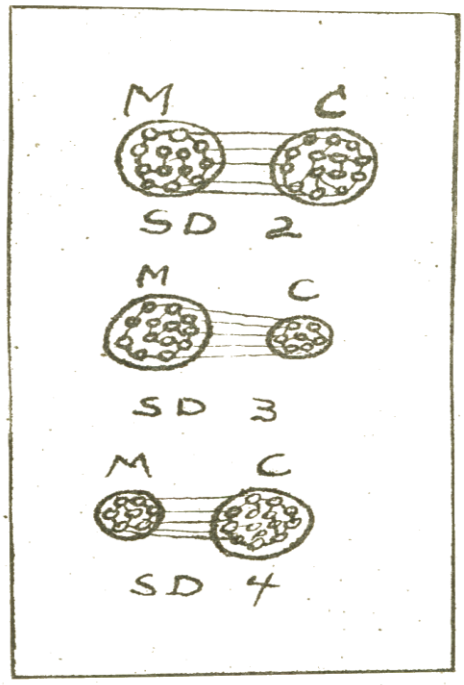


Illustration SD 2

This illustration shows a normal spinal muscle spinal cord cell colony. Not that the exaggerated enlargement of the cell bundle of both spinal muscle segment and spinal cord segment are of the same diameter

Illustration SD 3

This shows a hypremic condition of the spinal corresponding anemia of the spinal cord cells.

Illustration SD 4

This illustration shows an anemic condition of the spinal muscles and a corresponding hypremia of the cord cells.

Illustration SD 3 shows the effects produced by a hypremic spinal muscle cell bundle. When we have two compensating factors linked together by tubes and these structures are normally of near the same diameter and work under the same degree of stimuli and internal pressure, we normally expect them to both maintain this equality of size as long as the pressure in both remains the same. Fortunately for our physical welfare this pressure does remain the same as long as the vasomotor influence is normal, but if some degree of stimuli is in excess or is lacking, the vasomotor impulse will cause the spinal cell to contract to excess if the stimuli is increased or to dilate to excess if the impulse is impeded in its action. If the vasomotor impulse causes constriction in the spinal cord cells, we must naturally

presume that the compensating cells in the spinal muscles will be forced into a state of dilation and that is what has happened in SD 3 illustration. Being that the muscle cell is in an excessive state of dilation, that means that the spinal cord cell is very shortly going to feel the effects of its own anemia and its impulses are going to be feeble, causing the organs it ennervates to lessen their function and this lessened function is going to cause them to dilate and become engorged with blood. As this engorgement progresses, putrefaction will set up and then we will have inflammation of the organ or organs so ennervated.

It is a basic law of physics that heat dilates and that cold contracts. No metal is adverse to this law and the human body is very susceptible to its action. If the spinal muscle cells are dilated and the spinal cord cells constricted, we must use some therapeutic agent that will cause the muscle cells to contract and by this contraction force blood into the spinal cord cells and by this process we automatically wash the cells of the cord, give them new food and encourage them to resume normal activity and to become again susceptible to stimuli.

Therapeutic measures such as heat applied to the spinal muscles will, in the case of illustration SD 3, increase the spinal muscle hypremia and increase the spinal cord anemia, for by further dilating the muscle cells, we must further deplete the cells of the cord. On the other hand, cold applied to the muscles will constrict them and cause them to force blood into their compensating cord cells. Cold is analogous to a recoil adjustment, for a recoil adjustment is active stimulation. Instead of using cold to the muscle, we shall give a recoil adjustment to the spinal segment that is affected and this will cause vasomotor stimulation and will produce constriction of the spinal muscle cells and dilation of the cells of the cord and will so increase the circulation to all organs that are ennervated from this segment, that they will soon he able to resume normal function.

We have seen cases as illustrated by SD 3 that were so badly affected by application of heat, massage and prolonged manipulations, that the patient fainted. We have seen these patients gradually grow worse under wrong therapy, but the instant correct therapy was begun, improvement started and continued until normal processes were in force.

ILLUSTRATION SD 4

This illustration shows the effects of spinal cord cell dilation, causing the spinal muscle cell to become very small and constricted. This condition causes excessive hypremia of the spinal cord cells and so increases their function as to cause the viscera so ennervated to in crease their function way above normal. This process in its inceptancy will cause the patient to feel extremely good. Their skin is rosy and their cheeks may even become quite red. Their vitality is high and their endurance great, but any excess function, if maintained for a time, will cause so great a destruction of cells that the body can not furnish new cells as disintegration takes place and the first thing the patient knows their kidneys and heart go bad.

This excess first affects the heart and kidneys because the arteries receive the same ennervating factors as does the spinal muscle cells, and this constriction causes all the arteries that are ennervated from this segment or those affected segments to narrow themselves, causing the heart to increase its power and producing a raise in blood pressure. It is this raise in blood pressure that at first makes the patient feel so exhillarated, but as constriction increases, the heart is bound to weaken and even if the heart does not weaken, a capillary or artery in the brain can rupture and cause paralysis. The capillary systems in the

kidneys are put under an excessive strain and of course rupture is possible, ac counting for the blood and casts that will eventually appear in the urine.

In pathological conditions that are caused by spinal cord hypremia, our physiological aim is to produce dilation in the cells of the spinal muscles, for by so doing we dilated their bodies and this will let the blood drain from the spinal cord cells into the muscle cells and by this exchange of circulation will both cleanse and nourish the cells of the cord and by so doing automatically lowers the blood pressure, for the arteries receive a normal quantity of nourishment, their walls relax, the heart eases up on its excess function, the pressure in the kidneys is lowered and pathology is gone. Heat will dilate and if applied to the spinal muscles will be beneficial but it is far more specific to use a slow, rotary motion double transverse adjustment. This produces realization by inhibiting the vasomotors and will restore balance much quicker than will heat. It is also well to follow the adjustment with rotary finger manipulations to the adjusted area until all tension is gone from the underlying structures.

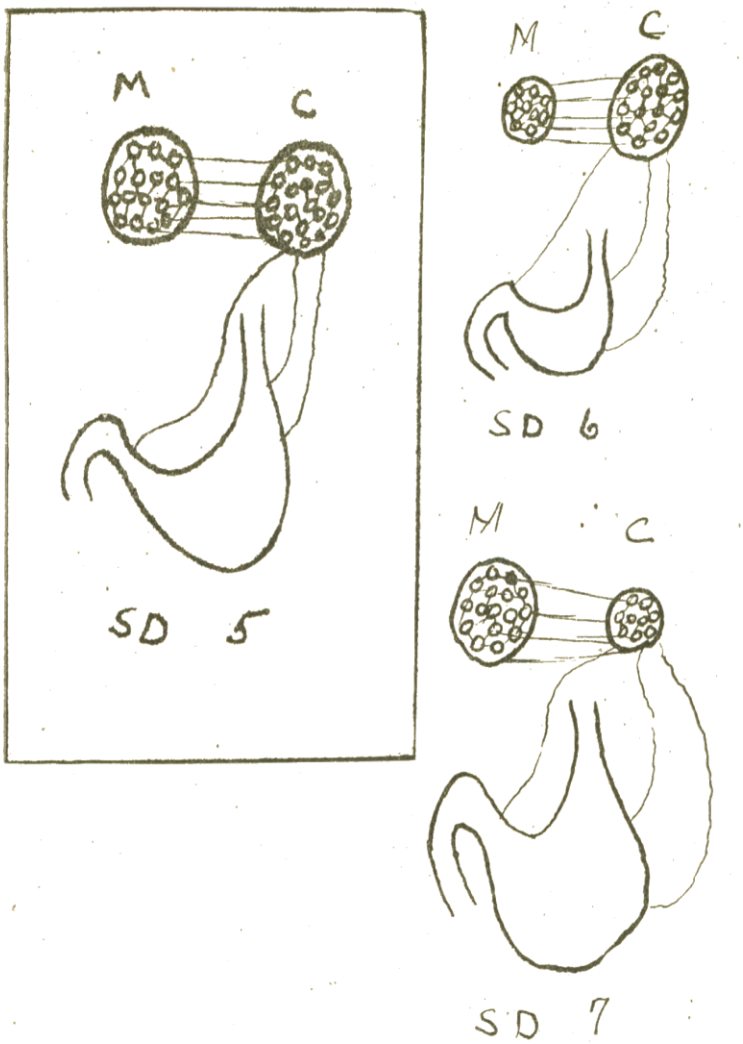


Illustration SD 5

This shows a normal balance of circulation between spinal muscle cell bundles and spinal cord cell bundles, and a normal stomach.

Illustration SD 6

This illustration shows an anemic spinal muscle cell and a hypremic spinal cord cell, with a contracted condition of the stomach. When the spinal muscle cell is contracted, the organs ennervated from the same segment that the spinal muscle is ennervated from is likewise contracted.

Illustration SD 7

This shows a dilated or hypremic spinal muscle cell and a constricted or anemic cord cell, with a corresponding dilation of the stomach.

The following cuts will illustrate the spinal muscle, spinal cord compensating factor in relationship with the size and function of the stomach. We have used the stomach as an

illustrative viscera, due to the fact that the stomach can be easily viewed with the fluoroscope and our deduction proven by any one.

Illustration, SD 5 shows a normal spinal muscle, spinal cord compensation. Both bundles are of the approximate diameter, showing that normal circulation, normal nerve impulse and normal function is in operation. The stomach is of normal size and activity. Digestion is with out trouble and as far as the stomach is concerned, all is well physically.

Illustration SD 6 shows hypremia of the spinal cord cells. The spinal muscle cells are constricted. As the spinal muscle cells and the stomach are ruled by the same nerve impulses, the stomach must consequently be in a state of constriction. Food causes distress, digestion is speeded up, the patients may eat heartily, yet receives very little good from the food eaten. Even though these patients may exhibit a tremendous amount of vitality for a time, yet they soon start down hill, and unless something is done, the end is soon. These patients often com plain of headaches and they believe the stomach is at fault, but the headache is due to the spinal cord and cerebral congestion and not to gastric pathology. Remember, that the stomach is constricted, but not necessarily diseased, for as soon as the spinal cord hypremia is reduced, the stomach immediately dilates to normal. If the stomach was diseased, return to normal would be very tedious.

Illustration SD 7 shows a spinal cord anemia and a spinal muscle hypremia. The stomach is excessively dilated. The cord cells are in a state of starvation, impulses to the stomach are feeble, the stomach acts feebly, food lays in its cavity and ferments, gas is formed, pressure is put on the heart, and these people, although appearing in perfect health, die, not of gastric disorders, but from heart failure. These patients are invariably gas makers and they constantly belch after eating. The blood pressure is low, their vitality is at low ebb, and they are generally very miserable. Due to the excessive amount of blood in the gastric membranes and the excessive amount of gastric juice that is secreted, combined with the poisonous gasses that are fermented, gastric ulcers and even cancer claim many of these people as victims. We have cured cases, so diagnosed as ulcers and even cancer, by doing so simple a thing as restoring normal balance between spinal muscle and spinal cord cells. This type of patient responds to a recoil adjustment, and will be immediately made worse by a double transverse adjustment if slowly given. Massage and heat can not be tolerated.

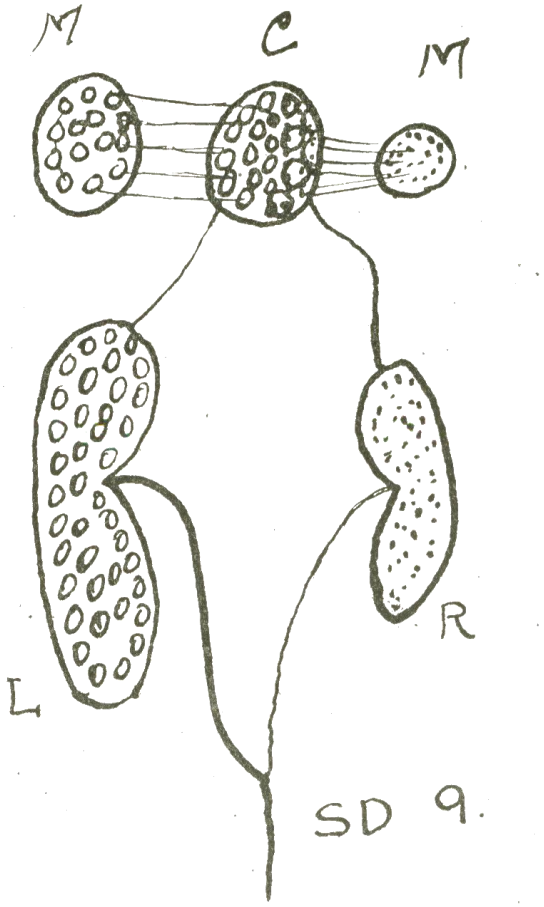


ILLUSTRATION SD 9

This is an illustration taken from an actual clinical case and is used here because it brings out a very vital therapeutic truth.

This patient was a lady of 45 years of age. Apparently in perfect health until one week before I saw her. She complained of excruciating lower back pains. The lower limbs were, swollen and the urine contained casts and blood. The right kidney was tender upon palpation. The blood pressure was 212 systolic, but how long it had been at that point no one knows for the patient had always enjoyed the very best of health. I made a diagnosis of acute nephritis. The eleventh dorsal segment was badly constricted. The spinal muscle opposite the spinous of the eleventh dorsal would show little redness even upon prolonged heat applications. The spinal cord cells of the eleventh dorsal were badly hypremic. Hospital tests showed a normal kidney function of the left kidney, but a very low function of the right kidney. After receiving this report, I took especial pains to note the effects of therapy as applied separately to each side of the spine. Rotary manipulation applied to the right side of the eleventh dorsal spinal area would reduce the blood pressure, but this same therapy applied to the left side of the eleventh dorsal showed no effect. Much against my better therapeutic judgment, the patient had the right kidney operated upon and the surgeon found a very small, pale colored kidney. The parachematous tissues and the interstitial tissues were greatly atrophied. After the operation the patient made nice progress for about six months, then the left kidney started to give signs that all was not well. The patient came to me and was under treatments for three weeks, which consisted of a double transverse adjustment at eleventh dorsal every third day along with adjustment of third occipital area. Complete relief was afforded and this patient is seemingly in the best of health. The blood pressure is now 165 systolic, which is the lowest possible point for safety.

This illustration shows you how definitely accurate one can be in spinal therapy work, and how even one-half of one segment may be solely responsible for a very severe pathological disorder.

You will please note in my illustration that spinal cord cells on its left half are normal, while on the right half are very large. The muscle cells on the left side of the spinal segment are normal, while on the right side are very small.

I might add that this patient is a Drugless Practitioner, but never took adjustments because she felt that she never needed them. While in College she was adjusted as a student clinical patient, and she noticed that a recoil adjustment made her feel very nauseated. Until I saw this patient, she had never had her blood pressure accurately taken.

VASOMOTOR FUNCTIONS

Illustration SD 8 very concisely shows the various Vasomotor functions.

The Vasomotor system is divided into the following branches:

Vasomotor fibers, contain Vasoconstrictor and Vasodilator fibers. The Vasoconstrictors predominate over the dilators, in that the vasoconstrictors are found from the first dorsal to the second lumbar, but the Caude Equina contains vasomotor fibers, so we find that the constrict ors predominate even to the last coccygeal vertebrae. The dilator fibers are found chiefly in the Medulla Oblongata and the floor of the fourth ventricle. The occipital ridge has a pronounced effect upon vasomotor action, in that therapy applied here balances the action of both dilators and constrictors.

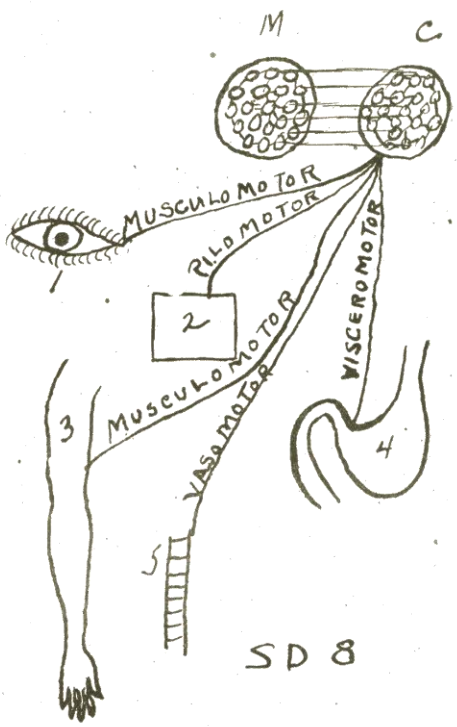


Illustration SD 8

This illustrates the manner in which the visceromotor, vasomotor, musculomotor and pilomotor fibers originate in the same spinal cord cell bundle.

The Vasomotor constrictors and dilators control the caliber of all arteries and capillaries and by so doing have a powerful influence upon circulation. This control is very marked upon the capillaries that supply the cells of the compensating spinal muscle and spinal cord circulation.

Over constriction endangers life by causing a raise to excessive degrees in blood pressure and by producing anemia of spinal muscles and hypremia of the cord and brain cells.

Over dilation produces excessive fatigue and complete cell and brain starvation. A patient will enjoy life to a much greater extent with overconstriction, than with over dilation. The terrific speed at which we live today is very wrecking on the vasomotor systems and accounts in a great measure for the many cases of nervous prostration that we deal with daily and to the many cases of suicides that you read about daily. Cancer is the direct effect of a depleted vasomotor system. I at one time was intimately acquainted with an automobile race driver. After every race this man would be so weak that he could hardly walk. Invariably his blood pressure would drop as much as 30 m

during a race. I have been in two car wrecks. In the seconds before, the crash, I had immense vitality, felt that I could do anything to keep the car righted, but after both wrecks I was so weak from exhaustion that I couldn't stand.

If I were a prison physician and was caring for a condemned convict, and his was a case of excessive dilation, I would administer adrenlin or would use constrictive therapy to his spinal muscles, and I as sure you he would be much steadier at the last minutes. That would be much better than to administer Scopolamine or Morphine.

The Muscularmotor nerves ennervate all sketal muscles. If normal, the muscle will have normal flexibility and strength. If over active the muscle will become stiff. If underactive, the muscle will become flabby.

The Pilomotor fibers ennervate the skin.

The Visceromotor fibers ennervate the muscular portions of all viscera. These play a powerful part in all glandular activity and must be carefully normalized.

In illustration SD 8 we show you a muscularmotor nerve ennervating the eye. As long as this ennervation is normal, the eye will have normal dilative and constrictive activity; if abnormal, definite eye lesions will be apparent. The eye must be perfectly nourished before sight is normal and that function is performed by the Vasomotor systems.

We also show you a muscularmotor nerve ennervating the arm: a Visceromotor nerve ennervating the stomach; a Pilomotor nerve ennervating an area of skin, and a Vasomotor nerve ennervating an artery.

Each one of these branches come from the same bulb and may all be affected at one time or only one may be affected, depending upon the severity of the bulb lesion.

A Vasomotor lesion at the first dorsal may affect tile constrictor fibers of the coronary arteries that feed the heart and cause angina pectoris, again the muscularmotor nerve that ennervates the pectoralis muscle may be affected and produce false angina pectoris, yet the treatment of the lesion at the first dorsal would be the same whether the lesion was causing true coronary angina pectoris or false pectoralis muscle angina pectoris.

A Vasomotor lesion at the second lumbar may affect the constrictor nerves in such a manner as to cause vasomotor dilation and cause severe appendicitis and in this instance the appendices will be found to be badly enlarged and inflamed, and again the appendicitis may be the sole results of a visceromotor disturbance affecting the appendix by causing a gas pocket to form and producing symptoms of appendicitis, yet the appendix upon surgical exploration, will be found to be normal. In some instances the mere act of relaxing the visceromotor fiber at the second lumbar will immediately cause the appendix pain to stop, while if the appendicitis is due to vasomotor dilation, manipulations at the second lumbar will immediately cause the appendix pain to increase and endanger life by further engorging the appendix, and may even cause a ruptured appendix and general peritonitis. This is one of the clearest and most easily proved vasomotor lesions that we have.

In a case of vasomotor dilation, we shall have a patient with low blood pressure. The spinal cord cells will be anemic and the spinal muscle cells will be hypremic. Upon slight pressure, redness will appear around the affected segment. An appendicitis due to a visceromotor lesion will cause the patient to have a very high abdominal blood pressure and this will

cause a pulse pressure of around 20 m. Relaxation of the involved fiber immediately reduces the high abdominal tension, allows the gas to move out and the patient is ready to get up and go to work. A safe estimate tells us that 65 % of our appendicitis cases are nothing but visceromotor lesions. Watch the appendices when you have a true vasomotor lesion, whether constriction or dilation.

Illustration SD 10 shows an appendix that is affected not by acute inflammatory reactions within itself, but by the blocking of gas within itself and the ileocaecal valve. This is due to a visceromotor imbalance. Note that the cord and muscle cells are normal. The cut illustrates the gas pockets by the fine lines within the colon and the appendices and the ilieum. If this condition is allowed to remain as such without correction, this blocking by convulsive visceromotor actions will tend to produce inflammatory reactions and gangrene may even result, due to the impeded circulation throughout the appendices, ileocaecal region and ilieum and colon proper. This type case will show a pulse pressure around 20 m.

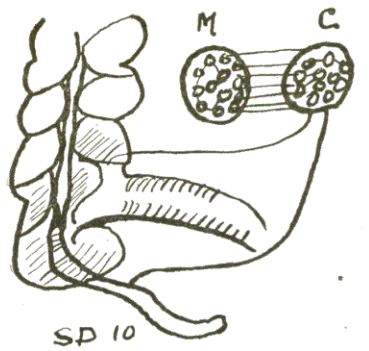


Illustration SD 10

This illustrates a normal spinal muscle, spinal cord cell circulation and its effect on the appendix. You will note that the appendix is normal in size, but that its lumen is occluded up in the colon. You will note that the black shading in the cut illustrates gas formation in the colon, ileo ceceal valve and appendix. This gas formation has completely closed the lumen of the appendix and has caused all symptoms of severe acute appendicitis. The blood cell count, however, is normal, but the pulse pressure is 20, showing abdominal visceroconstriction.

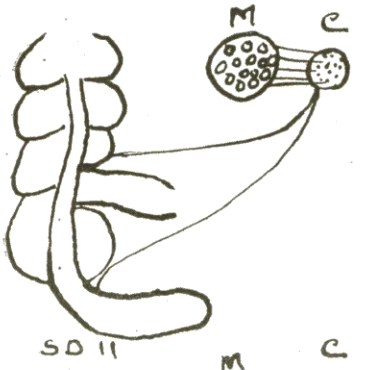


Illustration SD 11

This illustration shows you a type of appendicitis accompanied by severe acute pains and all cardinal symptoms of appendiceal inflammation. The appendix is swollen and inflamed. The spinal muscle cell bundle is hypremic and the cord bundle anemic, which accounts for the hypremia of the appendix.

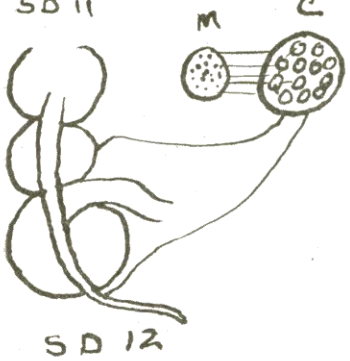


Illustration SD 12

This illustrates what is usually a chronic re-occurent type of appendicitis. The appendix is small. The spinal muscle cells are constricted and the cord cells dilated. The spinal muscle cell constriction accounts for the constricted condition of the appendix. The appendix, upon removal will be found to be narrow and pale.

Illustration SD 11 shows a case of appendicitis due to spinal cord cell anemia. This patient will have low blood pressure and both local and general vasodilation. A recoil adjustment or finger pressure over the offending spinal segment will quickly restore normalcy. Do not massage the spinal area and do not apply heat to either appendix or spinal region, for to do so increases dilation and may so engorge the appendix as to cause it to rupture.

Illustration SD 12 shows an appendicitis case that has appendicitis because of a spinal cord cell dilation. The appendix is constricted and very small. These are many times chronic cases. The appendix of this type, however, may make itself known by causing terrific intestinal and even gastric pains, due to the general abdominal constriction. Many

times you never suspect an appendix involvement, but look for either gastric or hepatic pathology. The blood pressure will be high. Give a slow, double transverse adjustment to the involved spinal segment. Heat may be used to both spinal segment and appendix.

Many doctors empirically either apply heat or ice to an appendix. Classification of patients and an understanding of the Vasomotor system makes this application easy and scientifically done.

RECAPITULATION

Spinal health is directly dependent upon spinal cord and spinal muscle circulation.

Spinal cord, spinal muscle circulation is dependent upon the ennervation supplied to the spinal muscle cells by the posterior internal division of the spinal nerves.

Bodily health is dependent upon the health of the nerves and the health of the nerves is dependent upon normal spinal cord cell function.

Hypremia of the spinal cord cell bundles causes anemia of the spinal muscle cells. The resultant spinal cord engorgement is responsible for increased functional and organic activity, due to the excess of blood iii the cord cells, this increases all activities due to vasoconstriction pre domination. The blood pressure raises to abnormal heights and after a. time the patient's life is severely endangered. All organs ennervated from the hypremic cord, cells are in a state of anemia due to excessive hypremia causing abnormal stimulation of the vasoconstrictors. Any diseased organ will be found to be constricted and its cells in a state of starvation.

Anemia of the spinal cord cells causes hypremia of the corresponding spinal muscle cells.. This spinal cord cell anemia causes the cord cell to have too little stimuli and therefore all organs ennervated from the anemic segment will be found to be in a state of dilation. The patient will have low blood pressure, will after a time become weak and very easily fatigued. Fainting may become noticeable. If any organ is attacked by infective bacilli, the engorgement already present will offer a fertile breeding field with resultant stage of severe inflammatory reactions occurring.

The spinal muscle cells receive the same source of nervous energy from the spinal cord that the viscera receive and also the same source of energy that the muscles of the sketal framework receive. An engorged muscle cell means an engorged visceral cell. An anemic muscle cell means an anemic visceral cell.

Heat is a dilator and cold a constrictor. A recoil adjustment is equivalent to cold because it stimulates and a prolonged pressure adjustment is equivalent to heat, because it dilates by inhibition.

NERVE LESIONS

We have headed this chapter "NERVE LESIONS" for we find that there are two distinct forms of lesions, namely, the lesion and the Spinal nerve lesion, the spinal nerve lesion consisting of lesions of the cerebro spinal nervous systems and the sympathetic nerve system, along with its cranial and myeliene nerve channel lesions.

We do not conceive of a nerve lesion being exclusively one due to vertebrael bony lesion pressure. We do not conceive of all disease being primarily due to a slippage of a vertebrae and result pressure upon one or more pairs of spinal nerves.

Primarily disease is due to spinal trauma, be this trauma slight or severe. No one has escaped injuries to one or more spinal segments. Few people have lived a span of years without at some time spraining their ankle, yet a spinal vertebrael lesion is very similar to a sprained ankle, and yet millions of people disregard a spinal injury and think of it as only a pain to be stopped by whatever means they have at hand.

In acute traumatic injuries of the spine, the thoughtful physician reduces as best he can all congestions and places the part at rest. When the acute stage has subsided, measures are used to replace both bony and muscular as well as ligamentous tissues.

We shall first consider, the Vasomotor Lesion. Vasomotor lesions are associated with chronic disorders. Practically all medical writers associate Vasomotor lesions with hot flashes, flushing of the face or body, and that is about all they seem to understand about this pathology. They construe most Vasomotor lesions as being of a dilative nature. Nothing is further from the truth. Many severe chronic disorders are due to constrictive vasomotor lesions. Probably the reason we have given so little thought to the constrictive lesion, is due to the fact that these patients usually feel so invigorated, due to increased cell activity, that they do not associate disease with their renewed vigor until it is too late, and the physician sees the patient only after they have had a stroke or some other severe disfunction.

A vasomotor lesion may exist for years without causing any symptoms of an internal wrong, and yet after a sudden fright or shock, a grave pathological disorder will suddenly appear. I have seen women develop toxic goiters in as little time as four days after receiving a sudden fright or shock. Vasomotor lesions are made worse by any emotional excess, that is one characteristic of this lesion.

I once treated a gentleman of some 76 years of age who, until the day previous to seeing his daughter pass away, was apparently in very good health, but the next day he could not urinate. I found his prostate badly engorged. Suitable therapy to the Vasomotors gave quick relief. I am satisfied that the shock of his daughter's passing was partly responsible for the exaggeration of an old lesion and producing great hypremia of the prostate gland.

Most of you have at some time or another heard of some Faith Healer who was seemingly securing marvelous results and possibly some of your patients have deserted you and gone to such people and secured results. A patient with a Vasomotor lesion is very susceptible to any system of therapy that uses enthusiasm for a basis of therapy, but sad to say this enthusiasm only lasts while the patient is near the healer and as soon as this said enthusiasm dies down, the old disease returns. Take a patient that has low blood pressure and we find that they have anemia of the spinal cord cells and hypremia of the spinal muscle cells. Anything that will increase the circulation will help the patient for by so doing the spinal cord anemia is benefited and the organ or organs affected are temporarily made better, but the mere act of increasing the circulation and not at the same time permanently correcting the lesion is getting the patient but very little for their time and money spent.

In my clinical work I have seen patients come to the c1inics for a given condition. The doctor would adjust or manipulate the area he believed to be in trouble and while the

treatment helped the disorder of which the patient was complaining, very often some other very trouble some disorder would appear as if out of space, and treat as best the doctor could, the disorder would persist, but when the Vasomotor nerves were treated, the disorder would end. A spinal therapist can by correcting a spinal lesion, produce a Vasomotor lesion, for Vasomotor lesions are produced very often by thrusts given to the spinal vertebrae, said thrusts affecting the circulatory balance between the spinal muscles and the spinal cord cells. You have often explained to your patients that they were retracing when they would complain of new pains and aches appearing. You were not retracing, you were producing vasomotor lesions in your sincere efforts to correct a spinal lesion.

A mechanic can adjust a spine, a blacksmith can work at fixing an automobile, but it takes a real therapist to adjust a spinal lesion and at the same time not disturb a vasomotor segment. Very fortunately Nature takes care of millions of Vasomotor lesions daily without any help from doctors; if she did not, this would indeed be a sad place in which to habitate. How many times during your day's work do you feel queer sensations in your body? Probably for no cause whatsoever your neck will feel slightly stiffened, yet you hardly notice this until it is gone. Your legs will feel a little wobbly, yet in an instant they are normal. You will have a slight difference with a patient, you become nervous, yet this soon passes. These are all Vasomotor lesions which Nature has adjusted to normal.

It may truly be said that it takes more scientific technic to correctly adjust a spinal segment than it does to remove an appendix. The surgeon can see every step of his technic in use, the spinal therapist has to imagine what is taking place under his hands; he has to imagine what has taken place before the patient comes to him; he ha to imagine what will take place after the patient leaves the office; and yet a surgeon can command $200.00 for being able to see every step of his technic, and the Spinal Therapist feels he is robbing some one if he gets $3.00 for using both his mental and physical powers to their maximum limits in giving a treatment of which he can only see the bare surface.

In the past as well as at the present time, many Spinal Therapists, like their older colleagues, the Medical Doctors, vie with one another, not in a spirit of cooperation but in a spirit of antagonism: One doctor will try to show his patients that he is giving them more for their money by using a lot of massage, manipulations, electricity and other procedures. The other spinal therapist says that he goes direct to the cause of disease and that the other things are only not necessary but harmful. Both are wrong. Some types of patients need more spinal technic than others, and it is your duty to your clientele to know what is needed and to be big enough to give just what is needed and. no more or no less.

To promiscuously manipulate a patient just to be doing something, is placing you in the class with a strong armed masseur, where it seems people think it is more essential to have big muscles and little brains. If by one well directed act you can restore a patient to normalcy, you will make an impression on this patient that will never be forgotten and will never go unsung as far as your patient is concerned, but if you pound, push, shove, pull, massage, twist and otherwise, exercise your strength on a patient and the patient feels worse in a few hours, your patient will refuse to take future wrestling lessons

Spinal therapy must be Specific whether it take one-half of one minute to give a treatment or whether it take two hours. You must know what to do and then know definitely how to do that thing or things.

THE VASOMOTOR LESION

The first effects produced by a lesion of the vasomotor nerves is its effect upon the circulation. We have two distinct vasomotor lesions.

HYPREMIC VASOMOTOR LESION

In this lesion we have hypremia of the spinal muscle cells and anemia of the spinal cord cells. We have dilation of the cells of the organ or tissue affected. The nerve energy as given off from the spinal cells is lessened so the function of the organ or tissue ennervated is lowered. The blood pressure is abnormally low if the lesion is severe and of long standing. We do not believe that it is possible to have an acute vasomotor lesion, for before we have a vasomotor lesion we must have a traumatic spinal lesion and we find the vasomotor lesion developing after the spinal lesion has become chronic. A vasomotor lesion may appear to occur quickly, but the reason is due to emotional factors, causing a sudden fall or drop of blood pressure.

The blood pressure is the keynote in determining the state of the vasomotor nerves, for we determine the lesion to be hypremic if the blood pressure is low or anemic if the blood pressure is above normal. A hypremic lesion causes dilation, while an anemic lesion causes constriction. In hypremic lesions we have feeble action due to engorgement, while often in anemic lesions, we have increased action due to cell irritation. When a man is drowning he has unusual power, when a cell is starving, it has greater power for a time. A car will make a greater effort to run if the gas mixture is too lean, but if the gas mixture is so rich that the air is excluded, the car runs feebly and then stalls. The same applies to blood circulation through the spinal cord cells.

FACTORS AFFECTING BLOOD PRESSURE

Before we can foretell the exact stage of the circulation by blood pressure, readings, we must consider what internal factors can affect the blood pressure.

We know that blood pressure is dependent upon vasomotor nerve impulses. Normal blood pressure means a balanced condition of the vasomotor nerve impulses. Blood pressure is also dependent upon a normal exchange of gasses in the circulatory tubes. In normal states of the circulation, we have a normal gas content in the tubes, we have a normal intake of oxygen and a normal output of carbon dioxide gas, but in abnormal states of the vasomotor nerves, this delicate balance is upset and in hypremic states we find the vascular tubes to be more dilated, therefore the gas pressure is lessened and the gas tends to be exhaled slower and the intake of oxygen is lessened. This dilation of the tubes of the circulatory apparatus causes gas to be liberated into the abdominal organs of the body and this produces embarrassment of the circulatory apparatus by interference with the normal operation of the diaphragm. Along with this condition we have a tendency to lowered digestive ability and food tends to ferment and this again embarrasses the heart by causing fermentative gas pressure against the diaphragm.

If the heart is strong and able to compensate, we find even in states of hypremic lesions a raise in blood pressure, and it is necessary that we use some means to eliminate this gas

temporarily before making our final blood pressure test, because if this is not done, we will give the wrong treatment and our patient will be made worse.

If the heart is weak, the presence of gas will lessen its power to pump the blood into the aorta and lungs and, the blood pressure till be lowered and more carbon dioxide gas will be retained and less oxygen, inhaled, making the patient very dizzy, short of breath and weak. Many cases so diagnosed as being autointoxication are nothing but this condition, and the mere act of eliminating gas removes all symptoms, temporarily at least.

ELIMINATING CARBON DIOXIDE GAS

The right side of the fifth dorsal controls the vasomotor fibers to the stomach. Both sides of the tenth dorsal control the vasomotor nerves to the intestines. Both sides of the second lumbar control the vasomotors to the colon. By applying therapy at these points, the vasomotors are temporarily normalized, the carbon dioxide gas is reabsorbed into the arteries and the blood pressure seeks its vasomotor nerve normal. Following this operation the blood pressure may either raise or lower itself, due to the power of the heart muscle, but you will invariably find that some difference has been made, for all vasomotor lesions create carbon dioxide gas disturbances. Fermentative gasses are also eliminated to some extent by this procedure, but not entirely.

BLOOD PRESSURE METHOD

This is the more accurate method, but requires a little more work. I believe you will be willing to use a little extra time, for you can command more fees for your work, if you do accurate work.

To classify your patient, you take the blood pressure, then make your gas eliminative pressure; then retake the blood pressure. You then know exactly the state of the circulation and the state of the vasomotor nerve function.

Use the position as illustrated by the cut on page 27. Always have the patient facing west if possible, but be sure the patient always faces the same direction for each successive treatment. The Magnetic Meridian has some influence on the blood pressure and this influence is due to its action on the vasomotor nerves. You must be accurate in your deductions, for a mistake means a wrong treatment in many instances.

After your blood pressure reading is recorded, you proceed as follows:

For the hypremic type or the type 1 patient, you will use your index and middle finger to make the pressure opposite the fifth dorsal, straddle of the tenth dorsal and second lumbar. On this type of patient your pressure is light, being about the same amount of pressure that you can stand comfortably applied against your own eyeball. The pressure is made for one second.

It is your object on this hypremic type to produce spinal muscle constriction, for, remember that the spinal muscle cells are hypremic the spinal cord cells anemic, and your object is to cause spinal muscle cell constriction so the blood will be forced into the spinal cord cells When the circulation is stimulated, the fifth dorsal segment produces constriction of the arteries in the stomach and increases the circulation in this organ, moving out the carbon dioxide gas and bringing in oxygen. The same amount of pressure is applied to the tenth

dorsal and. the second lumbar, only you straddle the tenth dorsal and the second lumbar, as illustrated by cut showing gas eliminative vasomotor areas.

The hypremic or type 1 patient has a blood pressure of less than 120 systolic.

Normal blood pressure in a patient with normal vasomotor function regardless of age, is from 120 to 125 systolic for men, and from 115 to 120 systolic for women.

THE ANEMIC VASOMOTOR LESION

This patient is the exact opposite of the patient described under hypremic vasomotor lesions. The spinal cord cells are in a state of hypremia and the spinal muscle cells are in a state of anemia. Due to irritation, the organs ennervated from the segments involved have their functions increased and the patient usually feels very good, until some shock or excitement destroys Nature's compensation. Many of these patients never realize they are sick until they have a stroke of apoplexy.

Due to the spinal cord cell irritation, the vascular tubes of the body are in a state of vasoconstriction and the blood pressure raises, due to a narrowing of the tubes. A definite amount of blood must pass each foot of vascular tubing every second. Normally if the vasomotors are balanced, the heart has no trouble in maintaining this circulatory equilibrium, but when the tubes become narrowed, the heart must in crease its function, so consequently the blood pressure raises. In this type of pathology, carbon dioxide gas is forced into the stomach and intestines and colon, not by lack of tension of the vascular tubes, but by over tension. If the gas could not escape into these cavities, rupture of blood vessels would occur. I have seen several cases of gastric hemorrhages, thought to be due to ulcers, to be due to nothing more or less than constriction of the gastric blood vessels, keeping the gas in those tubes and causing minute and even larger tubes to rupture, and the hemorrhage was stopped immediately upon relaxing the gastric blood pressure.

Your therapeutic object in producing normalization of gas pressure on the anemic or type 3 patient, is to dilate the spinal muscle cells, so as to relieve the pressure within the spinal cord cells and brain and when this is done by applying pressure to fifth dorsal, tenth dorsal and second lumbar, the vascular tubes of the stomach, intestines and colon relax, circulation is momentarily normalized, exchanges of gasses are more liberal and you are enabled to read the blood pressure as it is being maintained by the vasomotor nerve impulses.

Illustration 1-a

Technic position for taking blood pressure. This position allows operator to treat fifth dorsal, tenth dorsal and second lumbar for gas elimination without leaving his chair.

The anemic type patient will have a blood pressure above 140 systolic.

In treating fifth dorsal, tenth dorsal and second lumbar, you use a rotary finger pressure which is about three times as hard as pressure used for hypremic type and is maintained for 15 seconds at each center for gas elimination.

You then retake the blood pressure.

In this type of patient, if the heart is strong, the blood pressure may drop as much as 50 m. after gas elimination, but if the heart is weak, the pressure may raise as much as 20 m. after gas elimination.

I have treated patients that could not receive insurance because of so-called high blood pressure and have found that the procedure described above would reduce the blood pressure to normal limits, but remember, this is only temporary and before permanent results are to be had the Vasomotors must be corrected. Your gas eliminative technic is only temporary results to allow a normal vasomotor blood pressure.

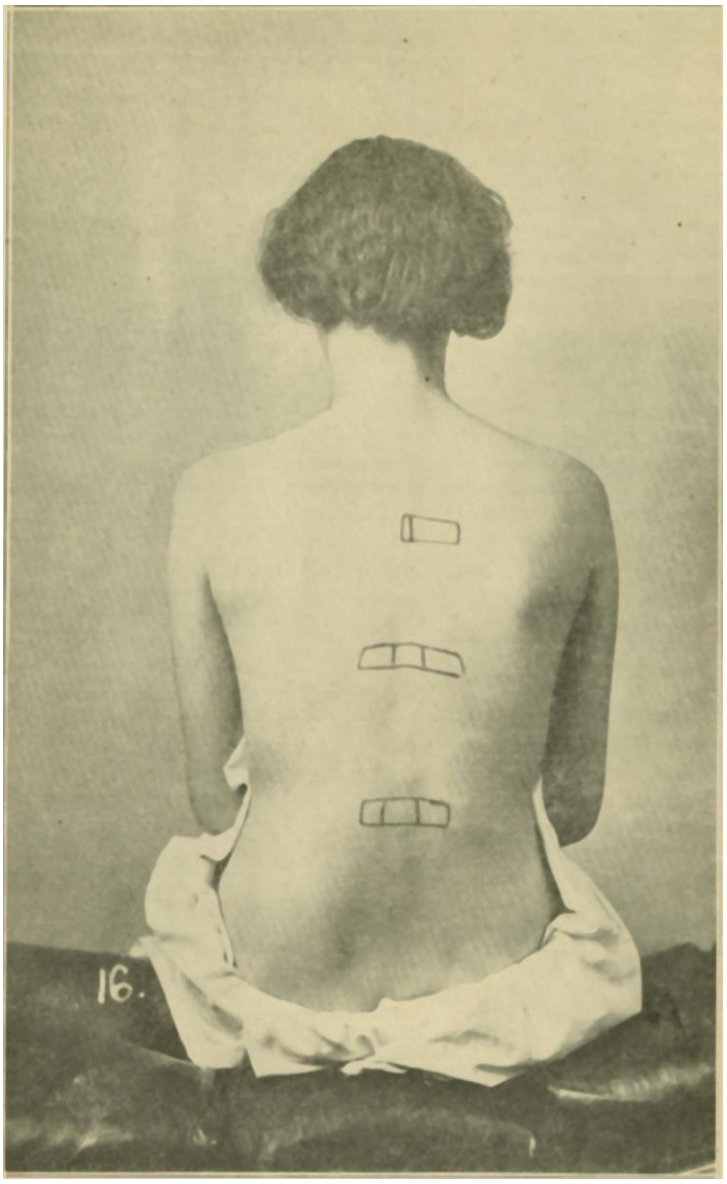


Illustration 16
This illustration shows you the vasomotor areas for eliminating carbon dioxide gas. Note fifth dorsal area is to right of spinous and the others are straddle of spinous and cover an equal distance on both sides of spine.

Not so long ago I was called to the bedside of a patient who apparently was dying. Breathing was terribly labored. Heart action was bad. I did not have time to make any kind of an examination, but proceeded to eliminate gas and almost instantly the patient responded. I am certain that this technic saved the patient's life.

It is not my custom to quote letters in a book on technic, but I am going to break that custom and quote from a letter written by Dr. Albon Herchleroth, of 1128 Narbcnne Ave., Lomita, Calif., for I believe this letter contains a lesson.

Dr. Herchleroth says: "By the way, I was called on a case that was diagnosed as Angina Pectoris by two medical doctors, one Osteopath and one Chiropractor. Patient was bedridden for five months, pain around heart and radiating down arm. Patient taking digitalis and bromides with Drugless treatments. (Doctor must have been a MIXER.) All I did when I first saw, the patient was to make pressure right side of fifth dorsal and as the patient termed it, she was cured instantly, but as you know, I only relieved the gas pressure from the diaphragm which was pressing against the heart."

THE ANEMIC-HYPREMIC PATIENT

This type of patient is probably one that requires more skill to normalize than any other type. You take the blood pressure and if it is below 120 systolic, you use light pressure to eliminate gas, but it the pressure is between 120 and 140, you use twice as much pressure as you used if the pressure is below 120. After you eliminate the gas, then retake the blood pressure, and if it is below 120, the patient is a hypremic type, but if it is above 120 to 140, the patient is an anemic type.

Following therapy, this patient may either show a raise or lowering of pressure. Some segment will be hypremic and another one anemic. Great care must be used to always note this peculiarity in treating this patient, for one day the patient may require a recoil adjustment and the next a double transverse may be indicated.

These patients have a very unstable balance of circulation, which accounts for the fact that they feel fine one day and are in the dumps the next. Many of these patients are asthmatics.

VISCEROCONSTRICTION TYPE

This is a type of patient that will pay you well to carefully study and watch for. These patients usually are seen with an acute abdomen. The symptoms will resemble appendicitis in every respect, your diagnostic point being blood pressure findings. Eliminate gas with same pressure that you use on the anemic type. Take the blood pressure, and if the pulse pressure is near 20 m you can be reasonably certain that you have a case of visceroconstriction. We have illustrated this case for you under the different types of appendicitis and if you will again study SD chart 10 you will readily see what is taking place with in the abdominal cavity. Never make a diagnosis of appendicitis until you know for sure that the patient is not a visceroconstriction case. Many needles cases of surgery are performed daily by sincere surgeons, when all the patient needs is a little spinal manipulation over the segment that is causing the constriction in the ileo caceal and appendiceal region.

CERVICAL TYPING OF PATIENTS

Many doctors will not wish to take time to type their patients. Some feel that they can not use the blood pressure technic for various reasons.

The cervical vertebrae have a definite relationship to the vasomotor nerves, due to the effects of the vagus, which contains a number of vasomotor fibers.

To make a test as to type of patient, the Operator manipulates over muscles adjacent to the cervical vertebrae and then watches the reaction that will take place.

If a pronounced redness appears immediately or within 30 seconds, you have a hypremic or type 1 patient, and the blood pressure will be found to be below 120 systolic; you then eliminate gas the same as under the blood pressure method.

If redness appears, but is delayed and of less degree, you have a type two patient, which is the anemic and hypremic type mixed.

If redness fails to appear and nothing but a faint flush appears, you have a type 3 patient or the anemic type.

In the hypremic type the redness will disappear very slowly and may last for as long as 30 minutes.

In the type 2 patient or the hypremic-anemic type, the redness disappears in five minutes or possibly remains for 10 minutes.

In the type 3 or anemic type, the redness disappears very quickly.

As soon as correct therapy is applied to the major vasomotor area, the cervical redness will disappear immediately, regardless of type, but you might find the hypremic type a little slower in showing the disappearance of the redness.

This test will not show a visceroconstriction type of patient.

An occiput adjustment on the correct occipital area will cause the cervical redness to disappear instantly, due to the control the occiput has over the vasomotors. We have demonstrated many times that the occiput alone will control 80% of all vasomotor lesions, provided nothing is done to the spine to redisturb vasomotor function. The hardest thing for you to remember and to practice is what not to do, instead of what to do. Most of you are too ambitious and want to do far too much for the patient.

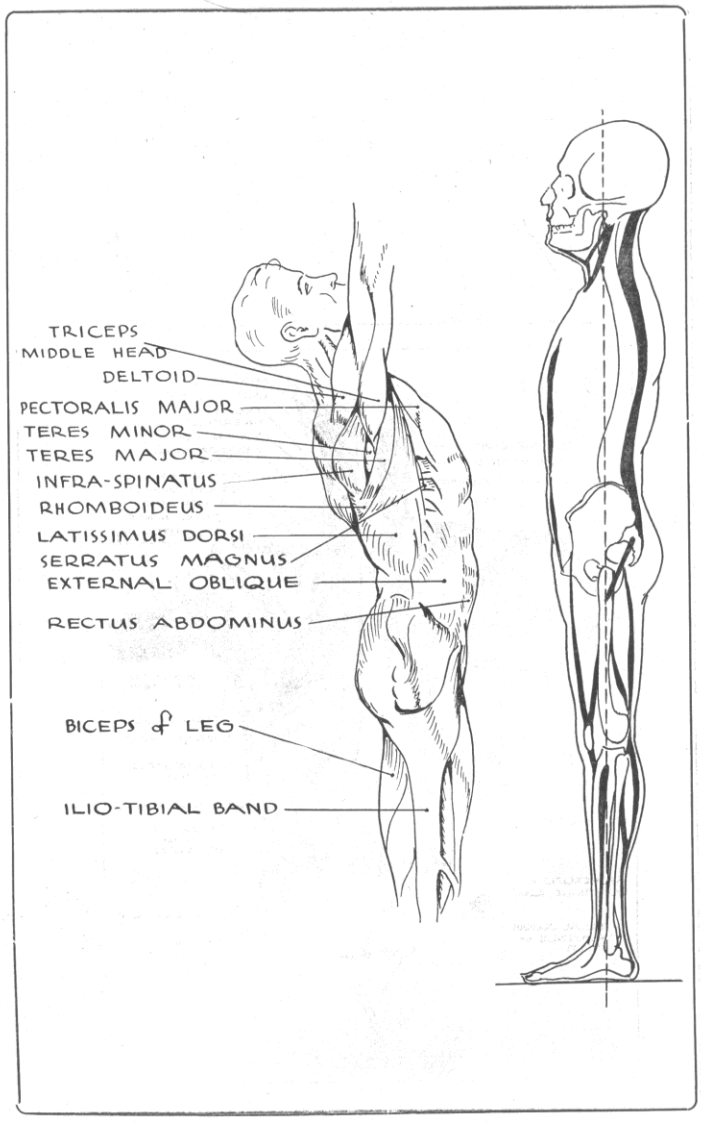
LOCATING THE VASOMOTOR LESION

In considering a patient from the standpoint of spinal therapy, it is essential that you determine the stability of the vasomotor system, for an unstable vasomotor system will do more to keep a patient from responding to therapy than any one other single factor. A vasomotor system that is brought to as near normal as possible, assures quick response to your other spinal therapy procedures.

After you have made a study of the blood pressure and have eliminated carbon dioxide gas, you know the exact state of the vasomotor system.

If the blood pressure is below 120 systolic, you know that you are dealing with a hypremic type of patient and you know that any hard treatments to the spinal muscles or any other therapy to the spinal muscles that will produce further dilation is going to be detrimental to your patient's recovery. You know that the patient's spinal lesions will respond to specific adjustive therapy and no matter how sick the patient may be, the simple act of giving a recoil adjustment to the correct spinal segment will balance the vasomotors and go a long ways towards normalizing the spinal nervous system. When the circulation is balanced, you have a normal intake of oxygen and a normal output of carbon dioxide. Balancing the gaseous contents of the body means better metabolism. A wrong gasoline mixture in the carburetor of your car will cause all kinds of motor trouble and may even make you think there is serious mechanical maladjustments to deal with, but when this gaseous mixture is corrected, the car runs 100% better. The same holds true of the human body its not what you do for a patient that counts but what you do and how you do it. A single thrust may be all that is necessary to cure a case of most any disease and again it may take the combined skill of using the vasomotors for therapy, the spinal nerves, the sympathetics, the cranials and the myeliene nerves to produce health. If it takes but a single thrust to produce results, you are a genius if you give that thrust and do no more. If it takes a combined system of therapy, again you are a genius, because you have at your command a system broad enough to analyze all nervous systems and to detect lesions and correct the lesions as found

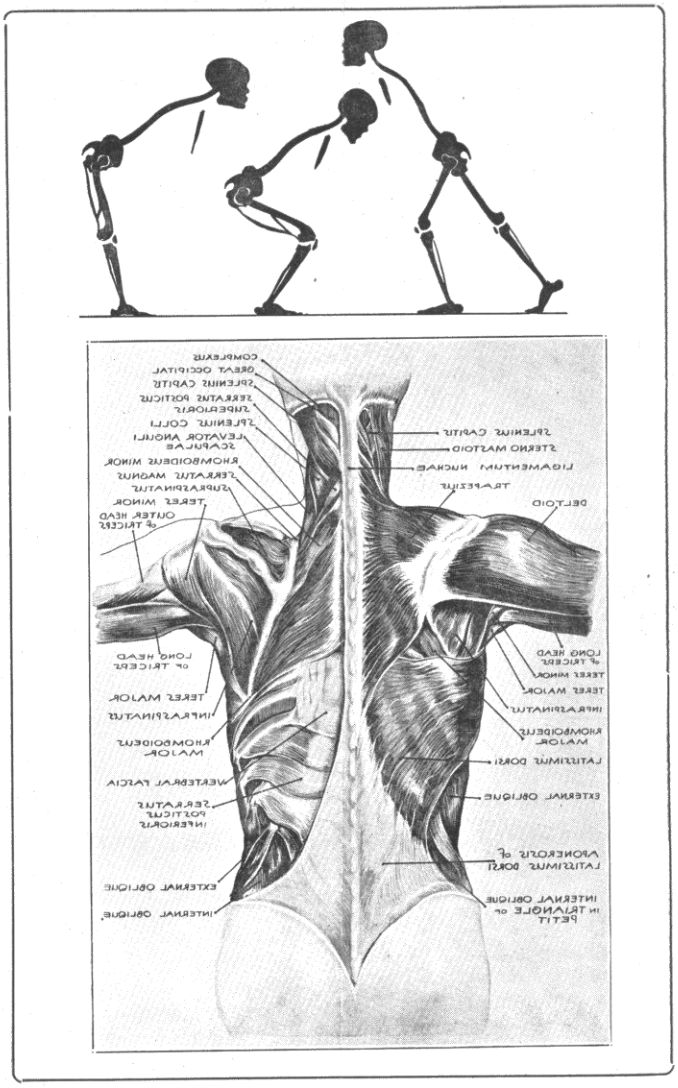
As has been previously stated, a correction for body balance will produce startling results in 90% of your patients and if you do this and nothing more, you will be rendering a service that will get sick people well, even after elaborate systems have failed; but if it takes more to care for the remaining 10%, be Doctor enough to know that it does, and be operator enough to be able to apply what is indicated.



If the blood pressure is above 120 and not higher than 140 systolic after gas elimination, you know that you are dealing with a type 2 patient or a combined anemic and hypremic type, and you further know that this patient may require a recoil adjustment today and a double transverse tomorrow, all depending upon the blood pressure findings from day to day.

If you find that the blood pressure is above 140 systolic, you know that you are dealing with an anemic type of patient and that you must not use any form of therapy that is stimulative.

If you find that the blood pressure shows a pulse pressure reading of near 20 you know immediately that you have a visceroconstricted area in the abdomen or pelvic cavity, and that this constriction must be eliminated before further therapy is carried out.



By following these basic laws, you can never use the wrong therapy on a patient. You will never need to make excuses to any patient, and if a patient comes to you that has taken treatments elsewhere and has been receiving a lot of massage, heat, electricity, etc., and if they are the hypremic type, you will automatically know that you can correct their lesions by a recoil adjustment and can do more for them in one treatment than the other doctor has done in any number of treatments. If this patient on the other hand has been going to a doctor that uses nothing but straight adjusting and they are type 2 or the anemic type, you will know that you must change your tactics to get the patient well.

A number of years ago I personally treated a very bad case asthma. This man had gone the rounds of doctors, with very little improvement. He had received all kinds of therapy. One climate would help his asthma but would aggravate a chronic gastritis, another climate would help the gastritis, but would increase the severity of the asthma. I found him to be a type 2 patient with a hypremic third dorsal and an anemic fifth dorsal. I used a recoil on the third dorsal the days his blood pressure was low and a double transverse on the fifth dorsal the days the blood pressure was above 120. In one week's time this man made a complete recovery. I gave him three treatments. Had I used the opposite form of adjusting, the man could have never gotten well, no matter what other high sounding therapies would have been used on him.

THE TESTS – MANIPULATIVE TEST

On your hypremic or type 1 patient, you must remember to use only moderate pressure in going down the spine, for too hard pressure will paralyze the vasomotors and will fail to bring in the proper coloring of the spinal muscles.

Have the patient prone on the table. Place one hand on each side of the spine at the first dorsal. Three fingers of each hand on the spinal muscles, index finger next to spinal grooves. Using moderate pressure and even pressure, draw your hands down the spine from the first dorsal to the coccyx. In a few seconds the spinal muscles will start to show a red line. This line may be complete from first dorsal to coccyx and again it may be intermittent. Wait for

five minutes and you will notice that many of the areas have faded. The area for therapy is the one that shows the brightest red color. A light suspended over the patient that has the red and yellow rays filtered out, will help to brighten the areas under observation, but it is not necessary. Mark the area that appears to be the brightest after five minutes and this is your major area.

You must be careful and have your pressure even at all times, for if the pressure is greater at one area than at the other, you will cause more redness at the area of greatest pressure.

Many doctors prefer to have the patient sitting, but we find that the prone position is best.

On this type of patient you will use a recoil adjustment on the area that shows the most distinct red coloration at the end of the five minute period.

TEST FOR ANEMIC OR TYPE 3

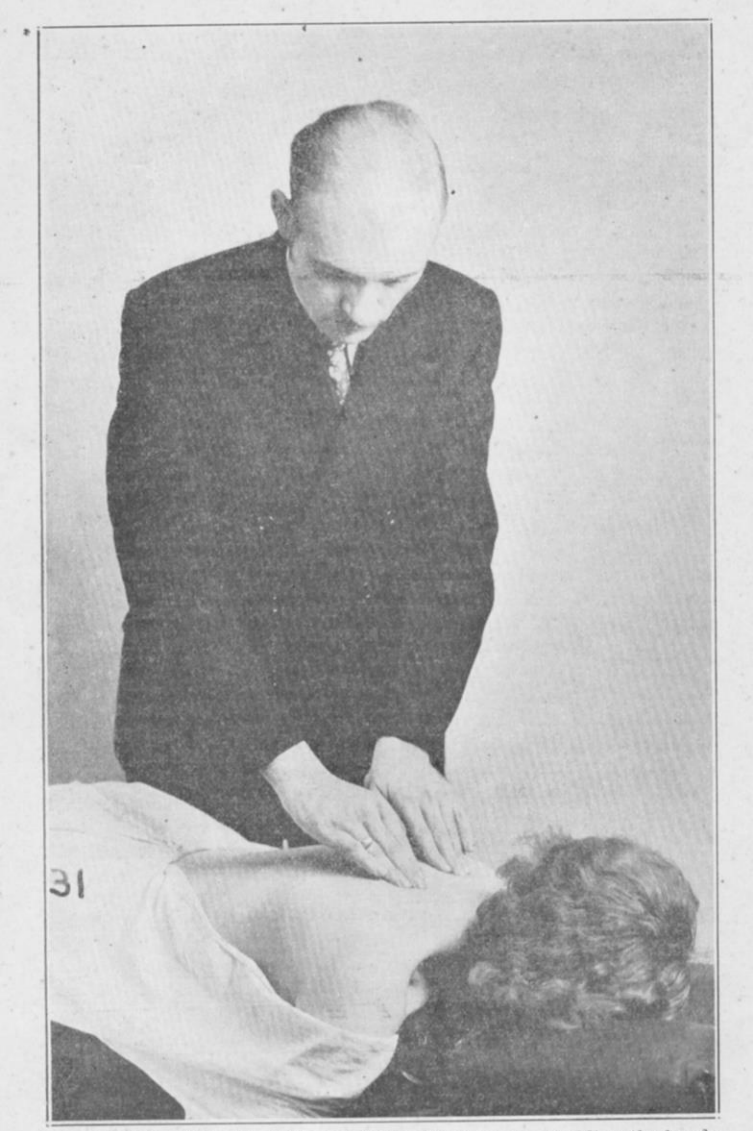


ILLUSTRATION 31.—This illustrates the manner of holding the hands while making friction on the spinal muscles to classify your patient. The contact is held firmly and the hands are then drawn down the spine. In the hypremic type the hands are drawn down the spine quite rapidly, while in the anemic and type 2 patient the hands are slowly drawn down the spine and more pressure is used.

Place patient in prone position after eliminating gas and determining blood pressure. Place hands on patient's back as directed under hypremic type. Your pressure with fingers will be about three times as hard as on the hypremic type, which will be hard enough to dent the tissues of the back considerable. Draw the hands slowly down the back. It is important that firm contact be had and that this be even all the way down the spine. It is also important that you draw the hands slowly, as you must produce inhibition of the vasomotor nerve impulses so as to produce vasodilation in the spinal muscles.

Your coloration will appear more slowly than in the hypremic type patient and will disappear more quickly. Due to the difference in time between the time you contact the first dorsal and the coccyx, you will have to allow for this difference in making your deductions.

In picking your major, you select the area that shows the least coloration and fades the quickest.

This will give you the area of greatest anemia, for its anemia leaves it colorless and causes it to fade more quickly. Your major area in fact will appear quite pale in color after the other areas have faded, showing an anemic reaction compared to the rest of the spine.

It is upon this major area that you use a double transverse adjustment and follow the adjustment with rotary finger manipulations to the adjusted area.

TEST FOR ANEMIC-HYPREMIC OR TYPE 2

Proceed with blood pressure test and gas elimination the same as in other types. Draw hands down spine with pressure of moderate degree, if the blood pressure is above 140 at time of test, but if blood pressure is below 120 at time of test, use same pressure as for hypremic types. If the first time you see this patient, the blood pressure is below 120, you will classify them as hypremic type, but possibly the next time they will have a blood pressure above 120, so you must be on your guard. If the blood pressure is below 120, you will proceed exactly as under hypremic or type 1 patient, but if pressure is between 120 and 140, you will use firm pressure, but will not take as long in covering the length of the spine as you do in the anemic or type 3 patient. In this instance your reactions will come in quite quickly and will be fully developed in about seven minutes. The area that fades to the whitest color before disappearing will be your major. You will have no trouble in selecting your major area once you see the reaction, for it will have a distinct paleness that you will easily recognize. Do not be in a great hurry to make your deductions, in fact it will be well to practice this technic many times before you say for sure that you recognize the major areas. Some day we hope to publish a complete set of charts in colors showing these reactions exactly as they appear on the patients backs. A little practice, however, will soon make you proficient in detecting your spinal major area.

DETECTING VISCEROCONSTRICTED TYPE

After blood pressure and gas elimination tests you will find a pulse pressure of 20 m. or near that mark. You will immediately know that you have an area of visceroconstriction in the abdominal or pelvic cavity. Place the fingers of one hand over the abdomen and palpate until you distinctly feel the transmitted throb of the abdominal aorta or common lilacs. If you palpate in the medial line on very thin subjects you of course will be able to detect the direct pulsation of the aorta, but in this instance you are not detecting the direct pulsation, but the transmitted pulsation of the artery. When gas is lodged in a gut, it makes that gut a powerful transmitter of pulsations. When you have detected the pulsating area, it will in all probabilities be very tender, you keep your contact over the pulsating area with one hand and with the other hand you make pressure on the same side of the spine that the pulsating area is found in the abdomen. Start at the tenth dorsal and make pressure over that segment and at the same time notice if the pulsation in the abdomen is changed. When you contact the correct area the pulsation will stop as long as you make pressure over the spinal area. You now place the patient on his side and with both hands gently manipulate the spinal area until all tension and tenderness is gone and as soon as this happens all abdominal pain will be gone. You will be greatly surprised at how many cases of appendicitis (so-called) you will be able to stop instantly, but if you happen to get hold of a real case of appendicitis and find that the pulse pressure is not 20 m. or near that mark, your results will be harder and of course will depend upon additional therapy, which will be found under Sacro Occipital technic.

Please do not expect to be able to detect your major areas the first few attempts. You didn't learn to palpate or adjust in five minutes. Be just as reasonable with this technic. If you spent one year practicing, you would be well rewarded. The writer has made over 15,000 such tests and finds them absolutely invaluable.

HEAT TEST FOR VASOMOTOR LESIONS

The heat test is probably the easiest test to use, in that the pressure part of the hand technic is eliminated.

HYPREMIC TYPE PATIENT

Heat causes dilation. The hypremic patient has dilation of the spinal muscles, with one area predominating. Heat applied to the spinal muscles will cause an increase in dilative power and will manifest its presence by causing the skin to redden.

To apply the heat test, you first eliminate gas and then determine correct blood pressure. Patient lays prone on table. Towels are wrung out of water at temperature to suit type of patient. For the hypremic type have the water 115 degrees. Take two turkish towels, fold each towel so it is approximately three inches wide and long enough to cover the spinal muscles from the first dorsal to the coccyx. Wring water out of towel, then lay a towel on each side of spine from first dorsal to coccyx. Leave towel on hypremic type patient for five minutes, remove, and you will then be able to detect coloration of spinal muscles. Your reddest area upon removing towels will be your n area.

You must remember that heat is contraindicated to this type of patient because it increases dilation, but by increasing this dilation, you are enabled to see the major area, because it will be the most exaggerated dilative area, therefore the reddest spinal area. It is imperative that you apply your recoil thrust as quickly as possible after removing the towels and then immediately apply alcohol to the entire vasomotor spinal area. This closes the pores and helps to reduce the spinal muscle hypremia. To hasten the action of the alcohol, you can blow on the spinal muscles with your breath or use a hand fan. This evaporates the alcohol and cools the muscles much quicker.

ANEMIC TYPE PATIENT

Heat is beneficial to this type of patient, because by producing dilation of the spinal muscle cells, the blood is drawn from the spinal cord cells, thereby increasing their power to receive nourishment and to normalize the action of the organs ennervated from their segment or segments.

Apply the towels wrung out of water at a temperature of 120 degrees Fahrenheit. Leave the towels on the spinal muscles for ten minutes. The area that shows the least degree of redness is your spinal major.

After picking the major area, apply your double transverse adjustment and then rotary finger manipulations to the major area.

DO NOT USE ALCOHOL TO THE SPINAL MUSCLES

UNDER ANY CONSIDERATION.

DETECTING VASOMOTOR LESION OF ANEMIC HYPREMIC PATIENT

After eliminating gas and taking blood pressure, if the pressure is below 120 systolic, you proceed exactly as described under hypremic type patient. If blood pressure is between 120 and 140, you use towels at temperature of 120 degrees Fahrenheit and leave them on the spinal muscles for seven minutes. The area that shows the least redness is your major.

On this type patient, when the blood pressure at time of test is be low 120 systolic, follow your adjustment with alcohol to spinal muscles, hut on days that pressure is between 120 and 140 systolic, do not use alcohol.

After you have completed your vasomotor adjusting, you finish this treatment by using the body balance technic which is completely illustrated in this book.

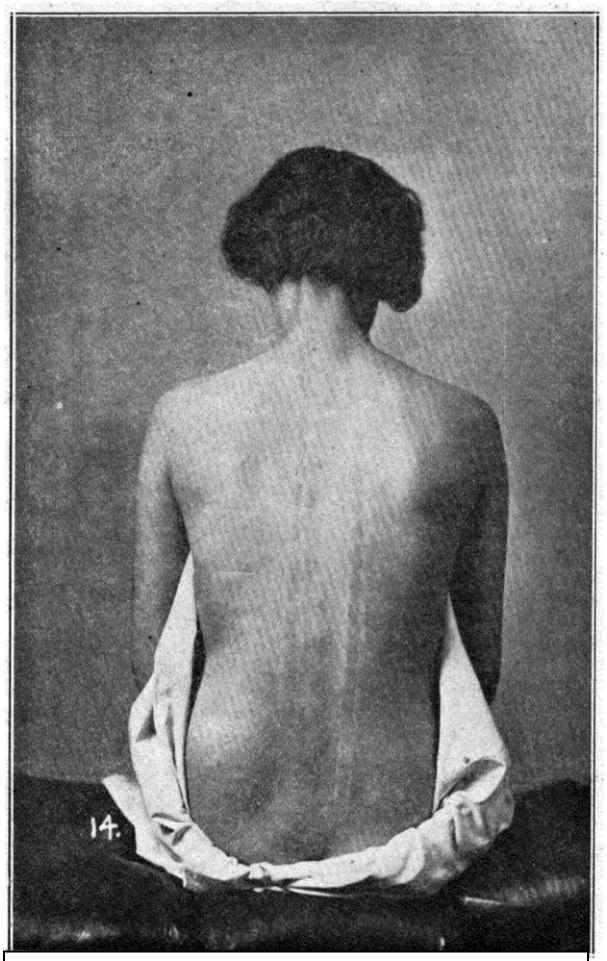


Illustration 14

This illustration shows the effects of drawing the hands down the spine of the hypremic type patient. The areas become very red.

Illustration 15

This illustration shows the same as number 14, but two minutes later. Note how areas in lower Spine have started to fade. All areas faded except dorsal five.

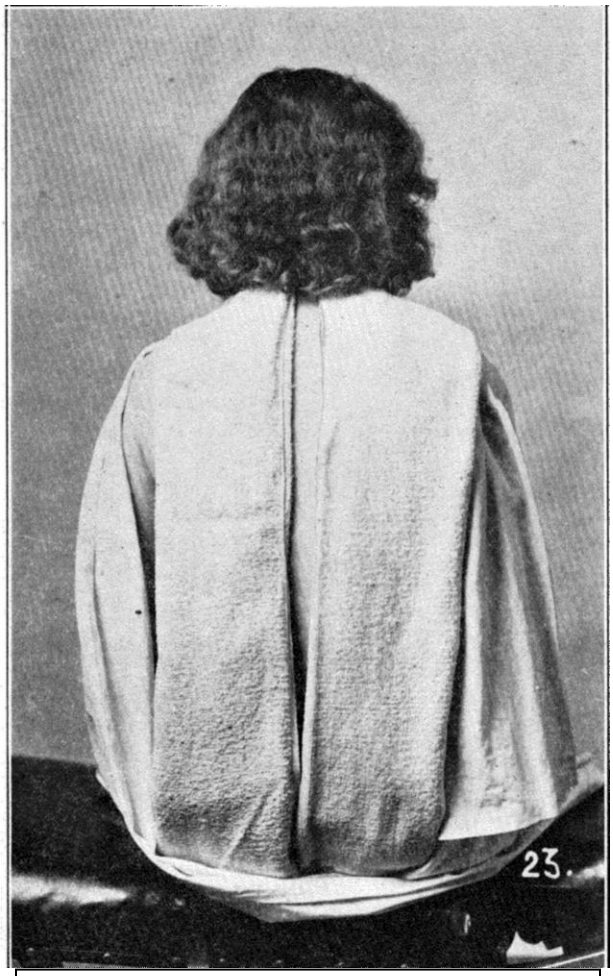


Illustration 23

Shows method of applying towels to spinal muscles for heat test in detecting vasomotor area lesions.

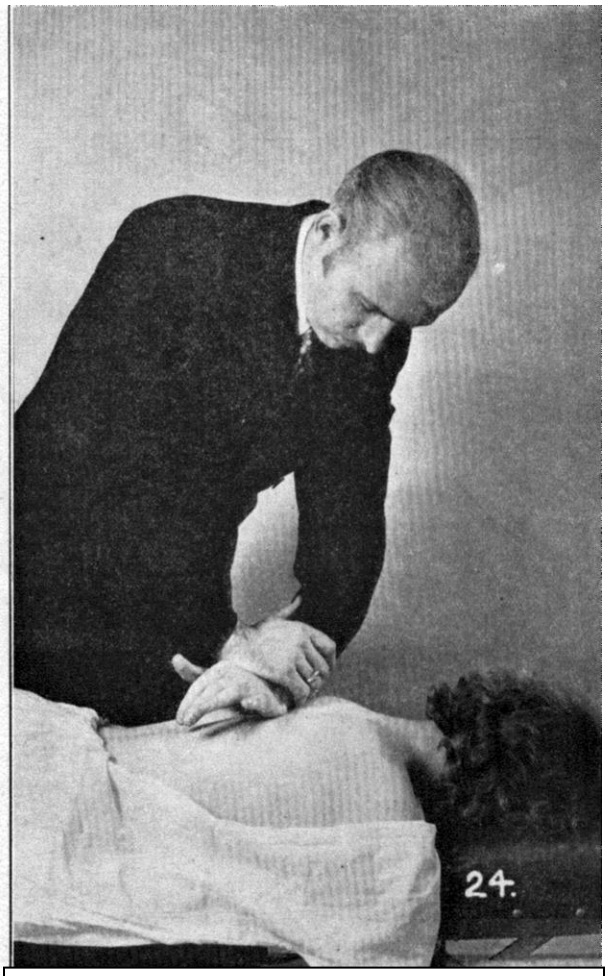


Illustration 24

This illustration shows contact and position for a recoil adjustment on a hypremia or type 1 patient: Please note that only the pisiform bone touches the spinious process. The hands do not contact the spinal muscles.

Illustration 25

Double transverse adjusting technic for type 3 patient and type 2 when blood pressure is above 120. Note that hand covers as much of spinal muscle area as possible. Adjustment is given without quick thrust.

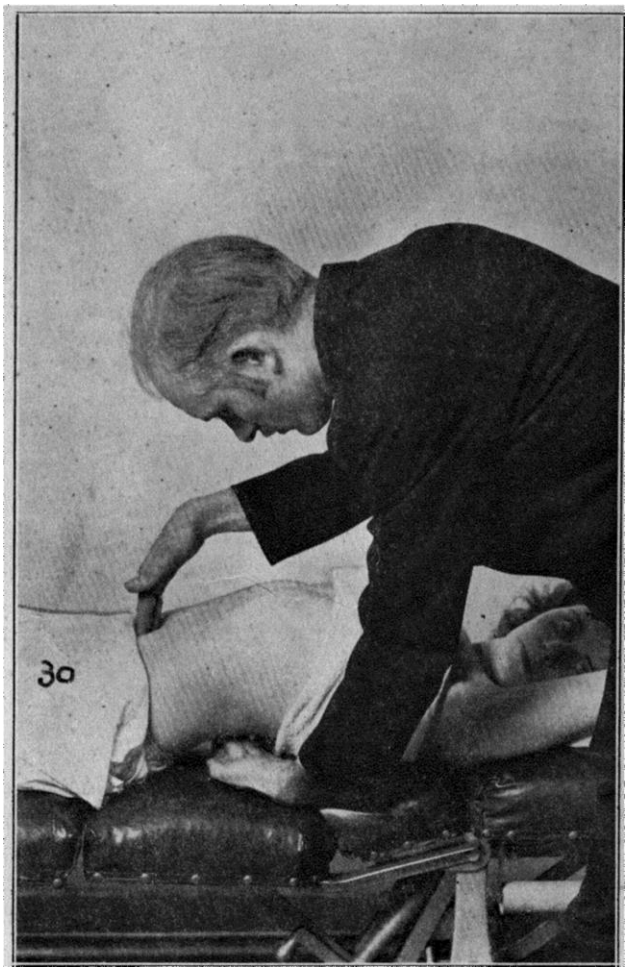


Illustration 30

This illustrates the technic used in locating the vertebrae area causing pulsation in a case of visceroconstriction. You may have the patient lay on the side if you choose. The hand on the abdomen is contacting the pulsating area and the hand under the back is exploring the segments to find the one that inhibits the abdominal pulsation.

PART II

THE OCCIPUT

We shall briefly consider the first part of our technic by telling you a few very important things about the occiput. We shall not write extensively about the anatomy of this very important part of the human body for to do so would be merely a repetition of what any Standard Anatomy would tell you, but we shall consider this part of the human machine from an entirely new angle.

The occipital bone, situated as it is, forms a very important factor in our technic. It is the topmost bone of the spine, in that it articulates directly upon the Atlas. It houses the formanen magnum which, as you all know, contains the lower stem of the Medulla and the Medulla Spinalis, and many other very important nerve centers. It is also at this plane that we have the pyramidal decussation. The fact that the occipital bone houses the foramen magnum is of itself so very important that we should at all times be positive that the occiput is directly situated in its exact planatary lines with its compensating factors of the spine and other skull bones.

From the external occipital protuberance a ridge or crest, the medium nuchal line, often faintly marked, descends to the foramen magnum, and affords attachment to the ligamentum nuchae; and the ligamentum nuchae is a fibrous membrane which, in the neck, represents the superspinal ligament of the lower vertabrae. It extends from the external occipital protuberance and medial nuchal line to the spinious process of the seventh cervical vertebrae. From its anterior border a fibrous lamina is given off, which is attached to the posterior tubercle of the Atlas, and to the spinious process of the cervical vertebrae, and forms a septum between the muscles on either side of the neck.

We can see that the ligamentum nuchae can and does have an important function to perform in keeping the cervical vertebrae in alignment with the occiput, but we further see that it is far more important to keep the occiput free from tension so nothing will be present in the way of irritation to place tension upon the nuchal ligament to cause it to place tension upon any vertebrae from the atlas to the seventh cervical. We can see why it is far more important to use therapy at the source of irritation, rather than at its terminus.

Briefly let us now consider some muscles that attach to the occipital bone. The Trapezius arises from the external occipital protuberance and the middle third of the superior nuchal line of the occipital bone, from the ligamentum nuchae and the seventh cervical, and the spinious processes of all thoracic vertebrae and corresponding portions of the supraspinal ligament. From this origin the superior fibers proceed downward and lateralward, the inferior upward and lateralward, the middle horizontally, the superior fibers are inserted into the posterior border of the lateral third of the clavicle, the middle fibers into the medial margin of the acromion and the superior lip of the posterior border of the spine of the scapula, the inferior fibers converge near the scapula and end in an aponeurosis.

Here we have a muscle that covers a portion of the back from the occiput to the twelfth dorsal vertebrae, but from the ninth dorsal on to the twelfth dorsal the fibers are much narrower and of course do not exert as much function at these points as they do elsewhere. Again we see how important it is to consider the occiput as being a balance wheel from the

first cervical to at least the ninth dorsal vertebrae and we can well see how an injury at any cervical or dorsal vertebrae, particularly the dorsals to the ninth must affect the occiput and we must realize how very important it is to see that this occipital irritation is completely removed as quickly as possible.

Besides the trapezius muscles, we also have the sternocleidotoideus, splenius capitis, the semispinalis capitas, and the oblique capitis superior. The inferior nuchal line receives the rectic capitis posteriores, major and minor.

In the lateral portions of the occipital bone we find the hypoglossal canal for the twelfth Cranial nerve, and we also find here an entrance to a menengial branch of the ascending pharyngeal artery. Another important consideration is the jugular notch through which the jugular vein passes, possibly explaining why correction of occipital tenderness will immediately relieve migraine headaches. We also find foramen for the glossopharyngcal, vagus and accessory nerves.

This brief anatomical resume has been taken from Gray's Anatomy, and is only given to show you in a small way why it is so very important that you carefully study the technic that is to be presented to you at this time. Many of you will not believe what you see demonstrated. Many of you will not believe what you, yourself, can demonstrate. We ask you to study any works on Anatomy for proof of the very important function of the occipital bone. It not only forms a protective covering for the Medulla Oblongata, the accessory parts of the hind brain, the floor of the fourth ventricle, many important nerves and muscles, but the fact is provable that the occiput does compensate for every spinal segment, and this fact alone is our one reason for giving you the Sacro Occipital technic, and for the reason that we have named this technic the MIRACLE SYSTEM, for we can and so will you be enabled to do likewise, perform seeming miracles of restoring health to suffering peoples, if we do nothing but give corrective therapy to the occiput. However, it is not our intention to make this technic empirical, but on the other hand we shall make it very broad and shall do our very best to make it easily comprehensible.

THE SUB-OCCIPITAL LINE

The Sub-occipital lines lies at the base of the occipital bone. Its center is about one half inch inferior to the external occipital protuberance and its lateral ends are about one half inch superior to the mastoid process of the temporal bones. By bringing your hands from the superior of the occipital bone down to its inferior border, you will note that the inferior border forms a distinct outline and this is the sub- occipital ridge upon which so much of our therapy in Sacro Occipital technic is performed.

From the external occipital protuberance laterally on both sides of the sub occipital line, we find areas that correspond with given vertebral segments of the nervous systems and by specifically using technic on these areas we are enabled to influence the activity of each spinal segment specifically. No other area of the human spine holds such a powerful key whereby we can either stimulate or inhibit the activity of a given spinal segment, without touching that segment, than does the sub occipital ridge.

The sub occipital ridge is the first part of the human economical system that suffers disturbances when the body is not functioning normally. It is here that the first tenderness is noticed in all functional and organic disturbances. The onset of influenza causes terrible

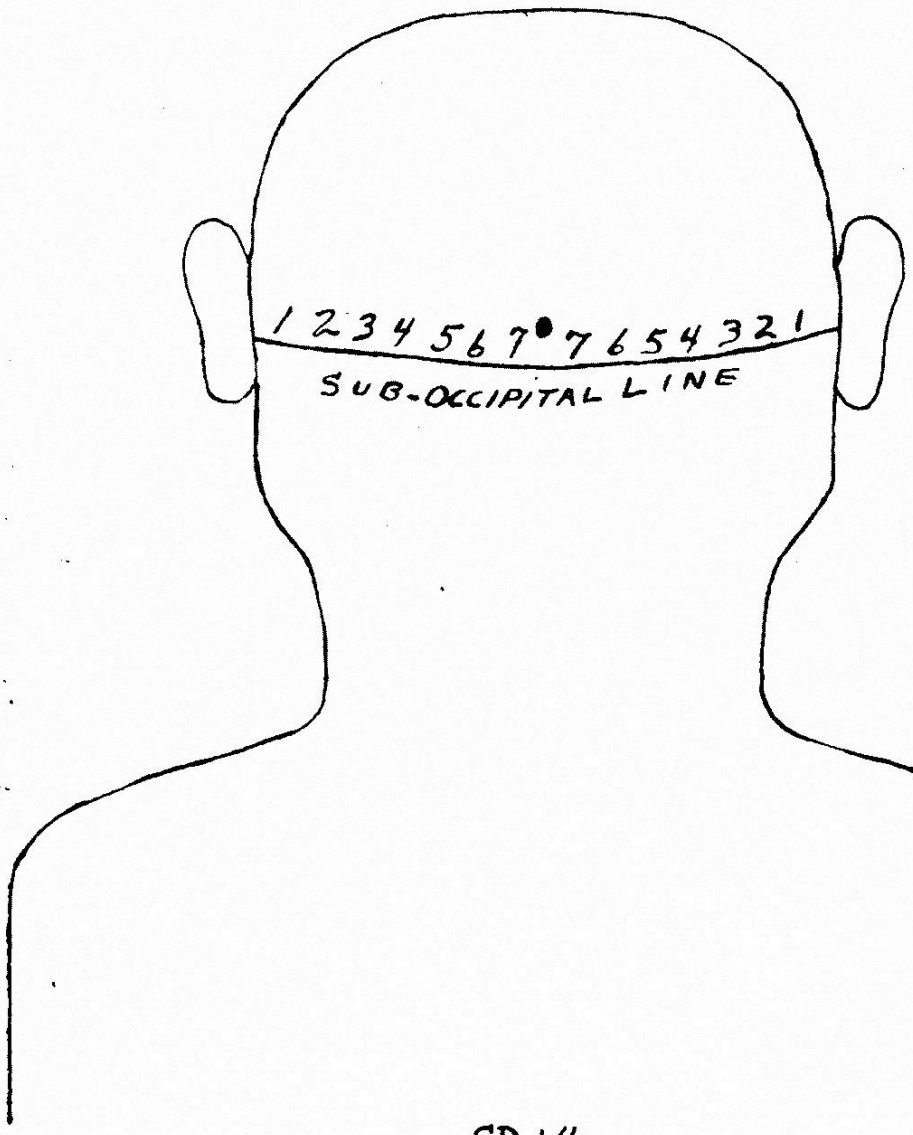


Illustration 14 SD

This is an illustration of the occipital line. Note that the line proper runs about one-half inch inferior to the external occipital protuberance. Each lateral half is divided into seven equal parts.

occipital pains, the post-operative headache and backache is due to disturbances at the occipital ridge and can be promptly relieved by applying technic at the indicated area.

Many of you have seen patients that were in so much pain that it was impossible to adjust anything but an upper cervical vertebrae, and you can recall many instances where you

secured miraculous results, but again you can recall instances where no results were forthcoming, and the patient might even have been made to feel worse.

A certain school of healing is making a great deal over the fact that an upper cervical adjustment is always the major area to relieve all disorders. It is fundamentally impossible to adjust either an atlas or axis without in some manner affecting the suboccipital line and even the occipital bone proper. The occipital bone in its anatomical relationship with the atlas must be affected if the atlas is adjusted and it is basically impossible to adjust an axis without affecting the atlas, so we candidly believe that the results they secure are due in a great measure to restoring occipital balance rather than atlas or axis balance.

SUB-OCCIPITAL AREAS

From the lateral ends of the sub-occipital ridge to the external occipital protuberance, we have seven sub-occipital areas. These are equally divided spaces and we empirically call them sub-occipital areas, for we find that each area exerts a powerful influence upon a specific spinal segment and we find that if this area is properly treated that its compensating spinal segment is benefited and if it is improperly treated its compensating spinal segment shows an unfavorable reaction.

The area lying immediately laterally to the slight inferior of the external occipital protuberance is designated as area number 7, and the area lying at the mastoid portion of the temporal bone is area number 1, and the intermediate areas from external occipital protuberance to mastoid portion of temporal bone are then areas 7-6-5-4-3-2-1. This includes both sides of the suboccipital ridge. As the suboccipital ridge is directly connected to all viscera and members of the body by nerve reflex impulses, we will find that definite areas of this ridge will be tender and that this tenderness will correspond to the affected spinal segment or segments that are in trouble. This sub-occipital ridge tenderness will so involve the muscular structure of the sub-occipital ridge and of the spine that it will by constant irritation tend to malalign the occiput in its anatomical relationship with the atlas and possibly this malalignment will be responsible in being the direct causative factor in producing many of the symptoms that the patient will complain of and until this correction is made perfect, clinical results will not be forth coming. If an atlas lesion causes a reflex at occipital ridge area number 1, it seems that the correction of the atlas lesion will correct occipital area number 1, but such is not the case, but correction of occipital area number 1 will normalize the atlas.

INTERCOMMUNICATING SPINAL AREAS

I believe that most of the readers of this technic have at some time or another realized that the segments of the spine were delicately interrelated, one to the other. You have also realized that the reflex arc is much more complicated than most physiologies tell you about. You have realized that on some cases apparent conflicts have been set up within the patient by adjustments or manipulations. You have seen patients immediately made worse by an adjustment, and yet you are at a loss to explain this reaction. For a time you probably have called this retracing, but I believe you have already come to the conclusion that it is not retracing, but interference with normal reflex arcs. You possibly have thought about the compatibility and incompatibility of certain spinal segments. You have realized that it was inconsistent with results to adjust certain spinal segments at one treatment time, because

you believed that one segment caused dilation of an organ while the other segment caused constriction in that organ. Let us once and for all times destroy that though, for it is without scientific foundation. Any spinal segment has the power to produce constriction or dilation upon its ennervated organ, depending upon the manner in which that segment is treated and this is accomplished by the actions of the vasomotor nerves. The reason you can not adjust certain segments and then adjust other segments at the same treatment is due not to constriction or dilation as much as to disturbance of reflex cycles. If you would adjust for instance a fifth lumbar and a ninth dorsal at the same setting of the patient and would adjust them with equal force, you would produce absolutely no results, either for good or bad, because they would neutralize each other, providing their vasomotor nerves were in like states of balance, bit if the vasomotor nerves at the ninth dorsal were in a state of constriction and you adjusted them with a recoil and the vasomotors of the fifth lumbar were in a state of dilation and you adjusted them with a slow, rotary adjustment, your patient would immediately become worse and possibly would faint, but if you adjusted the ninth dorsal with a slow, rotary adjustment, and the fifth lumbar with a quick recoil, you would produce very nice results, providing you finished your treatment by a seventh occipital area contact and if you forgot this seventh occipital contact, you would produce only fifty percent results, no matter how many treatments you might administer, for both the ninth dorsal and the fifth lumbar localize at seventh occipital, the ninth dorsal through the seventh cervical and the fifth lumbar through the first sacral.

The above statements are probably premature and might confuse you, but we have made them to impress upon you that your technic must be perfect at all times. You can be a good or bad adjuster at will.

The first thought to consider in the study of the intercommunicating spinal nerve areas is the fact that we have a superior and an inferior radiating nerve arc. The superior arc includes all segments superior to the middle of the ninth dorsal, while the inferior arc includes all segments inferior to the middle of the ninth dorsal. Superior to the ninth dorsal we find that the arc transverses the cervicals and then the occiput, inferior to the ninth dorsal all inferior fibers transverse the sacrum and then onto the occipital areas.

We once treated a patient that had been totally paralyzed front the tenth dorsal down for years. This patient had a spinal fracture. There positively were no sensations from the tenth dorsal down. The sphincters were relaxed and had absolutely no control over either bowel or urinary actions. We did absolutely nothing to this patient except occipital work, and we restored normal control to all sphincter action, but the patient never regained the ability to walk, although sensations were restored to the limbs, which, we believe, proves that our contention of superior and inferior forces are correct.

All of you have had the experience of adjusting the cervical vertebrae for a definite purpose and to your surprise some distant pathology was cleared up, but you will notice that you have never cleared up a pathology originating below the ninth dorsal by adjusting cervicals, unless you in some manner adjusted the occiput. Those that major on the sacrum have found that pathologies originating from segments inferior to the ninth dorsal can be readily cleared up by sacral technic, but that pathologies originating from segments superior to the ninth dorsal can not be cleared up by sacral work, unless the pathology is a purely organic relex. A man will have a cardiac lesion and will have a reflex pain at first dorsal, first cervical and first occipital area. A man will have a prostatic pathology, will have pain in the

sacrum, legs and back of the neck. The prostrate affects the fourth lumbar. This has a reflex arc with the second sacral and the sixth occipital area. This accounts for the leg pains and the neck pains. To properly administer spinal therapy one must carefully consider the reflex arc and the intercommunicating spinal nerve areas. You must remember that no single spinal area is ever alone in causing pathology, as a segment that is under irritation will influence its compensating spinal arc centers. Your adjustment, however, is always given upon the last localized area, but much more about this part of the technic later.

CERVICAL-OCCIPITAL LOCALIZATIONS

Each cervical vertebrae has a localization area on the occiput. We list these areas, but it is sometimes necessary to change the localizations as it is fundamentally impossible to treat sick people by rules, but it must be done by judgment. The areas we give will be usable on ninety percent of your cases and the other ten percent will have to be varied slightly.

First cervical localizes to first occipital area.

Second cervical to second occipital area.

Third cervical to third occipital area.

Fourth cervical to fourth occipital area.

Fifth cervical to fifth occipital area.

Sixth cervical to sixth occipital area.

Seventh cervical to seventh occipital area.

You will notice that the first occipital area is the extreme lateral area on the occipital line. This you will notice localizes to the first cervical and you will find that the first occipital area will eliminate all tenderness from the first cervical vertebrae. You will notice that the second occipital line area is the next area from the first occipital area going towards the external occipital protuberance, and that this area will remove all tenderness from the second cervical.

We believe this is a very good place in which to analyze some of our past experiences and we are sure these experiences are the same as you have had.

In diseases of the nose you will invariably find a tender third cervical, but an adjustment at this area will not by any means prove specific in clearing up nasal pathologies, but if you will localize from the third cervical to the third occipital area and will give your adjustment at the third occipital area, you will find that the nasal pathology will start to clear immediately. We have seen cases of hay fever that had a very tender third cervical, adjustments here and nowhere else did very little good, but by localizing to the third occipital area and adjusting there, the patient felt better immediately and in a very short time had no hay fever. You will never find a single case of nasal pathology that has no tenderness at third occipital and these patients will not get well until this third occipital tenderness is eliminated.

Take a case of thyroid gland pathology, with a sixth cervical involvement. You will find a very tender area at sixth occipital area and by localizing from sixth cervical to sixth occipital and apply your technic at that point you win secure quick results. All cases of thyroid

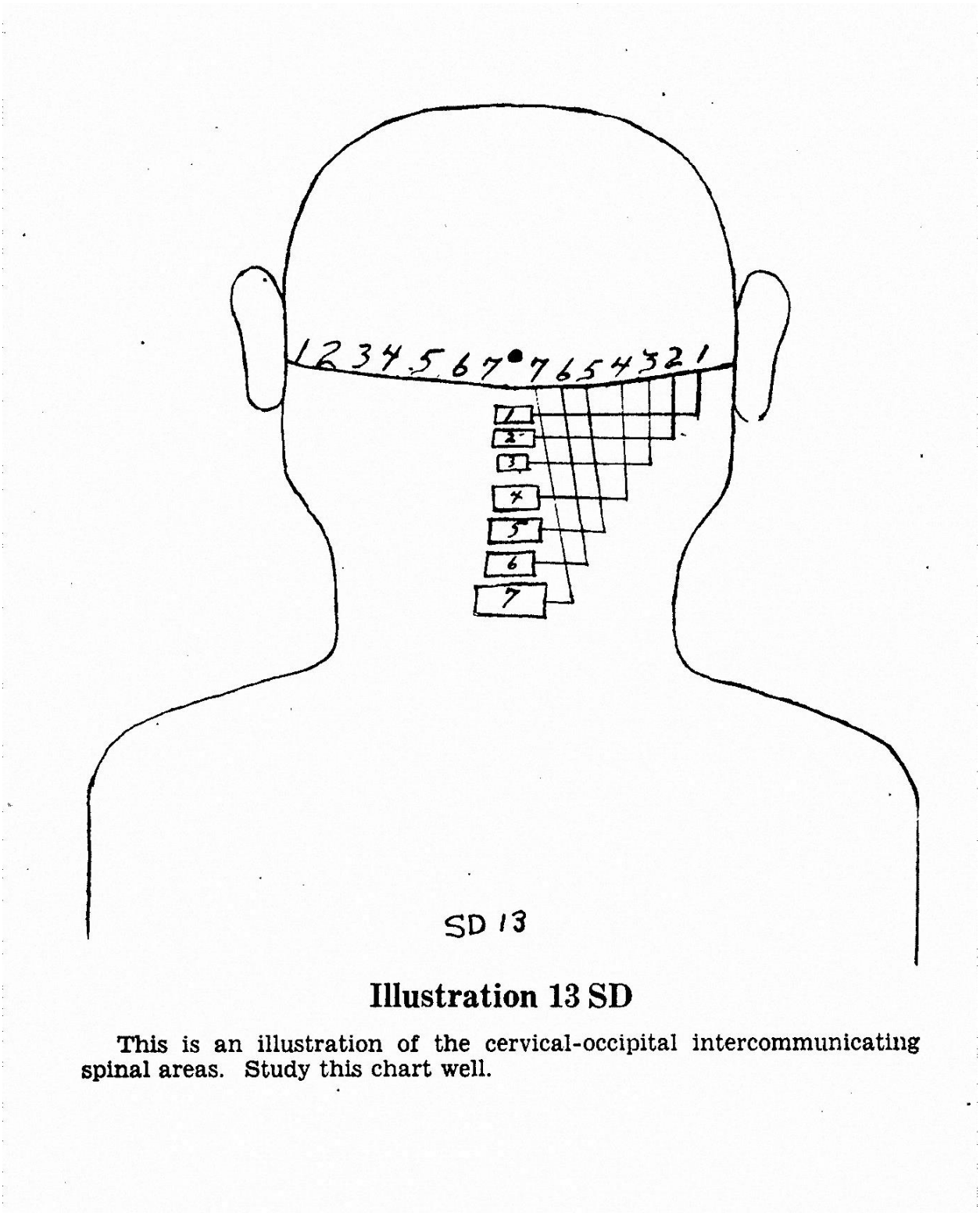


Illustration 13 SD

This is an illustration of the cervical-occipital intercommunicating spinal areas. Study this chart well.

disturbances will have occipital pains and you will relieve these pains by taking sixth occipital area for therapy after you have localized from sixth cervical.

Diseases due primarily to cervical lesions have as a rule responded quite well to therapy by all methods, as all of you adjust either atlas or axis and by so doing must affect the occiput.

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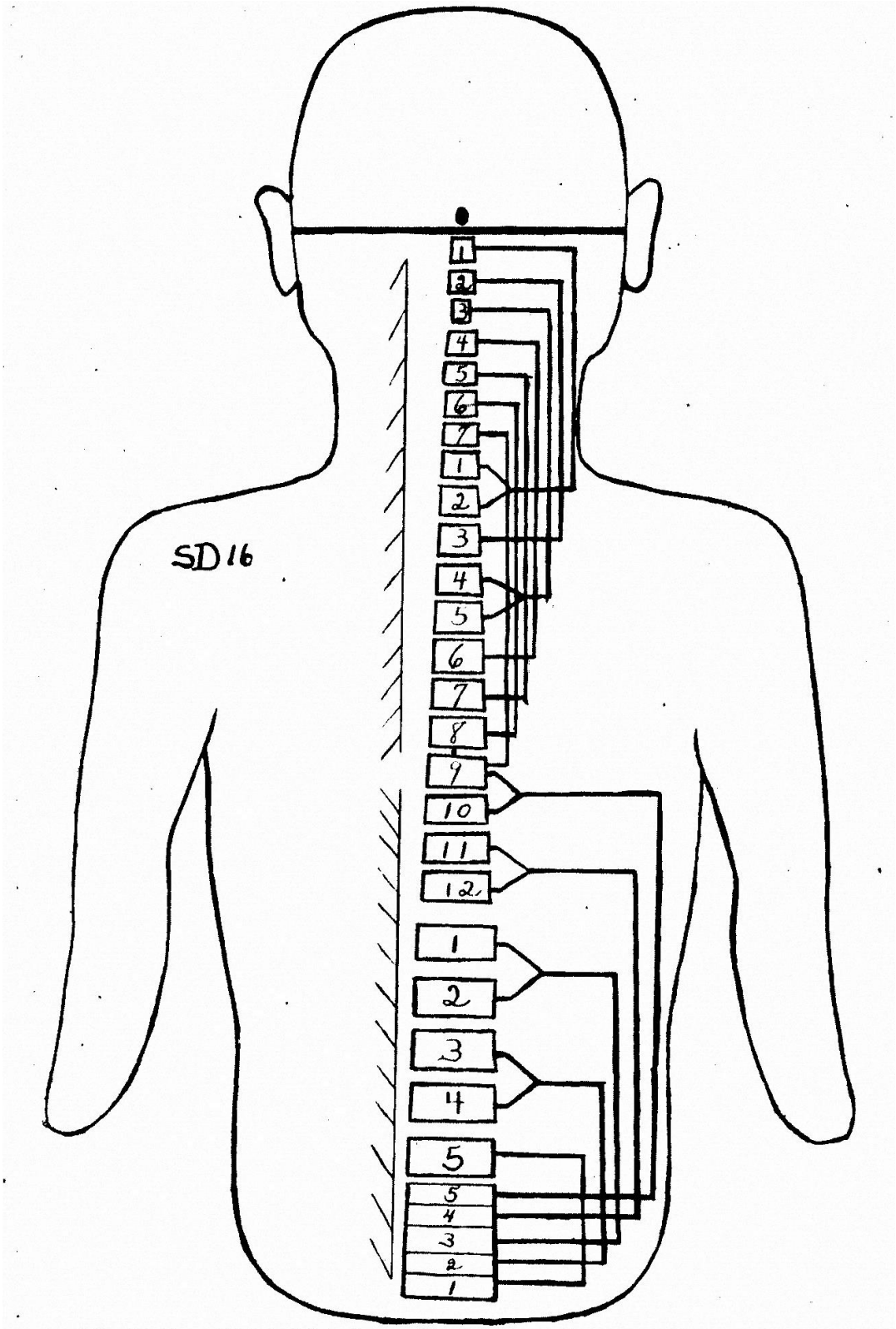


Illustration SD 16—This is an illustration of the superior and inferior radiating fibers of the intercommunicating nerve channels and illustrates the manner in which the fibers communicated with the cervical from the ninth dorsal superior and shows how the fibers inferior to the ninth dorsal communicate with the sacral areas.

DORSAL-CERVICAL-OCCIPITAL LOCALIZATIONS

You have noticed that pathologies affecting the abdominal organs or the arms invariably produce tender spinal areas in the dorsal spine, and these areas will correspond to tender cervical areas, for it is an impossibility to have a tender dorsal area without also having a tender cervical area. Abdominal lesions invariably produce either mild or severe nose, eye, throat, ear or brain disturbances. All of you have seen sore throats clear up after correcting a stomach pathology, but none of you probably attempted to clear up the throat pathology by taking care of the stomach pathology.

The first and second dorsals localize to the first cervical and to the first occipital area.

The third dorsal localizes to the second cervical and to the second occipital.

The fourth and fifth dorsals localize to the third cervical and the third occipital area.

The sixth dorsal localizes to the fourth cervical and the fourth occipital area.

The seventh dorsal localizes to the fifth cervical and the fifth occipital area.

The eighth dorsal localizes to the sixth cervical and the sixth occipital area.

The superior half of the ninth dorsal localizes to the seventh cervical and the seventh occipital area.

Take a case of liver pathology. You will find a seventh dorsal involvement and you will find that the fifth cervical will be tender and that the fifth occipital will remove the tenderness from the fifth cervical and also from the liver proper. You will find associated with liver pathologies that involve the seventh dorsal a tendency to laryngitis or pharyngitis, and many times a thyroid tendency.

Take a case of cardiac pathology and you will find associated with this a tendency to headaches caused by first cervical irritation and also a tendency to derangements of distant organs, due to interference with the cranial nerves which emit at this point. Adjustments at the second dorsal for heart trouble without considering the localization areas is only doing your patient one-third the good you would be enabled to do them should you consider the facts of cervical and occipital localizations.

INFERIOR LOCALIZATION FIBERS

NINTH DORSAL AND LUMBO-SACRAL

Inferior half ninth dorsal and tenth dorsal localize to fifth sacral and 1-2- occipital.

Eleventh and twelfth dorsals localize to fourth sacral and third occipital.

First and second lumbar localize to third sacral and fourth and fifth occipital.

Third and fourth lumbars localize to second sacral and sixth occipital.

Fifth lumbar localizes to first sacral and seventh occipital.

In numbering the sacral vertebrae we start at the first foramen inferior to the fifth lumbar and term that the fifth sacral. The last sacral foramen is the first sacral.

You will notice that we do not use the coccygeal vertebrae as localization agents. The coccyx is so intimately associated with the Myeliene sheath of the sympathetics that we prefer to consider it a separate unitage, and we use the coccyx with a separate therapy. It is possible to affect practically all organs of the body by coccygeal stimulation through the rectum and for this reason we have been unable to date to affect any specific coccygeal localizations.

As an illustration of inferior intercommunicative localization we shall consider briefly the lesions in appendicitis. The second lumbar will invariably be tender, in fact this is almost an empirical diagnostic point. You will, however, find that the second lumbar is not alone for the third sacral area will be tender and this tenderness will be associated many times with pains in the right thigh and often in the leg. You will find that the patient will complain of tension in the neck muscles. This case in its acute stage has often responded to a single adjustment at second lumbar, but this clearing of the symptoms of appendicitis has often left the patient with headaches until the fourth and fifth occipital areas are corrected. This proves that your cardinal point of attack in appendicitis is not at second lumbar area, but at fourth and fifth occipital areas.

SACRAL OCCIPITAL INTERCOMMUNICATING AREAS

It is an established anatomical fact that the sacrum and occiput bear a close relationship one to the other. Abnormal positions of the sacrum will cause abnormalities at the occipital areas and may even result in occipital subluxation of which seven distinct occipital subluxations may occur. Once an occipital irritation has occurred, nothing but occipital technic, directly applied will afford relief. A sacral subluxation may be directly and primarily the cause of occipital irritation, but sacral correction can seldom correct an occipital irritation unless the occiput is directly subjected to constructive therapy.

The sacral occipital relationship is as follows:

Sacral five localizes to occipital areas one and two.

Sacral four localizes to occipital area three.

Sacral three localizes to occipital areas four and five.

Sacral two localizes to occipital area six.

Sacral one localizes to occipital area seven.

Affections causing lesions of the lowest sacral foramen and irritation at this point all invariably cause a very tender area to be found at the first lateral position on the occiput from the external occipital protuberance. Involvement of the rectal tissues will often cause irritation at sacral area one and you will find occipital area seven to be likewise involved.

Sacral involvement always causes pelvic tippages with one limb being shortened. This tippage does many things to the pelvic contents and most of all severely interferes with normal circulation in the pelvic cavity. Many female disorders are the results of this tippage and like wise many disorders of the prostate gland are likewise caused by the same thing. Invariably patients will complain of occipital pains and in fact the patient will probably consult you not because of pelvic distress, but because of occipital pains, and for this reason you should always make sure that the pelvis is normally readjusted and this readjusting is

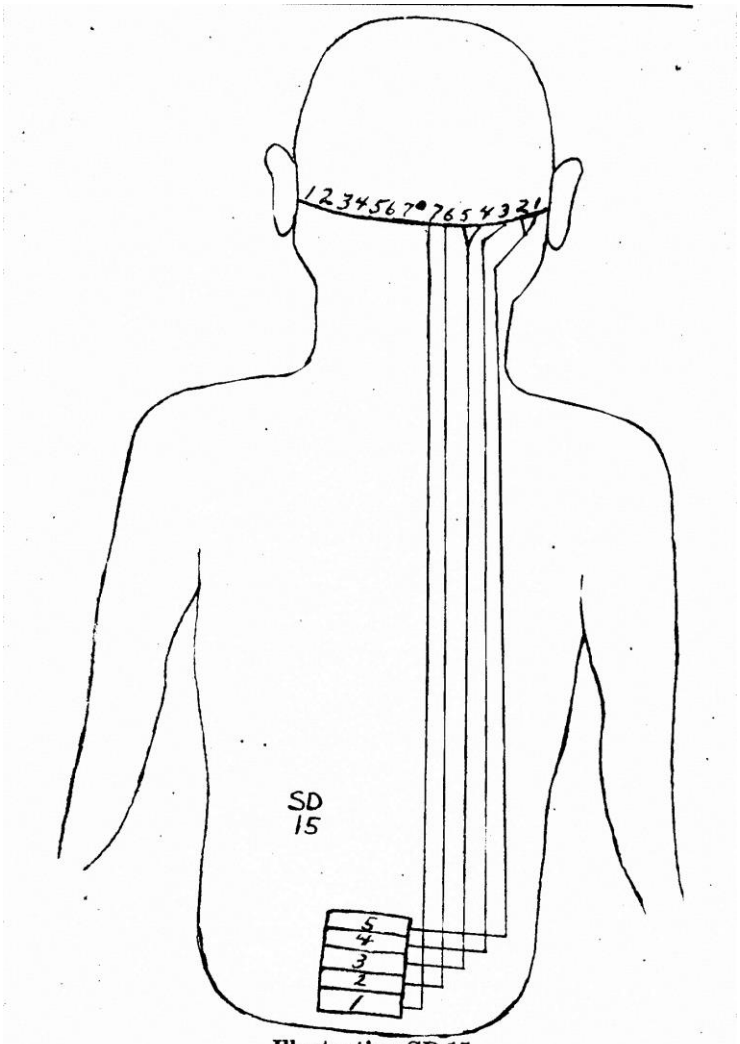


Illustration SD 15

This illustration shows the intercommunicating paths from sacral area to occipital areas. The sacral areas extend out and include the complete area covered by the gluteus maximus muscle.

not done by pulling the legs or attempting to adjust the pelvic bones, but by correcting the occipital tenderness. A little farther along in this technic you will be shown in detail just how this correction is made.

It may seem empirical that the occiput must be corrected before health can occur, even when it may not be the starting point of the disorder, but the matter still stands that this must be done, and by so doing you will be enabled to restore health in a very short time to a far greater number of patients than has been possible by any other technical procedure. If you could adjust at no other area than the occiput, you would be enabled to produce miraculous results, if this adjusting were properly done.

PART III

THE SPINAL NERVE LESION

The spinal nerve lesion is always associated with pain, either at the intervertebrael foramen or at the terminus of the spinal nerve.

A Vasomotor nerve lesion does not necessarily cause pain, unless the vasomotor lesion is also directly associated with a spinal nerve lesion. In the presence of a spinal nerve lesion, if there is no vasomotor lesion, the blood pressure will be near normal, as the spinal nerve lesions do not necessarily affect the circulation, unless the lesion is causing direct irritation of the cardiac muscle, in which case the heart will show irregularities.

In the presence of pain in any part of the body, you first think of a spinal nerve lesion, and this will also include lesions of the sympathetic plexuses, but as the spinal and sympathetics are treated in the same manner, there is no need to differentiate as to technical procedure or to consider them separately.

The spinal nerve lesion is many times directly associated with trauma, but can also be directly associated with acute infectious disease, but we still believe that the lesion must exist before the onset of infections; Trauma does not mean that the patient must have fallen out of a sky scraper building, for the slightest missteps or twists often produce the most acute lesions. A man once came to our office with a very pronounced painful back lesion. The gentleman could not figure out why the mere act of stooping to put on his overshoes could cause all of his pain, when he considered that he could lift very heavy weights without in any manner injuring his spine. It most often is not the weight he is lifting, but the twist under which the spine is placed, that produces the lesion. Lesions can also be produced by the intake of poisonous inorganic drugs and minerals and by the eating of spoiled foods. All of you are thoroughly acquainted with occupational lesions, so no need to elaborate upon that point of technic.

At the point of lesion we have one of four stages of inflammatory re actions: Infiltration, engorgement, swelling and pain. The period of infiltration may take one minute or may take one year, engorgement like wise may be sudden or prolonged, but when engorgement is present, pain is not far away. Pain will most often be of a radiating nature and will be felt not at the emergence of the injured nerve plexuses, but at its terminus. People can not understand why an adjustment can help a pain in the great toe or little finger. People can understand in a manner of speaking why adjustments and manipulation will help a back ache, but the fact is, the backache more often is more stubborn for the doctor to eliminate than is the pain in the great toe or little finger. Backache oftentimes does not mean spinal nerve injury as the primary factor, but vasomotor disturbances, and until this vasomotor disturbance is corrected, the backache will persist, fortunately, many vasomotor disturbances are corrected unknowingly.

Inflammation at the intevertebrael foramen will often cause the complete course of the impinged nerve to become inflamed. Disturbed cell function at the foramen causes disturbed nutrition. If this inflammation extends the full length of the nerve fiber, complete relief of pain cannot be immediately attained, for inflammation does not happen in a day to the termination of a nerve fiber, but requires time. Pain can be just as acute without complete

nerve inflammation, as with complete nerve inflammation. Some cases of very painful nerve disturbance can be conquered immediately, and others must require time. However, you will be able to produce temporary results in even the most advanced cases immediately for correct therapy produces better nutritional nerve balance and this tends to relieve the congestive factors at once.

If a nerve is badly impinged, degeneration may take place and it this does, the degeneration will usually be to the first node of Ravener. When this happens collateral nerve function must be established before normal function is restored.

LOCATING THE SPINAL NERVE LESION

We refer you to the charts on the intercommunicating nerve impulses. Study these again. Fix in your mind the radiating superior and inferior fibers. Keep in mind that the ninth dorsal is the point of superior and inferior nerve division. Fibers superior to the ninth dorsal localize first onto the cervicals and finally to the occipital line. Fibers inferior to the ninth dorsal, localize onto the sacral areas and then onto the occiput.

When infiltration, congestion, engorgement and finally inflammatory symptoms appear, excitation of the pain over the area affected and then pressure in the vertebrael groove over the foramen on the affected nerve, will inhibit the nerve impulses and the pain will be lessened immediately and in many instances stopped. The area of pain must be excited in order to know definitely that you have the proper area. A patient may complain of a pain in one certain area, yet pressure over that area will fail to produce pain and even motion may fail to produce pain, yet the area one-half inch from the point where you applied pressure will be very painful and it is the area that must be excited in making your localizations. When you have pain on motion, you will invariably have pain on pressure. Inflammation, by its action, makes a part susceptible to pain on pressure. Where you have pain, you have inflammation in some stage. This is an unbreakable rule.

A painful arm may not exhibit a painful vertebrael area, even to pressure, but when the arm is moved or the area pressed upon, you will be able to detect a painful spinal area. For this reason it is essential that you follow instructions as given to you. A painful spinal area may not be the causative area of a body pain of which the patient complains, but upon exciting the area under discussion, the segment above the painful segment may become extremely tender to palpation. If you adjusted the painful spinal area without exciting the painful body area, you would adjust the wrong segment and of course the patient would secure no results.

You cannot imagine that a segment is causing trouble, you must prove that it is the causative factor before you will help your patient.

In some painful states you will find that the occiput alone can relieve the pain, if the pain is above the ninth dorsal segmental line, and if the pain is below the ninth dorsal segmental line, some area on the sacral tissues will relieve the pain, in these instances, you will be unable to detect a painful spinal area that will relieve the pain. We believe this condition is due solely to body unbalance and is a direct result of pressure at either occiput or sacral areas and that no spinal vertebrael segment is involved. If you fail to find a vertebrael area to relieve your exaggerated pain, you will then explore the occiput for an area if the lesion is superior to the ninth dorsal and the sacrum if the area is inferior to the ninth dorsal.

We shall illustrate this point with an actual case. This patient had a very painful upper gastric area. Diagnosis by prominent doctors was ulcers of the stomach. Upon pressing over this area a feeling of nausea would appear and I was unable to detect a dorsal or cervical area that would afford any relief, but upon palpating the occiput, I found that occipital area 3 gave complete relief. The patient had a distinct body imbalance, the right limb was much shorter than the left limb, the right side of the spine was tense. Occipital area 3 was adjusted, immediately after the adjustment the patient expelled gas and within three minutes pressure could be comfortably borne on the stomach. Two treatments completely restored the patient to normal. In this instance, if one did not consider spinal intercommunicating impulses, one might adjust dorsal five and by so doing would secure no results, but by adjusting occipital area 3, direct results were secured, no doubt due solely to cranial nerve affects as to restoring balance to the vasomotor nerves, although the vasomotor lesions were not, at the time in seeming difficulty for the blood pressure was 118 systolic. No correction, other than the occipital area 3 adjustment, was ever used on the patient. The manner of making pressure on the stomach with operator's right hand, at the same time applying pressure to occipital area three is illustrated in cut number 20. You will note that quite hard pressure is being applied to the stomach.

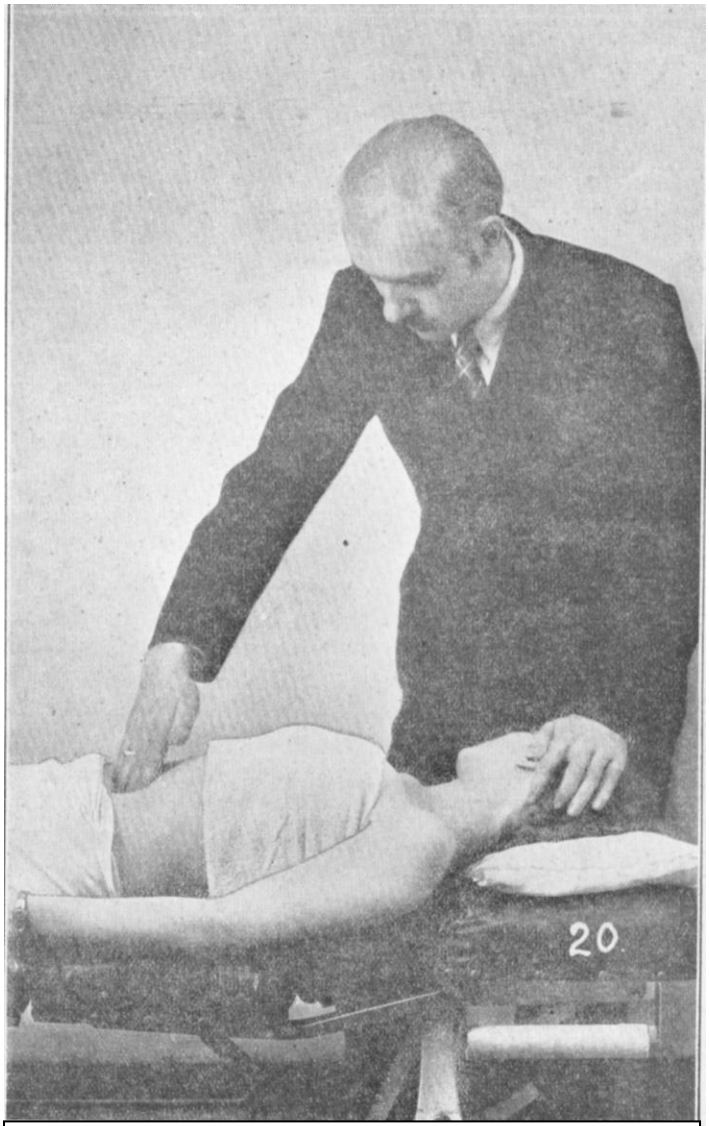


Illustration 20

Case of ulcerated stomach, according to previous doctor's diagnosis. Pain could not be relieved by dorsal or cervical localization, but was completely relieved by third occipital area pressure and adjustment technic.

ILLUSTRATING A CASE OF BRACHIAL NEURITIS

CUTS NUMBERS 10, 11, 12

We are using our model in this instance to react an actual clinical case which we believe will prove very interesting to you.

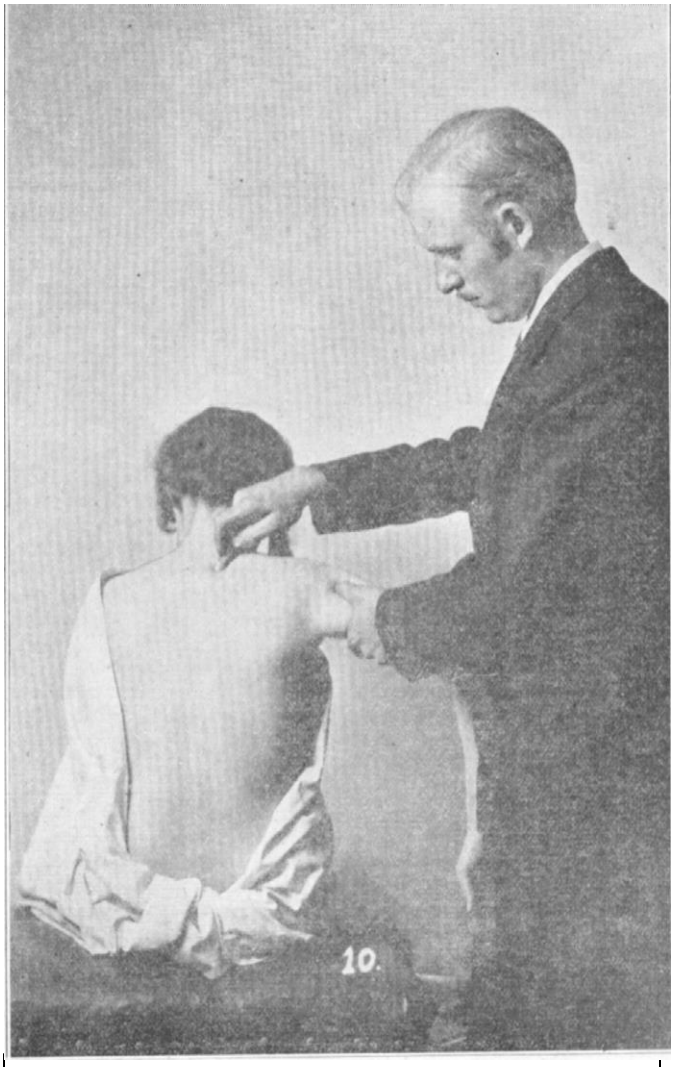


Illustration 10

Shows technic of exciting area of pain and manner in which this pain is localized to spinal area. Case of brachial neuritis

This patient had been in perfect health up to the appearance of the attack of brachial neuritis. Patient was a woman of 46 years. While caring for her flock of chickens she took a shovel of corn and swung it so as to scatter the feed. As she completed the swing a terrific pain was felt in her shoulder. The patient immediately thought she had dislocated her shoulder. A medical doctor took X-rays and said that the shoulder joint had been injured. The arm was strapped with adhesive and placed in a sling. Relief from pain was not to be had, even with complete rest of the injured shoulder. After about three months the patient consulted the writer and at that time suffering was intense. Motion was almost gone from the shoulder. All parts of the arm seemed to be very painful, but an area was found on the superior part of the shoulder that caused an intense throbbing in the whole arm when pressure was applied. This area made us think that some of the upper dorsals might be affected, so we made pressure at first dorsal and this stopped the pain in the shoulder area upon which we were applying pressure and as long as we held the pressure in the right first dorsal groove the patient could move the arm slightly without undue pain. The first dorsal became quite tender under pressure, so we knew a cervical was involved and being that the first cervical localizes to the first dorsal, we applied pressure here at the same time keeping pressure on first dorsal. The first cervical eliminated pain

Illustration 11
Second step in same technic, shows localization of pain from first dorsal to first cervical.

from the first dorsal. The patient complained that the first cervical area was terribly painful to pressure, but we found that the first occipital area eliminated all pain from the first cervical and pressure applied at the first occipital area completely eliminated all pain from arm, dorsal segment and cervical segment. The first occipital area was adjusted. We saw the patient two days later and she told us that the pressing we did on the bones in her head did her more good than anything she had ever had done to her. In three treatments all pain was gone, motion was good.

This case brings out a very valuable point in intercommunication nerve area distribution. In throwing the shovel of corn around, the patient evidently slightly twisted her head producing the occipital lesion, the occipital lesion produced irritation at first cervical, first cervical produced irritation at first dorsal, first dorsal produced irritation at the brachial nerve plexuses causing the brachial neuritis. An adjustment at first dorsal could have given temporary relief and adjustment at first cervical would have given more relief but the occiput had to be properly adjusted before permanent relief was to be had.

This case beautifully illustrates the intercommunicating impulses, but had not the first dorsal eliminated the pain in the arm and had no other dorsal above the ninth eliminated the pain and had no cervical eliminated the pain, we would then have depended alone upon the occipital area for relief, and had ho area been found here, we would have explored the sacrum for the occipital area could have been a causative factor, but of itself would not have relieved the pain, due to the reflex arc having produced a lesion of, its corresponding sacral area, and had this been the case we would have been able to relieve the pain in the arm by sacral pressure and from this sacral area we would be able to cause a tender occipital area to appear. The occiput bears a very direct relationship with the sacrum and it is possible for the occiput and sacrum of their own accord to be directly responsible for paths in any part of the body without causing tenderness or pain in any cervical, dorsal or lumbar segment. Such cases are rare, but when they do occur, you must be prepared to meet them, for if you do not, you will meet a therapeutic defeat. The complexities of the nervous systems are much deeper than many of you suppose and when one has truly mastered the reflexes of the

Illustration 12
Same case, shows localization of pain from first cervical to first occipital area. Pressure at first occipital area removes pain from first cervical, first dorsal and shoulder.

nervous system, he has covered much ground and is prepared to produce many therapeutic miracles. Do not say that these things are not so, just because you believe them untrue, for therapeutic results will prove to you that they are true, and when you learn to search for areas of true nerve interferences, you will be in position to command a suitable financial reward for your efforts.

Ninety percent of your cases will show perfect intercommunicating areas and you can treat them by chart work, but ten percent will present therapeutic puzzles, but if you will bear in mind the relationship of occiput to sacrum, you will be able to ferret out the area of true interference.

You will ask, why is it necessary to explore anything but occiput or sacrum? When you make a localization pressure on any spinal segment and that segment proves that it will reduce the pain in the part affected, it proves that it is capable of benefiting the painful part and the pressure you make over the area in your exploratory search proves of much therapeutic advantage, for by even momentary relaxation by inhibition, it allows the cells in that segment to balance themselves and gain strength to renew the fight to rebuild themselves. If you do not use your localization technic, you will leave some area unfound and that area will act as an irritant to its intercommunicating area and your therapeutic results will be curtailed,

It may seem like an endless job to explore these regions, but you will be surprised to find that the total exploration will take but a very few minutes and the work will prove so interesting that an hour would only seem like ten minutes; but at the most you will never spend over ten minutes locating the hardest lesion to ferret out.

SCIATICA

We shall now illustrate a case for you showing how the inferior radiating fibers are treated and localized. This case is illustrated by cuts 17 and 18.

Illustration 17
This illustrates a case of sciatica. Pain was intense over area on limb that operator's right index finger is making pressure. Fifth lumbar area completely eliminated pain from limb, but fifth lumbar area was very tender to pressure.

Patient had a severe case of sciatica. Pain was excruciating upon movement of limb or spine. While pressure was made over the sciatic nerve with index finger of one hand, the index finger of the other hand explored the inferior radiating fibers. Remember, the inferior fibers start at ninth dorsal, so we started at ninth dorsal and made pressure upon each inferior spinal segment until we contacted a segment that eliminated the pain from the sciatic nerve and this area was lumbar 5. Pressure here lessened the pain to a marked degree from the limb. Patient could move the limb with much less discomfort while pressure was maintained on fifth lumbar segment. The fifth lumbar segment was quite tender, the eleventh dorsal was tender also, but had no influence over the pain in the limb, so was ruled out. Pressure over the right sacral first area eliminated the pain from the fifth lumbar and manipulations of the tissues at the first sacral area completely eliminated all pain from both fifth lumbar and sciatic nerve, but this manipulation caused the first sacral area to become very tender, so this area was localized onto seventh occipital area and pressure on the occiput eliminated tenderness from first sacral area. The sacro occipital con tact was made with one hand on first sacral and the other on area seventh occipital and thrust was given.

In analyzing this case, had we made pressure upon first sacral area without localizing first onto fifth lumbar area, the pain would have been lessened in the sciatic nerve and the patient greatly benefited, but had the fifth lumbar been left untreated., irritation would still have existed at this point and the patient would have experienced a return of the pain in the limb. Had we found upon examination of the lower dorsals and the lumbars no area that would have relieved the sciatic pain, we would have known that the dorsals and lumbars were not causative factors in producing the sciatic pain. Even had a dorsal or lumbar area appeared tender upon pressure and yet not

Illustration 18
Shows technic of localizing fifth lumbar area to sacral area. Pressure over sacral area eliminated pain from fifth lumbar.

have influenced the pain in the limb, we would still thaw the conclusion that no connections existed between either dorsal or lumbar to the sciatic pain: in which instance our localization would have been directly from sciatic painful area onto sacral area and then onto occiput.

This patient gave a history of chronic lower back pains and a tendency to lumbago, but until one week previous to seeing us had no pains in the limb. The sciatic pain appeared suddenly one morning and continued unabated until we applied the sacro occipital technic. The fifth lumbar no doubt had at some time suffered a traumatic injury, the circulation through this segment was deficient, cell nutrition suffered, some action of the patient produced an acute reaction in the fifth lumbar segment and the sciatica appeared. Through the years of lumbar pains, the intercommunicating fibers to the sacral and occipital areas had suffered, until an acute imbalance had taken place in the gluteus maximus muscle and when this happened tension was placed upon the sciatic nerve direct,

which accounts for the sudden appearance of the pain.

RESUME

When a spinal nerve is impinged, one or all stages of inflammation exists. You may have infiltration as a cause of pressure, and this may cause very severe painful symptoms to appear, or you may have infiltration to a lesser extent and have no noticeable symptoms of acute pain. Infiltration may proceed to the stage of congestion, and pain may then appear, or congestion may proceed to the stage of engorgement, at which stage circulation through the spinal nerve neurolema may become so badly disturbed as to cause inter-spinal nerve pressure, i.e.: pressure within the sheath of the nerve, at which point pain will be noticeable through the full course of the nerve. This stage is seldom reached, how ever, unless the course of the engorgement is progressive and suitable therapy has not been applied to

remove the impinging factors. If the above stages run unabated, we then have a fully developed inflammatory reaction, at which time the patient will be compelled to seek relief, for the pain will be of such a throbbing nature that it will be unbearable. In the final stage of inflammatory reactions, you must not expect immediate result, for the inflammation must subside, before pressure either at the foramen or within the nerve sheath, is removed.

Inflammation or any of its stages may cause either a hypo or hyper function of a nerve bundle. It is an established fact that pressure applied at the seat of pain will excite nerve stimuli, be the nerve in a state of hypo or hyper function, therefore in making a diagnosis it is essential that the area of greatest pain be further excited before at tempting to associate a specific spinal area as the cause of the pain, for if this is not done, the wrong segment is often selected for therapy.

A spinal segment may be painful, due to reflex factors, and yet be unassociated with a painful body area, while a segment may show 11.0 painful symptoms upon examination, yet when the offending body area I irritated, a previously unpainful segment will immediately become very tender to pressure with the finger.

The body is a segmental unit and each body segmental unitage corresponds to a spinal segment, yet we can not say that a corresponding spinal unit to an offending painful body unit is responsible for the painful state in the body unit, for if we know the spinal intercommunicating paths, we know that an occipital subluxation may cause a pain in the great toe and a subluxation of a sacral unit may be the cause of a severe case of tonsillitis. If we consider the body and spinal unit that are associated as to segmental structures, we would have to concede that the pain in the great toe was due to sacral pressure and tonsillitis was due to cervical pressure, but as this is not so, we can not empirically say that just because a body unit corresponds in segmental structure to a spinal unit, that the spinal unit will be responsible for pain in the body unit. The Meric systems chart the body and say that each area is associated to a spinal unit and that pain in a corresponding body unit is always caused by pressure in its associated spinal unit. Doctors working upon this assumption too often fail to produce therapeutic results, for they do not seek out reflex centers. The therapist that adjusts or manipulates according to painful spinal centers without first irritating. the painful body area, is again working on a hypothesis that often leads him to failures.

ILLUSTRATING CUT NUMBER 26

This patient had a very painful condition about two inches lateral to the first lumbar. Pain was felt on motion. A deep breath caused pain. Pain was not present in back when pressure was made anteriorly on kidney, so we concluded that the pain was due solely to a lumbar lesion. While one hand made pressure over the painful area to cause increased excitement of that area, the other hand started at the right side of the first lumbar and made pressure in the spinal groove. We found that it was impossible to control the back pain from any of the lumbar vertebrae, so we next explored the sacral areas and while at this point, we shall digress a moment to tell you that our sacral areas are numbered from base to apex at 5-4-3-2-1, instead of 1-2-3-4-5. The base of the sacrum contains the largest groove, the apex the smallest, so we call the base number 5, because that designates more than number 1. The sacral area contains the complete area covered by the gluteus maximus muscle and it is this muscle upon which most of the sacral technic is applied. In the case under discussion we

Illustration 26
Case of severe pain about 2 inches lateral from the first lumbar. Lumbar areas would not relieve pain, but pressure in sacral area 1 completely controlled pain. This area then localized to occipital area 7.

found that sacral area 1 completely eliminated all pain from first lumbar lateral area, press as hard as we could upon the painful lumbar area, no pain could be felt by the patient, but by pressing quite firmly upon sacral area 1 the patient complained of severe pain. While holding our pressure upon sacral area 1, we contacted occipital area 7 and pressure here stopped pain at first sacral area. We then gave the sacro occipital thrust and completely eliminated all pain in less than two minutes. The Sacro Occipital thrust is illustrated under that portion of the technic. Irritation at sacral area 1 caused the gluteus maximum muscle to unbalance the pelvis and this caused the lumbar pain and the occipital area to be painful by reflex action.

THE SACRO OCCIPITAL TECHNIC

THE OCCIPUT

For a review of the occipital line we refer you to SD chart 14. Memorize the position of the occipital line. Fix in your mind the occipital area division of the suboccipital ridge.

Study charts SD 13, SD 15 and SD 16 for your intercommunicating spinal nerve areas.

THE SACRAL AREAS

GLUTAEUS MAXIMUS MUSCLE

The glutaeus maximus muscle, the most superficial muscle in the gluteal region, is a broad and thick fleshy mass of a quadrilateral shape, and forms the prominent of the nates. Its large size is one of the most characteristic features of the muscular system in man, connected as it is with the power he has of maintaining the trunk in the erect posture. The muscle is remarkably coarse in structure, being made up of fasciculi lying parallel with one another and collected together into large bundles separated by fiberous septa. It arises from the posterior glutael line of the ilium, and the rough portion of bone including the crest immediately above and behind it; from the posterior surface of the lower part of the sacrum

Illustration 19
Shows technic of giving sacro occipital thrust. Not that right sacral area is contacted and right occipital area. Patient's face is turned to right. Many operator's choose this method of giving the sacro occipital thrust, due to the fact that they can make a better contact with pisiform bone than using fingers.

and the side of the coccyx; from the aponeurosis of the sacro spinalis, the sacrotuberous ligament, and the facia (glutael aponeurosis) covering the glutaeus medious. The fibers are directed obliquely downward and lateral ward, those forming the upper and larger part of the muscle, together with the superficial fibers of the lower portion, end in a thick tendinious lamina, which passes across the greater trochanter, and is inserted into the iliotibial band of the facia lata, the deeper fibers of the lower portion of the muscle are inserted into the glutael tuberosity between the Vastus lateralis and Adductor magnus. (Gray.)

You will note that this muscle covers the complete sides of the sacrum and extends to the coccyx. The muscle is deep and very powerful.

The glutaeus is supplied by the fifth lumbar and the first and second sacral nerves, through the glutael nerve.

When one considers the actions of the Glutaeus Maximus muscle and its part in supporting the body in the erect position, one can well under stand how an adjustment of the occiput can correct a short limb. Tension in this muscle will draw the femur into an abnormal position. The occiput exerts a powerful influence upon the sacral areas and tension at the occiput will cause irritation in this muscle and a consequent shortening of one limb. It is essential that the correct sacral area first be localized before you can locate the compensating occipital area. If you adjust the wrong occipital area, you will have no influence on producing normal body balance.

THE SACRAL AREAS

In illustration 27, you will note that the sacral areas cover the complete area that is covered by the Glutaeus Maximus muscle. In studying the chart please take note of the fact that our

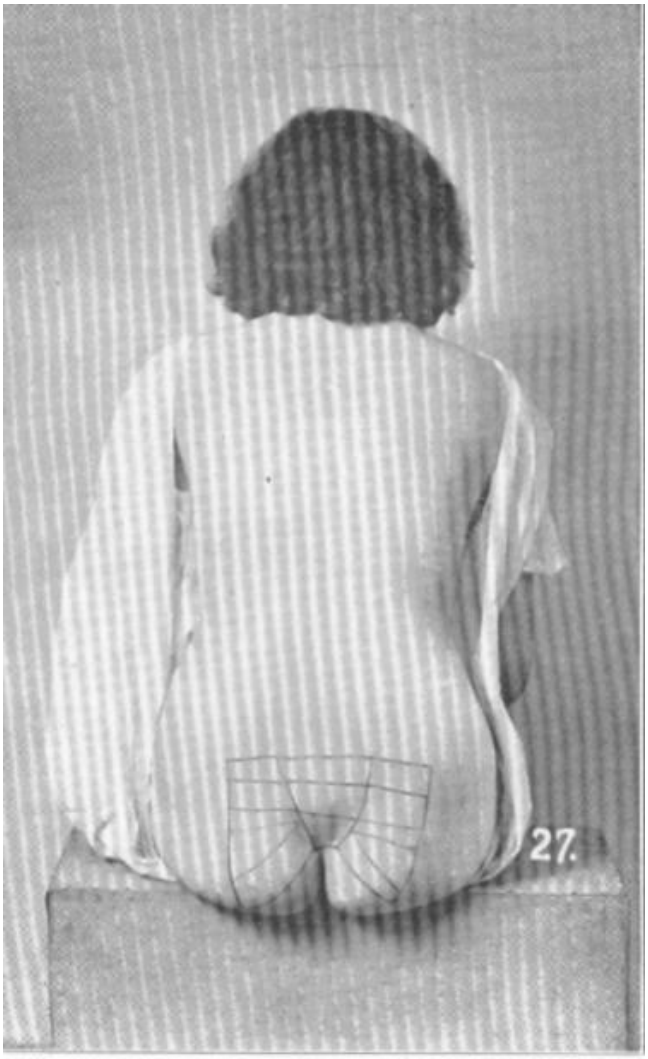


Illustration 27
Shows sacral areas as they extend out over the gluteus maximus muscle. The lines on the right side should extend as far down as on the left side. Left side shows areas more accurately.

lines were drawn about one inch higher headward than should have been. The lines on the right sacral area should be drawn as low as the lines on the left sacral area. The sacral areas are numbered from base to apex. Most superior area is number 5 and last inferior area is number 1.

In palpating your sacral area, you do not palpate directly over the sacral foramen, but lateral to those foramen and many times it is necessary to go to the extreme lateral sides of the area under palpation.

The index finger supported by the middle finger is used for palpation. You go well into the muscle. It is often necessary to make pres sure in marry different directions before you succeed in finding the correct position for inhibition of nerve function. You first make pressure directly downward on the area, if this does not relieve the pain, you then make pressure in towards the sacral area, if this fails you reverse the direction to the lateral, and if this fails you make a superior direction pressure and if that fails you change your direction to the inferior. When you have found the correct directional area on the correct sacral area, you will immediately secure relaxation of the area under palpation and the pain will become lessened. Take note of the direction you were pressing at the time relaxation occurred for this is the direction you will use in making your sacro occipital contact and thrust.

THE SACRO OCCIPITAL THRUST

We shall illustrate the manner of making contact and delivering the thrust by two case reports.

First is a case of sciatica which has been described to you previously and is illustrated by plates 13, 17 and 18. On this patient, by making pressure over the sciatic nerve we caused a fifth lumbar segment to act as control for the pain in the limb. From the fifth lumbar we localized onto the first sacral area which controlled the tenderness in the fifth lumbar segment. In illustration 17 you will note that pres sure at the sacral area is being made slightly towards the medial sacral line in which directional position all pain was eliminated from sciatic nerve and fifth lumbar area. At this sacral area a firm pressure contact was held

Illustration 13
Shows method of using the thumbs for the sacro occipital technic.

Illustration 22

This illustrates the technic used in using thumb percussion of a painful occipital area. The operator stands behind or to one side of the patient. In the illustration, the writer is standing in from of the patient so as to illustrate the contact more clearly. The writers left hand is supporting the patient's head by holding the patient's forehead.

for about one minute at which time the area relaxed. We then make our sacro occipital contact as illustrated in plate 13. Operator stands at side of table, right thumb presses on first sacral area and as you will note pressure is slightly towards medial sacral line. With thumb of left hand the seventh occipital area is contacted. Patient has face straight down on table as you will note, operator's left thumb is pressing towards external occipital protuberance to agree with directional point on sacral area. Firm pressure is made on both sacral and occipital area at same time and is held for one minute.

While holding contact it is very good to vibrate the fingers, as this tends to more quickly relax the fibers under the fingers. As the fibers relax, a quick thrust is made with both thumbs at the same instance. You must not thrust with force, but with a quick movement. The thrust, even with little force, tends to further relax the fibers and will tend to normalize the position of the occipital and sacral areas.

After you have done this, you have the patient lay supine on the table and measure the limbs. If the treatment has not completely normalized the two limbs so they will be of equal length, you then adjust the occipital area by the body balance technic. You will often find that it will be unnecessary to adjust the occiput as your sacro occipital technic will in most instances completely normalize the limbs.

While at this point it might be well to say a few words regarding the body balance technic. Remember that this part of the technic is intended for use after the vasomotor areas are adjusted. When adjusting the vasomotor areas, it is essential that the body be normalized. The adjustment of the Vasomotor centers do not necessarily control body balance, so the occiput is adjusted so as to normalize the limbs as to length.

The Sacro Occipital thrust will usually normalize the limbs, but we again state that if it does not, you are then to adjust the occipital area that you used for contact with the sacro occipital technic.

Please remember that a totally different technic is used in Vasomotor therapy than in spinal nerve therapy. If you get this differentiation clearly in your mind, you will quickly see that many technics are practically useless because they do not make this differentiation.

We shall now illustrate another case which brings out the fine points of the directional line technic.

This is illustrated by plates 26 and 19. Patient had a pain lateral to first lumbar. The first sacral area completely eliminated the pain from first lumbar lateral area. You will note that in this case the sacral area was well towards the lateral margin of the Glutael muscle, and the pain was relieved by a lateral directional pressure. Pressure directed towards the medial sacral line, even over this area, caused no relief from pain, bringing out the point of the necessity of securing the correct directional line for your pressure. Occipital area seven eliminated the pain from sacral area 1. In making our sacro occipital contact we used the pisiform bones for contact, as some doctors will prefer this method. Note that the operator's right hand is directed well laterally on the first sacral area, the hand on the occipital area is not placed as it should be to bring out the exact contact point. The hand should be farther towards the middle of the occipital line and just lateral to the right side of the external occipital protuberance. The patient's face is turned towards the right side of the sacrum, because the right side is under therapy. When using the pisiform contact, the head must be turned towards the side under therapy. If this is not done, your contact will not be secure and you will cause the patient unnecessary pain.

In illustration 22 we give you a technic of treating the occipital ridge by thumb percussion technic. In some instances you will find that the patient can not lay on a table or a suitable table may not be at your command. We have seen patients in such acute pain that they could not Be down even for the short time it takes to give an occipital adjustment. In this illustration you palpate the occipital line until you find a very tender area and by the way

the area in those instances will be just mighty tender. When the area is located, the doctor places his thumb against the area and the rest of the hand rests on the patient's neck and the doctor's arm can rest on the patient's shoulder. In this instance, as in exploring the sacral areas, you will find that directional pressure counts. A seventh occipital area may be causing a terrific pain in the leg, yet pressure at the seventh area will fail to give relict until the pressure is m in the correct direction. You will be mightily surprised at the manner in which you can relieve acute pains by merely using this very simple procedure. We have been places where it was impossible to have a patient lie down for an adjustment, yet would quickly relieve the pain upon giving the thumb percussion technic to the occiput. Many times the doctor will have acute symptoms appear and he can give himself much relief by using the occipital ridge with his own hands. I have had my own throat become sore when on lecture tours and have always been able to afford myself prompt results by using this technic on my own occipital ridge.

The name of a disease is very unimportant. Find the spinal area, sacral or occipital area causing the symptoms and the disease, condition, symptoms, or what have you, are gone.

PART IV

BODY BALANCE TECIINIQUE

This part of the technic could well be called a separate technic, for in all reality it can be a technic all of its own, and by its use exclusive of any other procedure you can secure results in a great majority of patients. One school of healing is laying a great deal of stress at the present time upon a single adjustive area in the spine, and we can not say that there is no logic in their contentions, for it so happens that the area they select for adjustive work is usually associated very closely w.ith the occiput and it is absolutely impossible to work this area, which is usually axis or atlas without affecting in a great measure the position of the occiput.

We must remember that the occiput has a great many functions to perform. Its bony cavity houses a great many important brain and nerve structures. Its position at the extreme uppermost part of the spinal column, means that the occiput is a balance wheel of the entire spinal, pelvis and brain structures.

You can build a skyscraper, put into it the very best of materials, but let its topmost part be out of line with its lowermost part and you will have difficulty in maintaining your structure in the air and if the size of the building is in the same proportions as to circumference from base to roof, as is the size of the occiput to the lower part of the spine, it will be impossible to maintain the building on a proper keel. Possibly you have never considered the occiput as being of any value in balancing the body, but let some one produce an occipital lesion on your occiput and then see if it does not produce in your body a very real sense of unbalance. At the occiput we can produce in an instance a complete imbalance of the entire body. We can cause one limb to shorten and this will stay short until the occiput is rebalanced. This fact has been demonstrated many times in public clinics.

In studying the subluxations of the occiput, we find that it is possible to have seven distinct subluxations, however not all will be present at one time, for this would be impossible, as the occiput is but one bone and could not assume seven positions at the same time and retain any part of the first position assumed. The subluxations of the occiput are determined many times to be caused solely by reflex action from either cervical, dorsal lumbar or sacral irritations, However, it is possible for the occiput to be subluxated and cause reflex action to produce apparent subluxations in any segment connected by intercommunicating fibers from the occiput to the spinal segments that may become involved.

Let me illustrate this point. Presuming that we have a lesion at the first occipital area, this by intercommunicating fibers can affect one or more of the following spinal segments: First cervical, first and second dorsal, tenth dorsal and fifth sacral. Traumatic injuries of any of these spinal segments can and does affect the occiput. How much the occiput is affected depends upon how quickly the spinal segment is reduced to normal. Every chronic case has an occipital area lesion.

We therefore see that if we did nothing but remove occipital irritation, that we would be doing a great good for our patient. We also see that it is not for us to criticize those who believe they should adjust at but one place, especially when this place is so relatively associated with the occiput. We can not deny that it is possible to produce miracles by a mere adjustment of the occiput or the atlas or axis and nothing more, for we by doing this do remove nerve pressure and we do not do one single thing that is going to upset the vasomotor system, because by not manipulating the spine we know we will do no damage and this is especially a vital factor, for 90% of our patients are the hypremic type and can not stand spinal manipulations and recover as quickly as they should.

The day has dawned when we shall not define sickness in periods of weeks, months, years, but we shall go directly to the cause of the disease, and if enough vitality remains, the patient shall show results immediately. The day when you shall sell 100 adjustments in advance is forever a memory, and to that memory let us erect a monument, for many a good doctor, was not a doctor but a super salesman; when his patient didn't get well he sold him another course. I have done the same thing.

DETERMINING THE OCCIPITAL LESION

The blood pressure determines the vasomotor lesion and the balance of the body determines the condition of the occiput. If you want to know whether or not the body is balanced you have the patient stand erect, you notice the curves of the spine, the position of the posterior ilia, the tilt of the pelvis, if the spine curves laterally, If the head is in an untrue position, if one ilia is high, if the pelvis is tilted, you have unbalance. Instead of doing all of this, have the patient lay supine on the table, completely relaxed, face directly forward, chin up, hands on abdomen, and then you pick up both feet, have toes extended slightly forward and notice the position of the malleolus. If the points of both malleoli are exactly centered one to the other, both limbs are of equal length, but if one is superior to the other, you have a short limb, and that means that the side of the body on the side of the short limb is contracted, all the tissues are tight, that side of the occiput is affected, the circulation through the spinal muscles on the short limb side is affected, due to vasomotor influences at the occiput. You will find that every patient will at some time show this unbalance, and if there is pain present and the occiput has not been corrected, the imbalance will be quite noticeable.

After you have determined that one limb is shortened, you have the patient lay prone on the table, and you must use a table with a split headpiece so that the face can assume a normal face down position with out putting tension on the cervical spine.

You are no ready to determine the occipital lesion. When an area of the occiput is lesioned that area becomes tender to pressure, so you must use pressure to detect the lesioned area.

With your index finger you start at occipital area number 1 and make firm, but not severe rotary pressure over occipital area number 1. If the area is painful you will be able to detect tension in this area and many times you will feel a slight gristle-like bulb under your finger. We prefer to ask the patient to tell us when we contact a tender area; this gives the patient something to do and most patients like to feel that they are co-operating. However, when you contact the major area, the patient will let you know about it, for the area will be severely tender. Proceed over the complete occipital line on both sides, marking each noticeably tender area with a skin pencil. You then contact the marked area or areas and ask

the patient to tell you which area is the tenderest; this will be your major area for contact adjustment of the occiput.

The patient now assumes the supine position once more. If you prefer, you may palpate the occiput with the patient in the supine position by having them turn the head to the left to examine the right occipital line and to the right to examine the left occipital line. This will save the patient the inconvenience of turning over on the table an extra time. Many doctors, however, in first starting this work, do not like to have the patient in a position so that the patient can watch them, but as they become proficient in palpating the occipital line, the act is over so quickly that no embarrassment can be caused the doctor, even if the patient persists in looking out of the corner of their eyes to see what it is all about. After palpating the occiput, you again measure the limbs, for remember that even by palpating the occiput you can produce relaxation of tissues and this procedure alone may normalize the limb and again it may cause the other limb to shorten and the previously short limb to assume a normal position. By taking this extra precaution you avoid all possibilities of errors.

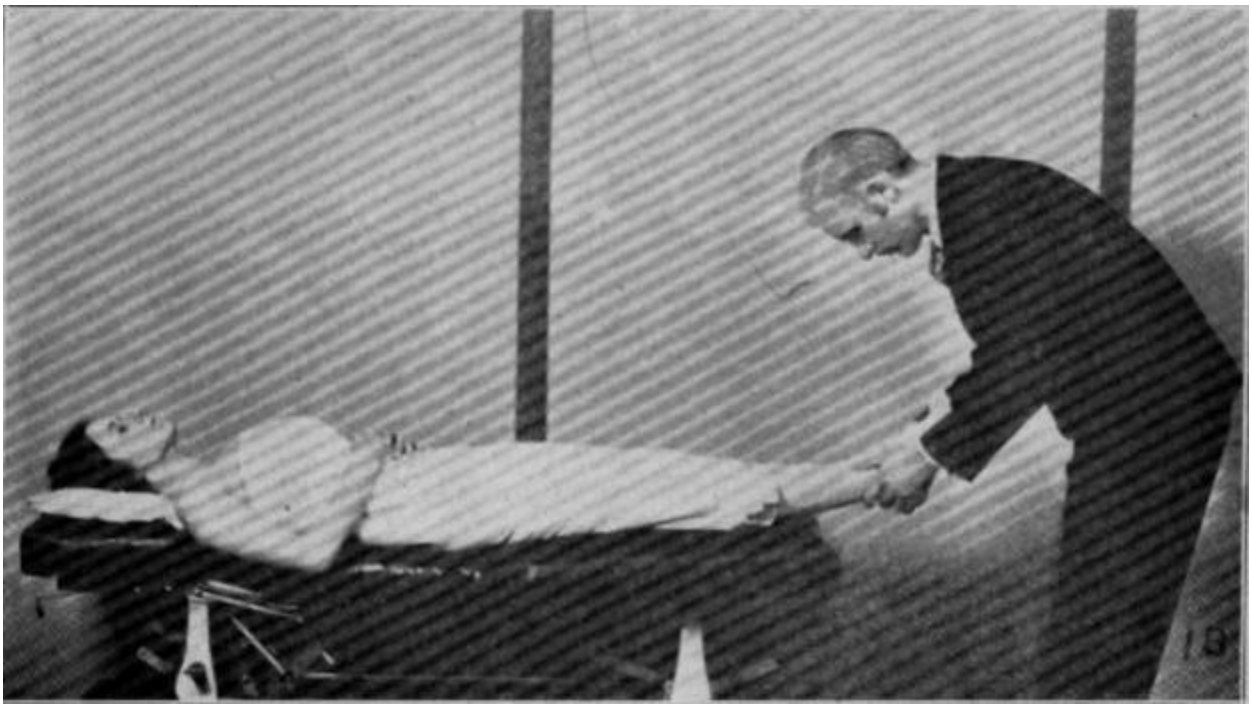


Illustration 1B

Technic of measure body balance. Patient supine on table. Hands on abdomen, face front completely relaxed. Limbs lifted slightly off end of table, undue tension avoided by doctors. Measurements for comparison with malleoli.

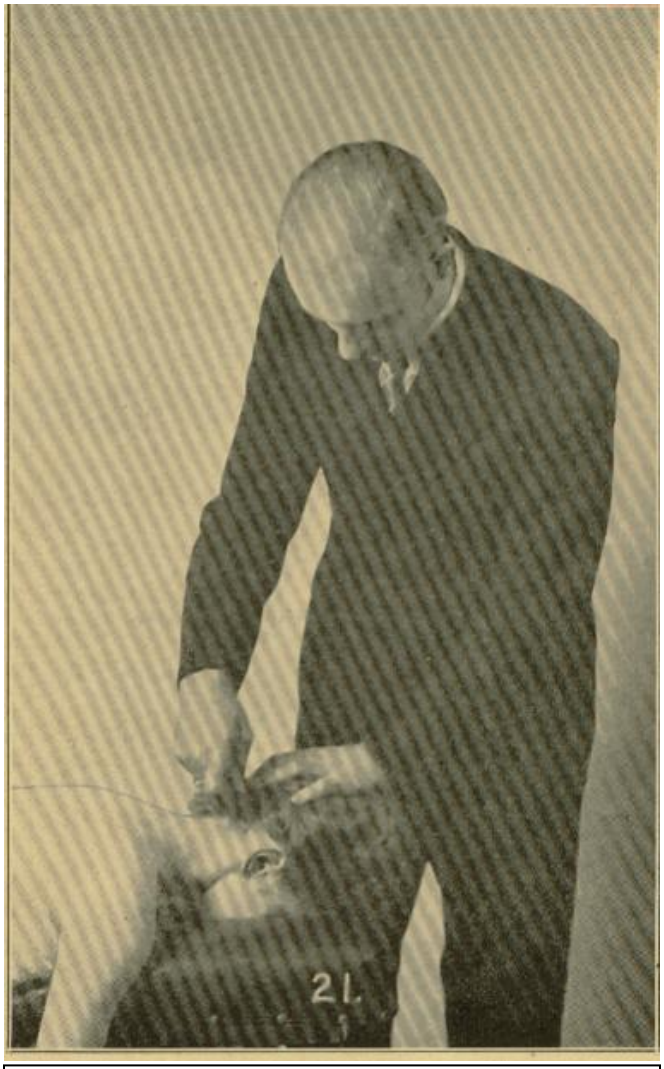
ADJUSTING THE OCCIPUT

In adjusting the occiput you use the head of the metacarpus of the index finger. This area of the finger is applied directly onto the lesioned occipital area. This part of the technic is important. The head of the metacarpus is the strongest part of the finger, its prominence will allow you to make firm contact against the occipital area. This part of the hand resembles the pisiform bone very much in contact ability.

In ninety percent of your patients you will find that the occipital lesion appears on the opposite side of the body from the short limb side. If the right limb is short, the left side of the occiput will be lesioned and vice versa. However we must consider that 10 per cent of our impulses go directly past the point of pyramidial dessucation and there fore reach the brain without transversing the point of pyramidal dessucation. This will account for the fact that about 10 per cent of your patients will show a short limb on the same side upon which the occipital lesion occurs. When this does occur, you proceed exactly as if the short limb was on the other side of the body, for your correction will be effective. In applying your contact, you turn the patient's face to wards the short limb. If the right limb is short, the patient's face is turned to the right side of the body, for your lesion will be on the left occipital line. It is in the instance of the occipital lesion appearing on the same side of the body that the short limb appears that you must guard against, for as stated above, this is due to pyramidal dessucation.

In teaching you the occipital technic, we shall start at occipital area 1, show you the contact for this area and proceed to area 2. Remember that occipital area number 1 is the extreme lateral area and that area 7 is next to the external occipital protuberance.

Illustration 1 C
Shows contact position at head of metacarpus for occipital adjustive technic.



Illustrating Cut 21
Illustration shows manner of palpating occipital line. Note that index finger is used and middle finger supports index finger. Use a rotary movement covering one occipital area at a time and comparing each against the previous one for tenderness.

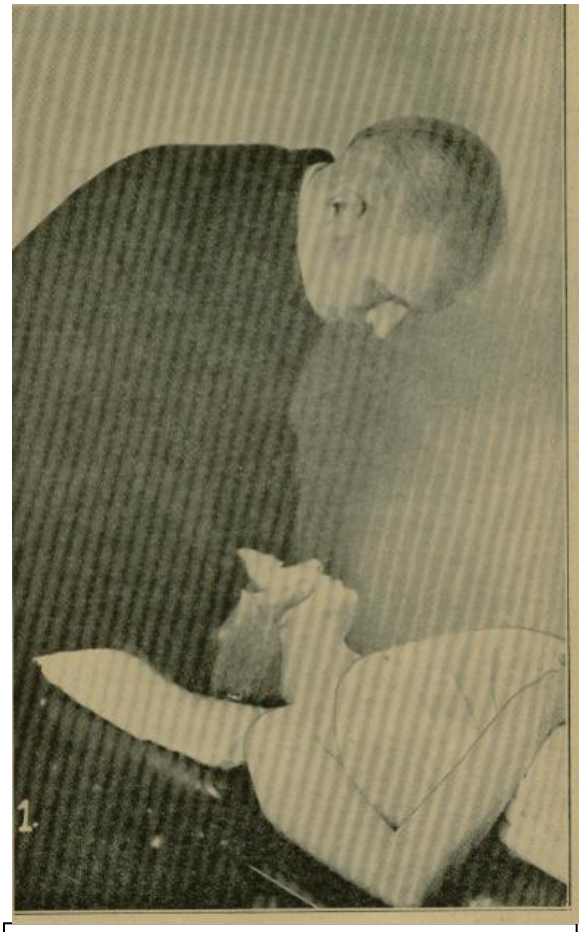


Illustration 1
Contact position of right hand for adjusting right occipital lesion. Left limb is short, patient's face always turned toward short limb. Note carefully position of operator's hand and body

ILLUSTRATION—PLATE 1

This shows the manner of placing the operator's right hand on the occipital ridge. Note that the patient's face is turned slightly to the left while contact is being taken with the right hand. The index finger is your contact finger and the hand is held in such a manner as to make a sideways contact with the index finger, as you will note in cut 1. The index finger circles the occipital line, the head of the metacarpus being placed upon the occipital area to be adjusted. Firm contact is made. You must no be lax in seeing that your contact is properly made and kept firm, for to do so means de feat and unnecessary discomfort to your patient. When this adjustment is properly made, it causes no discomfort whatsoever, in fact, it is one of the most pleasing adjustments that can be given for it produces immediate relaxation.

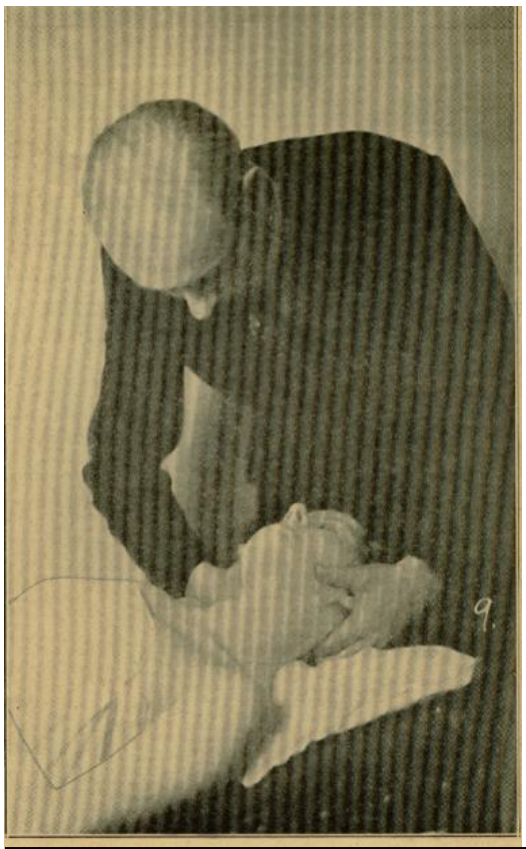


Illustration 9
Shows position of left hand in adjusting right occipital lesion. Note how fingers of rest of hand support index finger.

ILLUSTRATION—PLATE 9

This illustrates the manner in which the left hand contacts the occipital ridge. Bear in mind, please, that this is a continuation from plate 1, and is given to show you exactly how the left hand is used in adjusting a right sided occipital lesion. The index finger again is the anchor finger but it makes no specific area contact, rather it is used as a lever. The finger is hooked well under the occipital ridge and is used in the adjustment to pull the occiput and at the same time to make a block towards which the right hand can thrust. When the right hand thrusts, the occiput must be held so that it cannot turn or

allow the tension in the neck to defeat the adjustive idea. Note that in making occipital contact for both hands that operator stands at head of table. Keep this point in mind, for it serves a purpose. At no time make undue pressure, and do not make any false moves. So many people have been hurt by having neck adjustments that they are scared stiff to begin with and if you make a lot of unnecessary moves, you will cause the patient to tension up and an adjustment will be impossible. As soon as you make your contact, if you make it as instructed, the patient will relax, for the steady pressure you are making on the occiput feels very soothing to every patient.

The patient under discussion has a short left limb, the right side of the occiput will be considered lesioned in this series of illustrations.

The face is always turned towards the short limb. The lesion is occipital ridge opposite the short limb in every instance, but in 10 percent of your patients this will seem contradictory, due to the straight path to brain centers and lack of pyramidal dessucation of ten percent of nerve fibers.

ADJUSTING OCCIPITAL AREA NUMBER 1

ILLUSTRATING PLATE NUMBER 2

Lesion is on right occipital ridge, area 1, left limb is short, patient's face is turned towards left side of body, operator is at head of table, metacarpus of right index finger is placed against right occipital ridge area 1, left hand uses index finger to circle occipital ridge, hooked well under ridge, balance of fingers on left hand support index finger. Operator's right hand is now turned so that the side of the hand is a fixed wedge against the occiput. Operator drops his right shoulder slightly, left shoulder raises slightly, patient's face is turned to left and chin points out and slightly up. Operator moves slightly to right of head of table and this movement describes a slight arc to right. Thrust is given through center of ear and directed a little below point of nose. As thrust is given, the left hand pulls slightly to right and right hand thrusts quickly in a line running straight through from ear to ear. As your thrust is made you will hear a decided click, this click being a combination of atlas and occipital movement. If your thrust and contacts have been correctly made, the limb will be perfectly normal, the pelvic bones will align normally, the malleolus will be in a direct line one to another, tension will be gone from the spine and the sphincters will relax. Breathing will become normal and heart action improve.

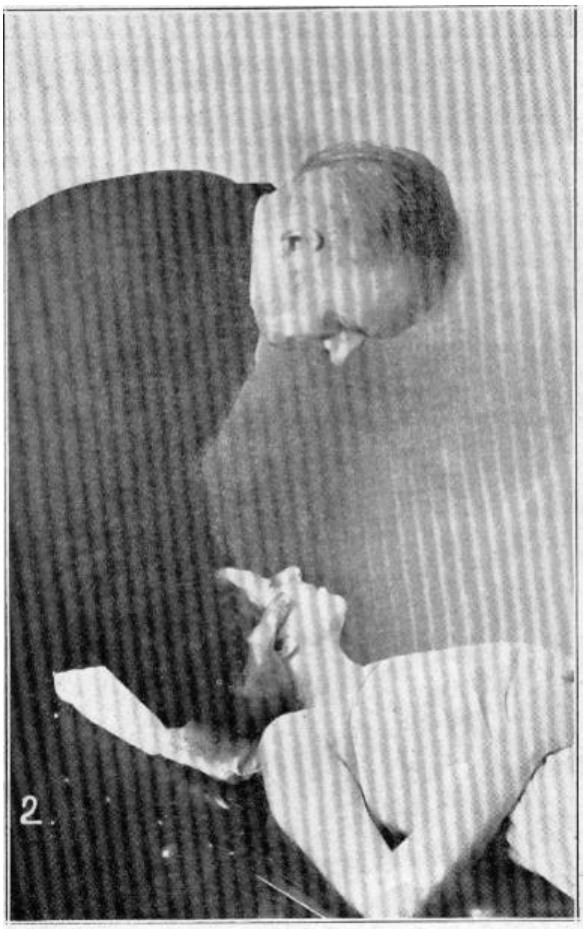


Illustration 2
Contact position for adjusting right occipital area 1. Note direction operator's thumb points and position of hand. This cut illustrates operator in position to deliver thrust onto occipital area 1.

We are trying to take you, step by step, in this adjustive work. This is the most important part of our technic, so please be patient and practice diligently.

Illustration 3
Contact and position for adjusting occipital lesion 2. Note position of operator's thumb, hand and body and position patient is assuming on table. This is important, as position of patient changes according to occipital area being adjusted.

ADJUSTING OCCIPITAL AREA NUMBER 2

ILLUSTRATING PLATE NUMBER 3

Patient same as for area 1. Left limb short, right occipital area number 2 is lesioned. Left hand uses same contact as for area 1, metacarpus of right index finger contacts occipital area 2. Operator's thumb of right hand points a little inferior to end of patient's nose. Right shoulder is dropped a little more than in area move 1. Position is slightly more right to head of adjusting table. Patient's face is turned more directly to left of body. Right hand is more inferior to one ear as cut will show. Elbow of right hand is a little farther from operator's body. Thrust is given in a line running through base of ear and directed as if an arc was to be made running slightly inferior to tip of nose. You will note that the patient's face is turned more to left in this move making impression of sternocleiodmastoid muscle show a more distinct outline on neck.

ADJUSTING OCCIPITAL AREA NUMBER 3

ILLUSTRATING PLATE NUMBER 4

Left limb is short, right occipital area 3 is lesioned. The face is turned more to the superior, showing patient's chin as pointing at more of a superior angle. Operator is farther to right of head of table, but notice that operator keeps close to patient, elbow points out at a more acute angle from contact point on occiput. Operator's hand is farther under occiput. Thumb points directly towards end of patient's nose. Back of patient's head rests more on table, while neck is slightly arched. Operator's right shoulder is lower than in previous cuts. Thrust is given directly through arc running through end of patient's nose and as thrust is given chin will describe a more superior arc.

Illustration 4
Contact position for thrusting occipital area 3. Note how operator has moved to right corner of adjusting table.

ADJUSTING OCCIPITAL AREA NUMBER 4

ILLUSTRATING CUT NUMBER 5.

Left limb short, right occipital area 4 is lesioned. Operator moves slightly from head of table and is more to right of patient. Body leans slightly to right. Operator's right hand is above clavicular groove and when adjustment is given arc will be slightly inferior to end of patient's nose. Patient's face is turned well to right, but not as far superior as in cut 4. Operator's hand is directed in a line that will describe an arc when adjustment is given that will be slightly inferior to end of patient's nose. As thrust is given left hand drops, but does not relax tension on patient's left occipital ridge.

Never make unnecessary moves. Many operators have, the bad habit of making a lot of false moves, intended to deceive the patient, but which only causes the patient to tension all muscles. Tell the patient what you are going to do. Never try to deceive your patient. You make your contacts, place the head in correct position, which will take all tension from neck muscles, move your hands into the proper arc, stop when you have reached a point of slight resistance, then give your thrust.

You will please note that we always have the patient fold their hands over the abdomen. This prevents them using the hands to hold onto the table and encourages the patient to relax. If a patient has hold of any part of the table, they will invariably tension up.

Once the patient feels how comfortably the adjustment is made, they will never offer resistance. If your arc is correct, your contacts correct, your adjustment will be automatic. Remember, when the thrust is actually made, your hands move less than a quarter of an inch. Isn't that better than using force and then moving your hands several inches? If the patient feels their head going through space at a mile a minute speed, they are going to try and do something about it.

Become an artist at adjusting the occipital ridge and you have an accomplishment that is invaluable. The writer has given over 75,000 occipital adjustments, and finds that the art is more perfect after every adjustment. Once, you acquire the technic, it will be as subconsciously given as your efforts are used in driving your automobile.

Illustration 5

ADJUSTING OCCIPITAL AREA NUMBER 5

ILLUSTRATING CUT NUMBER 6.

Left limb short, right occipital area 5 lesioned. Operator's right shoulder is dropped slightly lower in this position. Right hand is closer to patient's shoulder region, patient's chin is describing quite an acute superior arc, chin is well extended. Operator is at right side of table, left shoulder is raised. Thrust is given by dropping left shoulder slightly, and thrusting directly through a plane inferior to the end of patient's nose.

Illustration 6
Contact position for adjusting right occipital area 5. Note how much nearer patient is to right side of table and acute angle of neck with chin.

ADJUSTING OCCIPITAL AREA NUMBER 6

ILLUSTRATING CUT NUMBER 7

Metacarpus of right index finger is further under patient's neck. Operator is standing to right of head of table and slightly inferior to head of table. Patient's chin is dropped nearer to left side of table, but is well extended. Operator's thumb points toward patient's right eye. Patient's head is pulled well back towards operator's abdomen. Thrust is made in a plane through patient's right eye. Note position of patient's right elbow as it appears in cut, which is well below head piece of adjusting table. As patient's face is placed at a left acute angle, this pulls the right shoulder lower on the adjusting table.

Illustration 7
Contact position for adjusting right occipital area 6. Note patient has been placed lower on table, patient's elbow is extending over lower half of head piece. Doctor is directly opposite right side of patient's head.

ADJUSTING OCCIPITAL AREA NUMBER 7

ILLUSTRATING CUT NUMBER 8

Metacarpus of right index finger is placed next to external occipital protuberance, but slightly inferior to external occipital protuberance. Occipital line does not run directly through external occipital protuberance, but about one-half inch inferior.

Operator is directly to the right of adjusting table. Right knee is bent to allow operator's body to be in a lower adjustive plane. Patient's head is drawn well to right, chin making an acute right angle to patient's body, Operator's thumb points to patient's nose. Operator's left hand is considerably above plane of right contact hand. Patient's right elbow is more inferior to head piece of table. Patient does not lay straight on table, but right shoulder is farther down on head piece than is left shoulder. Thrust is given to describe an arc through patient's nose.

Illustration 8
Contact position for adjusting right occipital area 7. Note that patient is place lower on table and that patient's head extends slightly over upper right half of table. Not e angle of neck bend with body bend. Note position of operator's right knee, which is slightly bent to allow right side of operator's body to drop.

RECAPITULATION OF

OCCIPITAL TECHNIC

You have seven occipital areas.

The measurement of the limbs determines the occipital lesion as to side of occiput.

A right short limb means a left sided occipital lesion and vice versa.

You have two methods of palpating the occipital line.

One method has the patient prone on table. Doctor explores the occipital line from area 1 to 7, center of occipital line is area seven, which is one-half inch inferior to external occipital protuberance. Tender areas are marked. Most acutely tender area is your major.

Second method of exploration is having patient supine on table. To explore right side of occiput, head is turned to left. To explore left side of occiput, head is turned to right.

After exploring occipital ridge, again measure limbs to be sure that correction has not been made with exploratory technic. At times the lesions will be corrected with the rotary pressure used in exploration and if the lesion has been corrected, the limbs will be of equal length.

In ten per cent of your patients the short limb will be on the same side of the occiput that your lesion appears. This is due to 10 percent of the fibers not passing through the pyramidal decussation tracts. In this instance you disregard the short limb and adjust same as it opposite limb was short. For left occiput lesion, reverse technic as given for right occiput lesion.

ILLUSTRATION.

You palpate the occipital ridge and you detect your major area at fifth right occipital ridge, in ninty percent of your cases, you will find the left limb short and in adjusting the patient's face wilt be turned to the left, but in 10 percent of your cases, the short limb will be on the same side as the occipital lesion. In this instance, the fifth right occipital area will show a short right limb, and if you do not consider the factors that we are trying to make plain to you, you will adjust from the wrong side of the occiput and will increase the shortness of the limb instead of decreasing the shortness of the limb. To prove this statement, take a patient with normal limbs, both same length. Adjust the right side of the occiput and in 90 percent

of your cases the left limb will become short. Take a case with a short right limb, adjust the right side of the occiput and the limb will be shortened.

After adjusting the lesioned occipital area, remeasure the limbs, and if your adjustment is correct, the limbs will be normal. If your adjustment is incorrect, the limbs will not be normalized. If your first at tempt fails, do not make another attempt at adjusting, but place your finger on the lesioned occipital area and use rotary massage pressure until the area relaxes, this will in many instances normalize the limb.

In severe cases it is permissible to adjust the occipital area twice daily, but in chronic cases we advise that adjustments be given three times weekly, and then only when the limbs show an uneven length. The limbs are a positive indicator of body imbalance. Results will appear after the first correction. Nature demands time in which to re build. Do not destroy what nature is building.

Do not hurry your technic. Take plenty of time. Be sure every thing is right before you give your thrust.

Practice each position many times. Do not be a Wise Guy and think you need no practice. The mere reading of technic does not make you a technician.

If I had but one place to adjust, I should choose the occiput, for every part of the body is connected to the occiput, but that does not mean that we must be empirical. By removing reflex irritations, we help greatly to normalize the occipital areas.

It will take approximately five minutes to use this technic, but do not let that lessen its ability for vast good therapeutic results.

PART V

SHALL WE USE ADJUNCTS?

How many times has this question troubled you?

A true physician is one who first considers his or her patients. The patient's right to get well in the least possible time should be constantly foremost in the doctor's mind. No doctor can say that he will not use a thing that is not consistent with his mental idea as to what he shall do. Every step in the progress of the healing arts has caused a conflict in every doctor's mind. To adopt something new or to reject it, has been and shall always be a problem. If science offers something new as a therapeutic help, should we not forget our own selfish dreams and concede that the patient shall be allowed all that is consistent with the laws that govern our practice?

Laws have been enacted upon the statute books of the different states attempting to define what constitutes the practice of each opathy. A Chiropractor shall not administer medicine nor practice surgery. That is the law and it must be obeyed. An Osteopath is more free to do just about as he or she pleases, but most Osteopaths still depend upon the hands to do a great part of their work. A medical doctor has the sky for his limit.

No law has yet been enacted telling anyone how much air they may breathe. No one has enacted a law governing the speed of light, nor have they defined light in its part in caring for the universe. Some states have attempted to define surgical electricity, but no state can define the common use of electricity. No state, to our knowledge, has said how much water one can drink or use to bathe with.

The things of the universe are man's to use for man's welfare, and if used for that purpose belong to all schools of healing. Let no man say to one who is competent—YOU CAN NOT USE THE THINGS OF NATURE TO HELP THE CHILDREN OF THIS UNIVERSE TO LIVE LONGER AND TO LIVE BETTER.

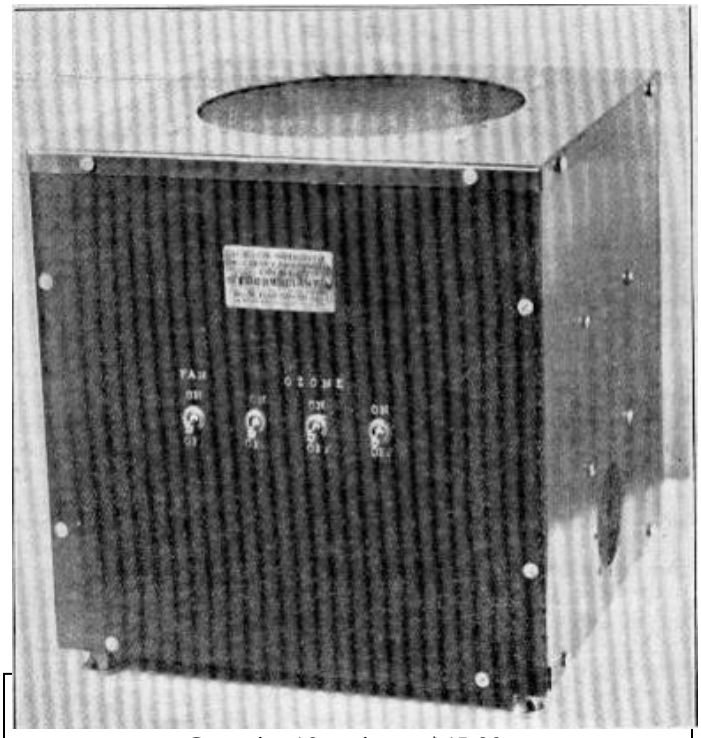
AIR

Air is probably the most important thing of life. Certainly it is the last thing you would desire to have a shortage of and yet most of you every day live in a shortage of pure air. A doctor goes to his or her office at 9 A. M., sees patients until lunch time. Works over these patients in a small room. Breathes the same air that the patient breathes. Comes back in the afternoon and does the same thing, and wonders why such a tiresome feeling takes place about 2 P. M.

Nature has given us something to purify every poisonous thing that exists. Nature has given us the lightning to purify the air, and how glorious the air smells and tastes after an electric storm. Nature has given us electricity and the wisdom of man has harnessed this electricity and by placing suitable apparatus in a box can, by its operation, purify the air in the same manner that Nature uses, a mild electrical storm, started by the snap of a switch and stopped in the same manner. After a few minutes of operation the air smells better, breathes easier because it is lighter and purer and in a very short time every one feels invigorated. This is OZONE. Ozone contains three parts of oxygen.

Just a few days ago, the writer was called in to see a girl of four years. The child had bronchial pneumonia and breathing was labored. Suitable manipulations quickly allayed the laborious breathing, but a cough the child had would not respond to therapy. In this condition it is natural to cough, so we presumed that the cough would be better the following day, but quite the contrary ruled. The cough was worse and continued to grow more irritating. The child couldn't sleep and in a condition such as this, sleep is necessary. I even stooped so low as to use ipecac and opia to give the child relief, but this failed utterly. When one gets up against a proposition like this, thinking becomes necessary. After analyzing the situation, I came to the conclusion that the child was starving for air. An Ozonator was placed beside the little patient and within five minutes the child was asleep. Results were so sudden that I drew the conclusion that a coincidence had happened, so the generator was stopped and within ten minutes the child started to cough, the generator was turned on again and left going for three days, and I can honestly state that the child did not cough five times in the three days. Did I do wrong to give this child rest? Should I have refused to use what science has given us, and have gambled with the child's life? You might think that an adjustment would have stopped the cough. It would have, could the adjustment changed the atmospheric condition in the room. It is the external things that we often find hard to combat. Not all causes lie within. Please remember that.

Many diseases are made worse by air hunger. Many coughs are air hunger coughs. Anemia is primarily a disease of air starvation, although in these conditions we must not feel that all we have to do is correct the atmospheric condition, for that is untrue. We must correct all maladjustments. Asthma, tuberculosis, bronchitis, and many kindred diseases are benefited by adjusting not only the spinal areas, but the things that the patient lives with, breathes in and eats.



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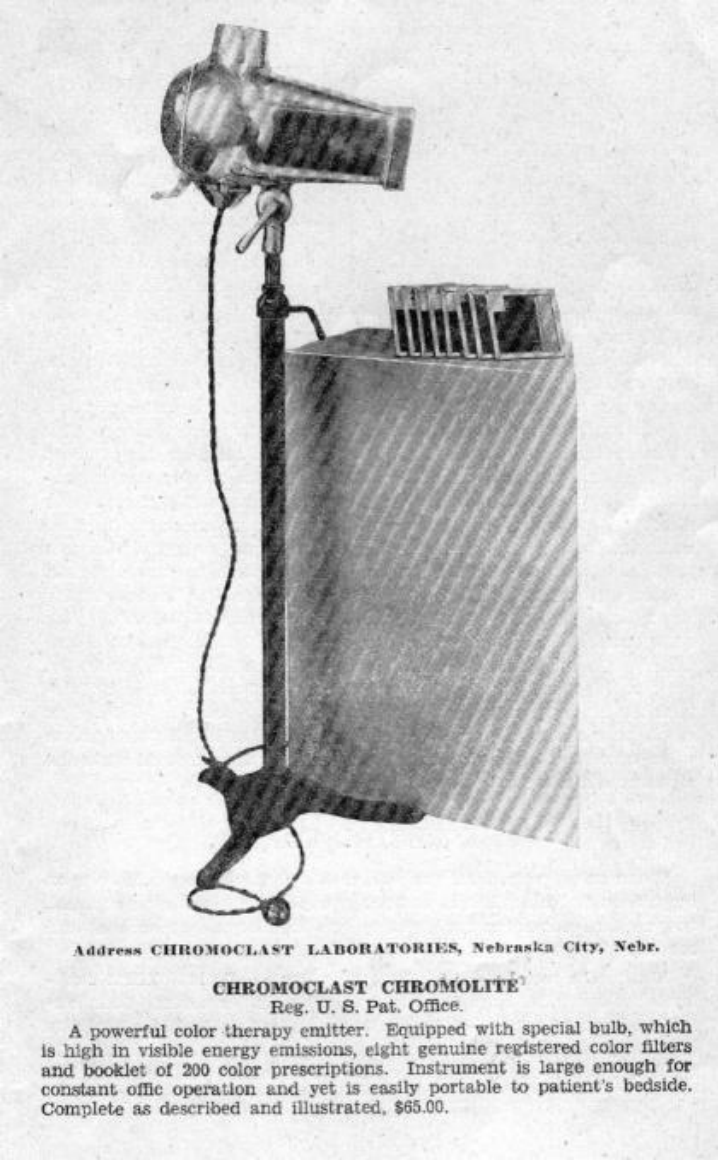
It is our desire in this brief outline to present to you a few of the phenomena of colors. Most of you recognize the influence colors have upon yourself and your patients, but I wonder how many of you ever do anything about this force. Do you wear clothing that is compatible to your color vibrations? Do you live in surroundings compatible with your color charts? Do you associate with people that vibrate on a compatible color plane with your color plane?

LIGHT AND COLORS

Another very important part of Nature's scheme for the preservation of life is LIGHT. I wonder if any of us really ever think of the dependence we have upon light. Every phenomena of Nature is governed by vibrating forces, all vibratory forces are the effect of planetary lights. The light from the moon has a controlling factor upon the great bodies of water and should this force ever expand itself to unheard of bounds, the entire universe would be destroyed in a very short time. The sun controls the growth of crops, timber, grasses, human, and animal life.

The green foliage of a tree in the heat of summer is cooling to you, even though the temperature under the tree is no lower than outside its branches, yet the leaves have shut out so much of the red, and yellow rays, that you are made to feel as though the temperature had dropped several degrees. A blue room or a green room is cooler to you than a red or yellow room. A red or yellow room feels warmer in winter. If your color plane is on the cold side of the spectrum, you will feel cheered by bright colors, such as red or orange, but if your color plane is on the hot side of the spectrum, you will be irritated by red, orange or yellow colors. When you are mentally depressed, red will cheer you up; when you are excited, red will further excite you. When you are excited, blue will calm you.



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The glandular systems of man are very dependent upon correct color vibrations, and as is the glandular systems, so is man. The ovaries in women and the testicles in man respond when sluggish to a combination of blue and red. When over stimulated, a combination of blue and green will restore normalcy. The thyroid, when sluggish, responds to yellow and red. The pituitary responds to green. The adrenals respond to red and violet. The Isles of Langernham respond to yellow and red.

The heart, when irregular, responds as if by magic to red and violet,

When very feeble it responds to red and blue; when very fast, it responds to violet.

All Inflammations are materially helped by blue, as blue is very cooling. All dormant pathologies respond to red.

Again, the patient has a right to get well. The release of nerve energy is paramount and must be done before anything will offer permanent help, but when this release is accomplished, is it a therapeutic sin to help nature help the patient to get well faster and easier?

Shall you have a crown of glory atop your head, just because you have released nerve energy and then sat down and waited days, weeks and months for nature to struggle into her own rights? Would not that crown of glory be more appropriate had you restored free nerve flow, then gotten busy and helped nature remove other obstructions?

Supposing you had a very severe attack of appendicitis. Supposing this had gone on for hours or a few days before nerve pressure was released. Your appendix would be badly inflamed, the peritoneum possibly would be affected. Your pain would be intense. Should your doctor sit by your bed and wait? Would he not be a greater man if he would do something to help nature remove the inflammatory processes and restore you to health? Which one would you want as your physician?

Supposing your heart muscle, through some inflammatory process, had been affected and could no longer do its proper work. A nerve is in trouble, your doctor releases the nerve, but the inflammatory process is so great that reflex irritation does not allow free nerve flow. You are adjusted time after time, you should feel better, but possibly you do not. Then, supposing your doctor uses a blue color to your chest wail, the inflammation is cooled, heart energy is conserved, irritation is lessened, you feel much better. Then when the inflammation is gone, your doctor uses red and violet color to the chest wall to regulate the speed of the heart. Your circulation is normalized, respiration is even, health is again yours. Would you rather wait for nature to do it all, or would you rather help nature?

The average case will not need anything other than the release of nerve flow, but it is the unusual case that makes your name known for miles around. Cure 100 average cases and your work is taken for granted; cure one unusual case and you are famous.

No one has the right to tell any doctor what he shall purchase to help the sick. Every doctor must weigh all arguments and then he alone must be the final judge. All high pressure salesmen should be executed by having their heads chopped off. When the writer was just a boy, he opened up his office for the rush of anticipated business. The business didn't rush, in fact it didn't even come for a matter of about five months. When a patient would come in, the anxiety was so pronounced that clear thinking was impossible, consequently the patients didn't get well as fast as they should. Then the salesmen got in their work and in a period of three years $16,000 hard earned dollars was sunk in equipment. Each instrument was supposed to cure a certain disease, but unfortunately we never could find the right instrument for the right disease. At this period of life your writer started to do some real personal thinking and out of those years of thought grew the Sacro Occipital technic as a system of adjusting, air purification by electricity, color therapy and rectal therapy. The Sacro Occipital technic liberated the impinged nerves, the air purification by electricity insured us clean, pure air, color therapy gave us a method of helping our patient when functional help was needed, and rectal therapy is used when the myeliene sympathetics are impinged.

THE RECTAL CANAL

When one considers the powerful effects that can be produced upon respiration and heart action by therapy applied within the rectal canal, no one can censure us for devoting this small space to such a vital subject.

Within the rectal walls we have very fine capillaries. These capillaries are controlled as to diameter by the Vasomotor nerves. Communicating from the ganglia of Impars in the rectum we have the Myeliene sheaths of the sympathetics going directly to the ganglia of Ribes in the brains. Can one then not see how rectal therapy does exert such a powerful effect upon circulation and respiration and is not this essential enough to make us consider ways and means of affecting these functions so as to be compatible with natural laws?

When a patient acts badly under an anesthetic, in fact, if respiration ceases, the assistant usually inserts as many fingers as possible into the rectum so as to produce as great a divilusion of tissues as possible. This stimulates heart action and has saved many hundreds of lives. This lowly act may seem rather out of step with the more scientific principles employed in our modern hospitals, but the fact remains that as a last resort, rectal dilation does do the work. If this is the case, why not use rectal work as a therapy?

It is a proven laboratory experiment that if a cold dilator is inserted into the rectum of a hypremic type patient, that the blood pressure will raise and the patient will feel invigorated. A warm dilator inserted into the rectum of an anemic type patient will lower the blood pressure and make the patient feel fully relaxed. Cold contracts by vasomotor stimulation. Heat dilates by vasomotor inhibition.

The rectal canal may not be constricted as far as the sphincters are concerned, yet the capillaries in the rectum may be in a very severe state of vasoconstriction, in which instance a warm dilator will give instant relief. A rectum may feel constricted and hardly admit the examining finger, §et the capillaries may be in a very bad state of dilation, in which instance the cold dilator will afford instant relief and you will note that the sphincters will relax and the examining finger will be easily admitted.

In all circulatory maladjustment (and what disease does not have a circulatory maladjustment) rectal therapy is certainly to be thought of and can only produce good results, if used correctly.

The old idea was to always stretch the rectal walls as far as they would go, which to say the least, was bad manners and produced in not a few instances irrevocably bad results.

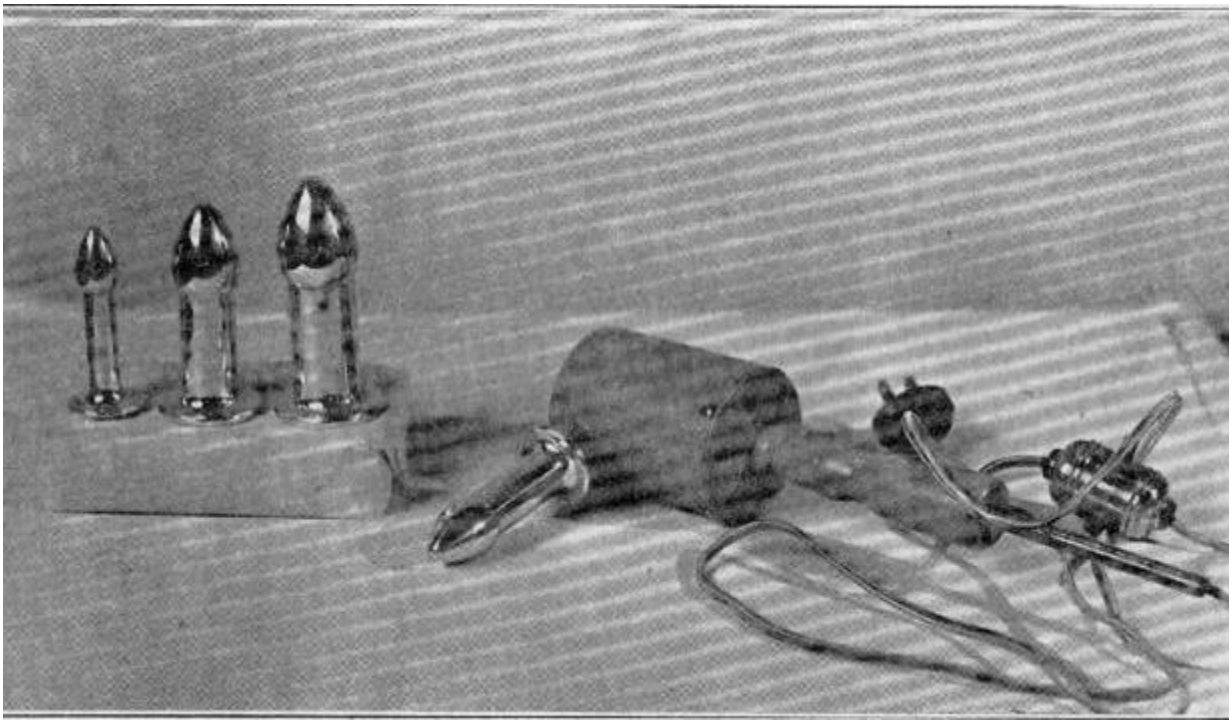
Your thought must not be to produce divulsion but constriction if the capillaries are dilated and dilation if the capillaries are constricted.

We have experimentally shown that cases of asthma could be materially helped by using a dilator at the indicated temperature and we proved that this procedure helped not solely by rectal stimulation, but by general vasomotor adjustment.

RECTAL VIBRATION

When a dilator is inserted into the rectum at the indicated temperature and then mild vibration produced, results are much faster. The dilation not only hastens the effects of the

dilator temperature, but stimulates the ganglia of Impars and this affects the ganglia of Ribes, and we then have increased cranial nerve function, causing all organs supplied by the cranial nerves to normalize themselves.



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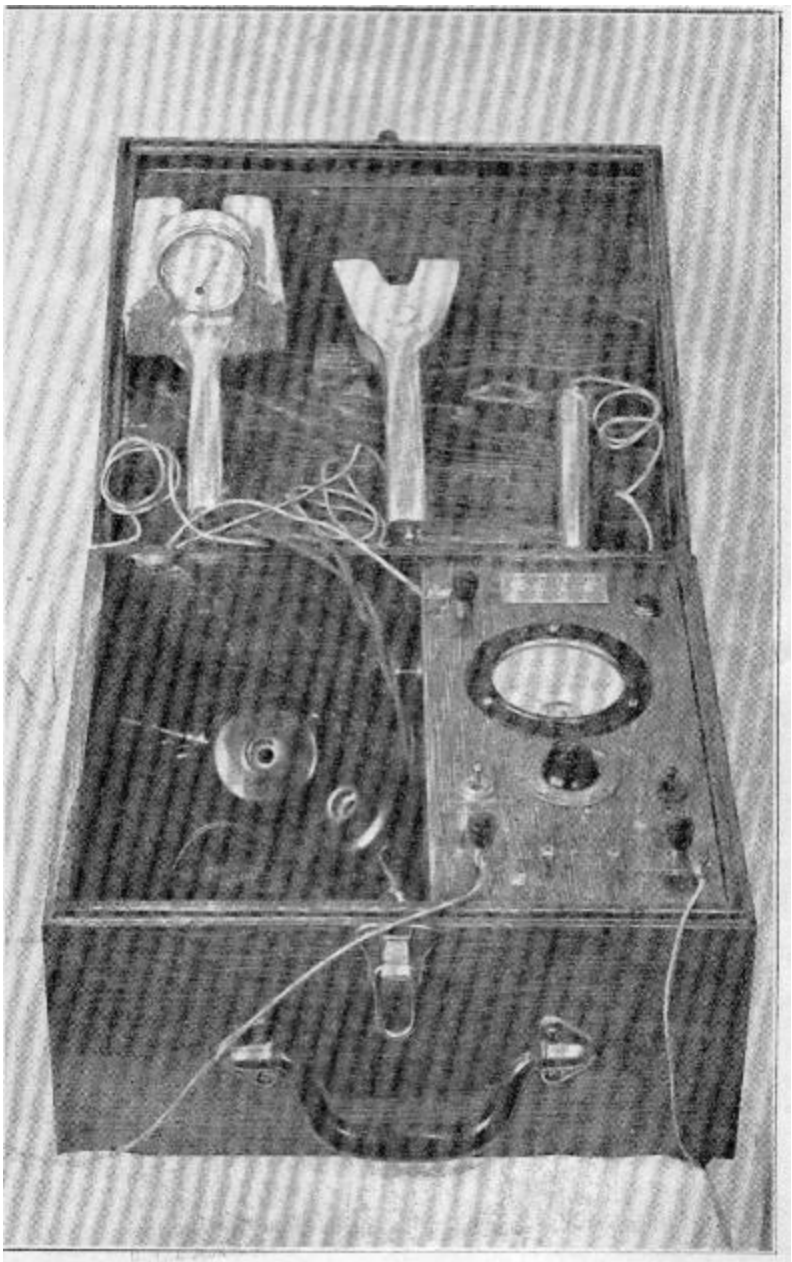

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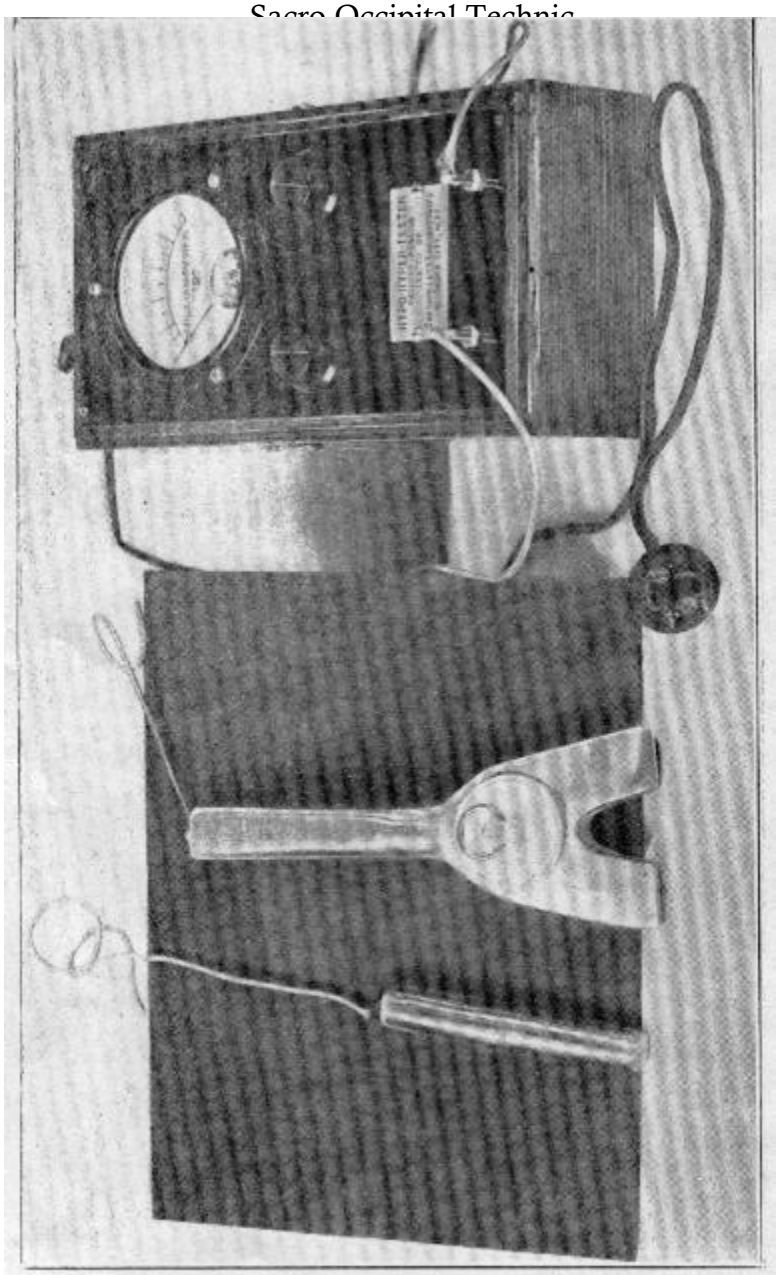

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