Fundamental Applied Kinesiology Course
Session 6

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Session 6

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Rectus Abdominis: (After Beardall)

Meridian:
- Small Intestine

Origin:
- From the crest of the pubis and the symphysis pubis

Insertion:
- Into the costal cartilage of the 5th to 7th ribs and the lateral border of the xiphoid process

Nerve Supply:
- Ventral rami of T5-12 and iliohypogastric and ilioinguinal

Neurolymphatic:
- Anterior: Upper ⅓ of the anterior medial thigh
- Posterior: Between PSIS and L5 spinous process

Neurovascular:
- Bilateral on the posterior parietal eminence

Action:
- In standing, supports organs anteriorly and holds the ribs and pubis together. Supports the lumbar spine anteriorly with the aid of the gluteus max and hamstrings. Keeps the pelvis from tipping anteriorly.
  - The rectus abdominis is separated into three divisions. These three divisions are divided by inscriptions and have nerve supplies from different levels. Also, it appears that these divisions can act independently.

Testing Position:
- Patient seated with arms crossed, making sure not to TL the Chapman reflex for the upper trapezius with the torso at 90° to the table. The contact is made on the side being tested.
  - During the testing of all seated abdominal muscles, fixation of the hip is required

Stabilization:
- The thighs against the table

Test:
- Must make sure that the hips are fixated to the table. Also, observation must be made to look for separation of the xiphoid and pubis. The gross position may remain the same due to the action of the psoas but the ribcage and pubic bones may separate.

Body language of weakness:
- Testing position: The patient can’t hold the testing position or will change or shift the position of their hips
- Movement aberrations: The patient, when weak, will turn their body to recruit other muscles as they stand up from a lying position

Considerations:
- This is one of the most important muscles to consider for low back pain due to its anterior support of the pelvis and increasing the lumbar lordosis and jamming the facets
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- Will be involved in chronic problems with the small intestine such as Crohn’s disease. Typically the Chapman reflex will usually be involved and must be treated thoroughly. Also, consider increased water and retrograde lymphatic technique. Don’t forget the correlation of a weak rectus to a sagittal suture fault.

**Nutrition:**
- Vitamin E, Duodenal Nucleoprotein extract or concentrate.

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**Individual section of the Rectus abdominus**

**Rectus Abdominis 1st Division (Inferior)**
**Origin:** Symphysis pubis and crest of the pubis
**Insertion:** Tendon between the first and second divisions
**Patient position:** Seated with trunk flexed to 90° with 23° rotation of the trunk away from the side being tested. The arms crossed and the lumbars flexed to take out the lumbar lordosis.
**Stabilization:** Ipsilateral thigh
**Test:** Pressure applied to the ipsilateral shoulder

Notes:______________________________________________________________________
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**Rectus Abdominis 2nd Division (Inferior Middle)**
**Origin:** Tendon between the second and first divisions
**Insertion:** Tendon between the second and third divisions
**Patient Position:** Seated with trunk flexed to 90° with 23° rotation of the trunk away from the side being tested. The arms crossed and the lumbars extended to increase the lumbar lordosis.
**Stabilization:** Ipsilateral thigh
**Test:** Pressure applied to the ipsilateral shoulder

Notes:______________________________________________________________________
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**Rectus Abdominis 3rd Division (Superior Middle)**
**Origin:** Tendon between the second and third divisions
**Insertion:** Tendon between the third and forth divisions
**Testing Position:** Seated with trunk flexed to 70° with 23° rotation of the trunk away from the side being tested and the arms crossed
**Stabilization:** Ipsilateral thigh
**Test:** Pressure applied to the ipsilateral shoulder

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Rectus Abdominis 4th Division Medial

**Origin:** Medial half of the tendon between the 3rd and 4th divisions  
**Insertion:** Costal cartilage of the 5th rib and xiphoid process  
**Patient Position:** Seated with trunk flexed to 45° with 23° rotation of the trunk away from the side being tested and the arms crossed  
**Stabilization:** Ipsilateral thigh  
**Test:** Pressure applied to the ipsilateral shoulder  

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Rectus Abdominis 4th Division Lateral

**Origin:** Lateral half of the tendon between the 3rd and 4th divisions  
**Insertion:** Costal cartilage of the 6th and 7th ribs  
**Patient Position:** Seated with trunk flexed to 45° with 45° rotation of the trunk away from the side being tested and the arms crossed  
**Stabilization:** Ipsilateral thigh  
**Test:** Pressure applied to the ipsilateral shoulder  

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Pyramidalis

**Origin:** Anterior aspect of the pubis and symphysis  
**Insertion:** Linea alba midway between the umbilicus and the pubis  
**Action:** Tense the linea alba and compress the abdominal contents  
**Patient Position:** Seated with trunk flexed to 110° with 45° rotation of the trunk away from the side being tested and the arms crossed  
**Stabilization:** Ipsilateral thigh  
**Test:** Pressure applied to the ipsilateral shoulder  
**Nerve Supply:** Subcostal T12  

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Transverse Abdominal

**Origin:** Lateral 1/3 of the inguinal ligament, anterior 3/4 of the internal edge of the iliac crest, lumbodorsal fascia and the lower 6 costal cartilages  
**Insertion:** Linea alba  
**Action:** Constricts abdominal contents, assists in forced expiration  
**Test:** Seated with trunk flexed to 90° and full rotation of the trunk. The patient will be asked to not allow the doctor to de-rotate the trunk.  
**Stabilization:** At the knee with the doctor’s thigh  
**Nerve Supply:** 7th - 12th intercostal and iliohypogastric and ilioinguinal nerves  

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Oblique Abdominal General

Meridian: Small intestine
Organ: Small intestine
Neurolymphatic:
  Anterior: Upper ½ of the anteromedial thigh
  Posterior: Between PSIS and L5 SP
Neurovascular: Bilateral on the parietal eminence
Nutrition: Vitamin E, duodenal concentrate or extract (See GI notes)
Nerve: 8th to 12th intercostal and iliohypogastric and ilioinguinal nerves

Notes:

Internal Oblique Anterior Division

Origin: Lateral ⅔ of the inguinal ligament and from the anterior ⅓ of the middle lip of the iliac crest
Insertion: Crest of the pubis and linea alba
Action: Unilaterally, rotates the opposite shoulder to the opposite hip, the same as the anterior division of the external oblique on the opposite side. Bilaterally flexes the spine.
Patient Position: Seated with trunk flexed to 90° with 45° rotation of the trunk toward the side being tested with the arms crossed
Stabilization: Thighs against the table
Test: Pressure is applied to the shoulder area on the opposite side
  • Allows for internal rotation of the PSIS, may be weak with a Cat II or I
  • When standing the muscle has constant EMG activity to protect the inguinal region
Notes:

Internal Oblique Lateral Division

Origin: Middle ⅓ of the iliac crest
Insertion: Inferior boarders of the 10th, 11th and 12th ribs
Action: Unilaterally, approximates the pelvis and thoracic cage. Bilaterally, flexes the trunk on the pelvis.
Patient Position: Seated with trunk flexed to 100° with 45° rotation of the trunk away from the side being tested with the arms crossed
Stabilization: Ipsilateral thigh
Test: Pressure applied to the ipsilateral shoulder on the lateral side of the body. Attempting to separate the thoracic cage and pelvis.
  • Cat II or I
  • Interior rotation of the PSIS
Notes:
External Oblique - Anterior Division
Origin: External inferior surface of the 5\textsuperscript{th}-8\textsuperscript{th} ribs
Insertion: Linea alba
Action: Unilaterally rotates anteriorly and flexes laterally and is synergistically helped by the opposite internal oblique. Bilaterally flexes the trunk.
Patient Position: Seated with trunk flexed to 90° with 45° rotation of the trunk away from the side being tested and the arms crossed
Stabilization: Ipsilateral thigh
Test: Pressure applied to the ipsilateral shoulder, attempting to de-rotate the spine and separate the pubis and ribcage
  - Anterior support of the pelvis, pendulous abdomen
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External Oblique - Lateral Division
Origin: Lateral inferior surfaces of the 9\textsuperscript{th} to 12\textsuperscript{th} ribs
Insertion: Anterior half of the iliac crest
Action: Unilaterally, along with the internal fibers of the internal oblique on the same side, laterally flexes the vertebral column. Bilaterally, flexes the spine.
Patient Position: The patient is supine, laterally flex the trunk to the side being tested approximating the iliac crest and rib cage 10° from center and the legs lifted 10° off of the table
Stabilization: Patient must hold the table and the doctor must stabilize at the greater trochanter
Test: Arm under the legs gripping the lateral ankle pulling lateral to medial bringing the legs back to midline
  - Gives support to the lateral flaring of the ilium. AS subluxation, Cat I
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TMJ Review

Neurologic Tooth

Indications / Testing:

- Strong muscle weakens with biting (no therapy localization)
- Weakness showing after trauma to the mouth or jaw or after any dental work
- Chronically weak muscle, see chart of tooth muscle correlations

Procedure:

1. Find a strong indicator muscle, have the patient lightly contact their teeth together
2. If the strong indicator weakens this is an indication that this technique is needed
   - Have the patient TL the tooth gum line 5-7 teeth at a time using the strong indicator muscle
   - The TL that weakens the strong indicator is the tooth or one of the teeth that needs therapy
3. Once the tooth has been located, gently challenge the tooth lingually and buccally
4. Go in the challenge direction on the phase of respiration that negated the challenge

Nutrition:

- If neurologic tooth returns, check patient’s zinc status

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Strong muscle weakens with opening (no therapy localization)

Procedure:

- Fascial flush to the jaw closing muscles:
  - TL masseters. If weakness is negated, localize the side then fascial flush that muscle
  - TL anterior, medial and posterior temporalis. If weakness is negated fascial flush division of temporalis. Could be multiple divisions.
  - TL internal pterygoid. If weakens, fascial flush.
- Remember that fascial flush technique is ironing out the muscle towards the heart

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Strong muscles weakens with TMJ therapy localization.

Jaw Neutral with TL
- Therapy localize TMJ without opening or closing (jaw in neutral)
  - Positive TL in neutral indicates TMJ “disc pathology”
  - What you really should check is Small Intestine due to SI 19

Biting Down With TL
- Positive TL to TMJ while biting is a need to spindle cell down closing muscles
  - TL masseter, temporalis, internal pterygoid while biting. Positive TL (weak muscle) indicates need for spindle cell treatment.
    - TL masseters with closed jaw. If weak, spindle cell down.
    - TL anterior, medial and posterior temporalis with closed jaw. If weak, spindle cell down.
    - TL internal pterygoids with closed jaw. If weak, spindle cell down (have to stimulate spindle cells like a fascial flush).

Jaw opening with TL
- Spindle cell down external pterygoid (Mandible deviates away from tight pterygoid)

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TMJ Deviation with TL:
- **Strong muscle weakens with mandible deviated to right**
  - Right temporalis, left internal pterygoid
- **Strong muscle weakens with mandible deviated to left**
  - Left posterior temporalis, right internal pterygoid
- **Strong muscle weakens with protruded mandible**
  - External pterygoid
- **Strong muscle weakens with retracted mandible:**
  - Posterior fibers of the temporalis or deep fibers of the masseter

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Holographic Mandible Subluxation: See Session 4
This is the application of holographic or “bent bone” subluxation to the mandible. This is due to chronic long term muscle imbalances of the TMJ. The muscle imbalances need to be corrected before you employ this technique.

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Aerobic/Aerobic Muscle testing of the TMJ
As we have learned, muscles can weaken to aerobic and anaerobic types of muscle testing. The application of this into the TMJ is a relatively easy but profound procedure.

- **Aerobic deficiency**: If a strong indicator weakens to the patient moving their jaw at an aerobic pace without touching their teeth. This is an indication of an iron deficiency. Remember to check stomach on all mineral deficiencies.

- **Anaerobic deficiency**: If a strong indicator muscle weakens to the jaw moving faster than one cycle per second. This is indicative of an anaerobic deficiency in the TMJ muscles and a need for supplementation of B5 (pantothenic acid).

- **Aerobic and Anaerobic both weaken**: This can be indicative of a need for EFA’s

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Miscellaneous
- Based on the work of Dvorak & Dvorak from Switzerland
  - We can get the pain out of the pterygoid pocket by tapping T3-4 area of the spine at 1 cycle per second. Could take 30 seconds to several minutes. This simulates gait.
    - If you don’t have the gait fixed you never keep a TMJ Fixed
  - You may not be able to get all the clicking out of a jaw due to the stretching of the posterior ligaments that hold the disc posteriorly. In extreme cases, this will cause a locking of the jaw by not allowing the condyle to open properly.
- The TMJ muscles are on the stomach meridian
  - Think B12 intrinsic factor
  - Emotions

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Acupuncture Review

Normal (80%)

Diagnosis:
- Pulse Points:
  - Only one pulse point should TL to a strong indicator
  - More than one - occiput
  - None - dehydration, C1 or diaphragm
- Muscles
  - Test muscles related to the meridians on the weak pulse point
- Alarm Points
  - The weak muscle should TL to its associated alarm point

Treatment:
- Nutrition:
  - Physiologically related to the organ system and related to the muscle that is inhibited
- Adjust:
  - At the associated point on the bladder meridian that is related the deficient meridian
- Tonify:
  - Tap the tonification point on the deficient meridian

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24 Hour Clock (15%)

Diagnosis:
- Pulse Point:  Only one should TL
- Muscles:  One should be weak
- Alarm Point: The muscle’s alarm point will not strengthen its own muscle
  - Back up on the clock until you find an alarm point that strengthens the weak muscle from the pulse point

Treatment:
- The alarm point that strengthens the weak muscle is considered the excess
- The meridian that is immediately after the excess on the 24 hour clock is considered the 1st deficient meridian
- Treatment:
  - Give nutrition and adjust on the excess
  - Use the Luo point on the first deficient meridian to pull the chi forward on the clock

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5 Element (5%)

Diagnosis:
- Pulse Points: Only one should TL
- Muscles: No muscles will be week

Treatment:
- Sheng:
  - Go forward on the Sheng cycle one element point and test muscles
  - If one muscle is weak on the next element, we treat the element point (that was determined by the pulse point) on the weak muscle’s meridian

- Ko:
  - If no muscles were weak by going forward on the Sheng then we must go backward on the Ko
  - Test the muscles that are related to the element that is backwards on the Ko cycle
  - Treat the element point (determined by the pulse point) on the weak muscle’s meridian

Notes:
Then and Now Technique

Discussion:
• In Chinese Medicine, there is the flow of energy through the 24 hour cycle of the day
  • Each of the twelve basic meridians has its own two hour time window that it is most active
• Using this principal, Dr. Goodheart discovered a simple procedure to diagnose problems that occur at specific times of the day. This is especially useful when it may not be convenient to check that patient when the symptoms occur.
  • An example would be a problem occurring at 3 in the morning. It would be very impractical for the doctor to treat the patient then.

Procedure:
• Test any strong indicator
• TL the alarm point of the time that the symptoms occur
  • This is the Then time and should not positively TL
• TL the alarm point of the current time according to the 24 hour clock
  • This also should not TL
• Then TL both points at the same time. If this weakens the strong indicator THEN and NOW technique is indicated.

Treatment:
• The treatment is using the Luo point that negates the weakening of the simultaneous TL
• Since both of the patients hands will be used for the TL of the Then and Now alarm points, the doctor will have to tap the Luo points working backward until you find one that negates the weakening of the TL
  • A good guide line is to back up on the clock from the THEN time
• As with the 24 hour clock problems we have previously discussed, we will tap the Luo point that negates the weakness. This is the FIRST deficient meridian, so we will have to back up on the clock to determine where the excess chi is and support the body nutritionally there.

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Myo-Fascial Gelosis
In 1998 Goodheart was studying fascia and the work of Dr. Robert Fulford. He came to realize the importance of fascia. Fascia is a connective tissue that is derived from the mesoderm embryologically. It is composed of an elasto-collagenous complex. The elastic component is stretchable and forms the core of the complex and the collagen fibers are palpable and very tough. This matrix creates a web from the top of the head to the tip of the toes and surrounds every organ, muscle, bone, nerve and blood vessel down to the cellular level. Functionally, the fascia helps support and protect every structure. The fascia also has a propensity to “store” trauma and will organize itself along these tension lines created from the trauma. Meyers talks in his book, Anatomy Trains about fascial planes and makes the statement that we are one muscle that is divided into 600+ divisions.

Diagnosis:
• Take any strong muscle and pinch across the muscle belly perpendicular to the muscle fibers
• If this causes weakening of the muscle then it indicates a fascial problem
  • The treatment will be percussive technique on that muscle at 1 Hz (1 Cycle/Sec)
  • You may use your hand or a percussor instrument
• This will have wide ranging and possibly surprising effects in the body

This is a rudimentary discussion of the technique that Dr. Goodheart was working on the last few years of his life. He lectured extensively on it the last few ICAK meetings that I was able to see him lecture. You can study the works of Meyers and delve more into the far reaching effects of unwinding the fascia.

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Body Into Distortion (BID)
• When the patient is lying, the doctor cannot reproduce posture related weakness
• Put patient into similar position while on exam table
• Retest muscle while patient holds copy of standing posture

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Idiopathic scoliosis
• 2-25% of the population
• Usually affects teenage girls
• Scoliosis is a dural torque problem
• Psoas and sacrospinalis problem
• Concavity of lumbar spine is on weak psoas side
• Measure patients height before and after treatment
• Can correlate x-ray findings to muscle testing
• Teenage patient think hormone balancing and switching

Scoliosis Treatment
• Usually a psoas muscle problem, but you will rarely find it weak on the concave side of the scoliosis
  • This psoas will normally show weak to aerobic muscle testing
  • Remember that K27 is involved in switching
• Also check sacrospinalis
• Check dural torque
• Switching (K27)
• Hyoid

• R/L brain testing
• Pulse points
• Upper gait
• Lower gait
• P.L.U.S.
• Feet
• TMJ
• EID, BID
• P.R.Y.T.
• Spondylogenic reflex
• Fixations/Limbic
• Categories III, II, I

Notes:
Feet
Screening:

Any articulation, in the body, should be able to withstand a mild to moderate stress without manifesting abnormal responses. This procedure can be used as a screening device to rule out any hidden subluxations within a joint. The “Shock Absorber Test” is a very quick and easy screening method for the feet or any other extremity for that matter. The procedure is simple and is generally a form of “challenge” to the joints of that extremity.

- For the foot, find any strong indicator. Psoas is usually considered the best/easiest for the foot.
- Challenge by tapping on the foot with the fist, then re-check the strong indicator. If it weakens, you more than likely have a foot subluxation.

Procedure:

- Test for a strong indicator muscle
- Shock the joint in question by striking one of the bones directly associated with the joint with a force of five to ten pounds
  - Note that any joint that the shock is transferred to must be considered

Muscle Bone correlations:

Anterior Tibia (distal):
- Muscle Correlation: Neck Flexors
- Set Up: Cup the calcaneus with your lateral hand while having the calcaneus on the table. With your medial hand slide the heel of up the foot until you contact the tibia just about the talus.
- Thrust: Straight P-A

Anterior (Superior) Talus:
- Muscle Correlation: Neck Flexors
- Set up: Thumbs go under the 1st and 5th metatarsals. Sliding down the tibia, contact the talus with the middle finger of the medial hand and back it up with the middle finger of the lateral hand. Make sure your elbows are close together.
- Thrust is a scooping motion of the wrist with a traction

Lateral Talus:
- Muscle Correlation: Psoas
- Set up: Cup the heel with the lateral hand, slide the 5th finger of the medial hand down the tibia until you reach the talus. Evert the foot with your palm. Elbows remain close together.
- Thrust is a traction S-I

Lateral Cuboid
- Muscle Correlation: TFL
- Set up: Standing lateral to the foot, grasp the foot with the medial hand placing the thumb over the cuboid by following the 5th MT down to the cuboid and putting your thumb right in the “saddle”. Grasp the heel with the lateral hand while backing up the thumb contact with the “heel” of you hand.
- Thrust is a traction with a lateral to medial thrust.
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Posterior Calcaneus
- Muscle Correlation: Gastrocnemius
- Set Up: Patient’s knee bent foot on the table, the Dr interlaces their fingers around the calcaneus and sits on the patient’s foot.
- Thrust: Thrust is directly P-A making sure there is NO I-S component!

Inferior Navicular
- Muscle Correlation: Posterior Tibialis
- Set Up: With lateral hand, reach around the foot and contact the navicular bone with your middle finger. Backing that up with your pisiform from your medial hand standing on the medial side of the foot.
- Thrust is a traction and I-S push with the pisiform and middle finger

Superior 1st Cuneiform
- Muscle Correlation: Anterior Tibialis
- Set up: Full dorsiflexion and eversion or the bone can’t move inferiorly. Follow the 1st MT up to find the 1st cuneiform. As with the superior talus, contact the 1st cuneiform with your middle finger of the medial hand backing it up with the middle finger of the lateral hand placing your thumbs at the distal base of the 1st metatarsal. Elbows are close together.
- Thrust is S-I making sure to keep full dorsiflexion and eversion of the foot

Superior 2nd Cuneiform
- Muscle Correlation: Pec Maj Clav
- Set up: Full dorsiflexion and eversion or the bone can’t move inferiorly. Follow the 2nd MT up to find the 2nd cuneiform. As with the superior talus, contact the 2nd cuneiform with your middle finger of the medial hand backing it up with the middle finger of the lateral hand placing your thumbs at the distal base of the 2nd metatarsal. Elbows are close together.
- Thrust is S-I making sure to keep full dorsiflexion and eversion of the foot

Superior 3rd Cuneiform
- Muscle Correlations: Supraspinatus
- Set up: Full dorsiflexion and eversion or the bone can’t move inferiorly. Follow the 3rd MT up to find the 3rd cuneiform. As with the superior talus, contact the 3rd cuneiform with your middle finger of the medial hand backing it up with the middle finger of the lateral hand placing your thumbs at the distal base of the 3rd metatarsal. Elbows are close together.
- Thrust is S-I making sure to keep full dorsiflexion and eversion of the foot

Rotated 5th Metatarsal
- Muscle Correlations: Peroneus Tertius/Brevis
- Set Up: Grab the entire 5th MT with one hand stabilizing with the other
- Thrust is to laterally rotate the 5th MT

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Knee

Due to the anatomy of the knee, it is one of the most vulnerable joints for severe injuries. The joint is anatomically a hinge joint and functionally a gliding joint with the femoral condyles rolling over the tibial plateaus. The patello-femoral joint is also a gliding joint. The posterior capsular ligaments prevent hyperextension. The lateral ligaments prevent lateral motion. The anterior support is provided by the quadriceps muscle which keeps constant tension on the ligaments of the patellae. The intra-synovial structures in the knee are the semilunar cartilages and the popliteus tendon. The cruciate ligaments and all other ligaments are extra-synovial. The lateral collateral ligament run from the fibula to the femur and is very ineffective at lateral support, thus leading to the fascia lata becoming thick and fibrous providing the most support for the lateral aspect of the knee. Remember that the glute max inserts into the the I.T band. The menisci are non-weight bearing structures, most of the weight bearing is between relatively small areas of the femoral condyle and tibial plateau.

Important for knee stabilization:

- Lateral Stabilization
  - Glut Med & Max
  - TFL
- Medial Stabilization
  - Adductors
- Posterior Stabilization
  - Hamstrings
  - Gastrocnemius
- Femur Stabilization
  - Piriformis
  - Psoas
- Tibial Stabilization
  - Proper foot function (good shoes)

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Knee Treatment-Muscle Correlations

- Posterior Tibia = Quads
- Lateral Tibia = TFL
- Laterally Rotated Tibia = Popliteus
- Posterior Fibula = Lateral hamstring
- Inferior Fibula = All peroneal muscles weak
- Medial Meniscus = Sartorius/Gracilis
- Lateral Meniscus = TFL
- Patella = Genuarticularis

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General Guideline for any Joint dysfunction in the body.

1. Joint Alignment
2. Nerve Supply
3. Muscles/Ligament
   1. Local
   2. Global
4. Holographic Subluxation
5. Skin
6. Emotions
7. Nutrition

For Arthritic and Stiff Knees
- Test the popliteus and a strong indicator
  - Check the gallbladder NL
- Have the patient do a deep knee bend
  - If either of the muscles weaken or the GB NL becomes active
  - Adjust T4 (on inspiration - expiration - inspiration)
  - Test the muscles, they should be strong
  - Re-stress the joint (have them do the deep knee bend)
  - If any of the muscles re-weaken adjust T4 again
  - Have them keep stressing the knee, ie walk up and down stairs

Acute knee injuries
- Test the patient in the position of injury
  - If they were a cyclist, test them seated. If an offensive lineman, test them in a squatted position.
  - See above Joint Flow Chart for what to treat

Chondromalacia Patella
- Is a roughening of the underside of the patella
- The test is to hold the patella down while the patient contracts the quads. If this is painful, it is positive.
- This is in reality an ICV problem
  - Fix what you find…

Knee bursitis
- Pain worse at night
- Synovial fluid becomes thick like toothpaste
- Body breaking down proteins from synovial membrane
  - Could result from a protein deficiency
    - Check the diet and stomach (Protefood- which is SP’s DL-Methionine)
  - In the case of any “itis” check the adrenals
  - With bursitis, you will find that the fluid in the bursa has just become to thick
    - Cal-amo, at the frequency of 1 every 15 until they yawn then 1 per hour
    - See bursitis below

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Meniscus

Diagnosis:
- History alone may give you the diagnosis if the patient tells you they have repeated episodes of their knee “locking”
- Tenderness will be found along the medial or lateral margins of the joint where the injury is
- With the knee partially flexed, lateral stress will usually cause pain. Rotatory motion at the knee will localize the area of injury.
  - To locate hidden meniscus problems, the knee should be fully flexed then hyperflexed. If there is a posterior tear of the meniscus there will be a definite click.

Etiology
- Defined as disruption to the integrity of the meniscus. Typically caused from twisting impact injury to the knee. May also be associated with repetitive abnormal stresses secondary to chronic ligament laxity or damage (especially MCL and ACL sprain). There may also be anatomically abnormal meniscal shape or attachments.
- Degenerative tears common in prolonged hyperflexion of knee
- Knee instability can cause secondary meniscal tears. Instability can be due to anterior cruciate ligament deficiency. 75% had associated medial meniscus, 60% had associated lateral meniscus 40%, both meniscus was torn.

Signs and Symptoms
- Usually related to mechanical dysfunction causing traction on the periphery of the meniscus, which may produce synovitis, swelling of synovial lining, mechanical blocking as seen in a bucket handle tear

Treatment
- Balance the muscular weakness around the joint
- Examine and correct any foot or ankle problems
- Correct pelvic imbalances
- Correct any subluxations of the femur or tibia
- Aerobic/Anaerobic function of leg muscles
- Ligament interlink
- Most importantly adjust the meniscus
  - With external rotation of the tibia for lateral meniscus
  - With internal rotation of the tibia for medial meniscus

Notes:
Patellofemoral Syndrome

- Is described as a diffuse ache in the anterior compartment of the knee. The pain is exacerbated by climbing stairs or standing from a sitting position. There is usually crepitis. They feel as though the knee will collapse. You may also observe diffuse swelling on the lateral or medial aspects of the knee.
- The patella will track medially when the patient is asked to bend their knee. Holding the patella laterally when the patient bends their knee will usually improve their pain.
- If you mark the middle of the patella and measure to the lateral edges of the knee there should be no more than 5mm difference side to side.
- If there is an imbalance it will usually indicate a weakness of the vastus medials inferior division.

Leaf says to treat the rib pump area at the 8th intercostal space, I say fix what you find.

Notes:
Iliotibial Band Friction Syndrome

- Is a tight TFL
  - What that really means is that the muscle on the other side of the joint or body is weak
  - Test adductors opposite TFL, fix what you find

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Popliteal Syndrome

- In the posterior knee, the popliteus and the soleus muscles form an arc through which the popliteal artery and vein and tibial nerve travel
- Entrapment of the nerve is rare, but the vasculature may become easily entrapped
- Intermittent claudication following activity may occur. They may complain of numbness, leg cramping or feeling cold.
- This is normally a result of overtraining
- The patient will usually report that they have swelling, edema or a general ache in the calf muscles especially after walking. This condition will look and sound like intermittent claudication.

Symptoms

- Suspect this condition
  - If the calf muscles appear to be hypertrophied
  - Localized trauma behind the knee
  - A Baker's cyst
  - Cases of hyperextension injuries of the knee where the popliteus has been injured

Common causes

- Anterior slippage of the talus is the initiating factor in this condition
- Common in people who wear elevated heels on their shoes or boots. Localized trauma should also be suspected.
- Chronic ICV
- Pain walking up stairs, check P.R.Y.T.
- Pain walking down hill, check retrograde.
- Check for toxicity
- Tight TFL = weak adductors

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Reactive Muscles
- Suspect in cases where muscle action causes pain or soreness
- Determine the prime mover of the action and test for strength
  - If weak correct the muscle
- Test a related synergist to the original muscle, and then quickly retest the original muscle
- If the reactive pattern is present, the original muscle will now test weak

Reactive Muscles-Treatment
- Treat the spindle cells (approximate) of the muscle that when tested caused the weakening of the original muscle. The spindle cells are stimulated as if to weaken the muscle.
- Imagine that the muscle is set too strong and therefore overpowers the second muscle creating the weakness
- Retest the muscle testing sequence to make sure that the muscle stays strong after treating the spindle cell

Reactive Muscles-Alternate Procedure
- Test the prime mover of the joint
- Therapy localize the synergistic muscles and check the prime mover for weakening
- If weakness occurs, spindle cell down the synergistic muscle that therapy localized and caused prime mover weakness

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Hip
Hip pain can be any combination of pelvic dysfunction. Make sure to balance and treat all aspects of the pelvis.

Anterior Femur head
If the femur head has become subluxated anteriorly, this may be described as pinpoint, sharp, knife like pain at the anterior portion of the femur. This pain usually occurs in gait or when arising from a seated position.

**Diagnosis:** Weakness of the reflected head of the rectus femoris

**Treatment:** The adjustment is accomplished by full flexion of the hip with external rotation and and slight deviation to the midline of the body

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Pelvic Muscles:
• Gluteus Maximus
• Gluteus Medius/ Minimus
• TFL
• Piriformis
• Abs
• Hamstrings
• Quads
• Adductors
• Pelvic Floor Muscles

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Adductor Pollicis

Origin:
• Capitate bone and the 2nd and 3rd metacarpal bones

Insertion:
• Ulnar side of the base of the proximal phalanx of the thumb

Action:
• Approximate the thumb to the palm of the hand

Stabilization:
• The hand

Test:
• Pressure applied to the thumb attempting to abduct the thumb

Nerve:
• Ulnar C8, T1

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Flexor Pollicis Brevis/Longus

Meridian/Organ:
• Stomach

Origin:
• Longus: Anterior surface of the radius and interosseous membrane and the medial epicondyle of the humerus
• Brevis: Flexor retinaculum, the trapezium, the trapezoid and capitate bones

Insertion:
• Longus: Palmar surface of the base of the distal phalanx of the humerus
• Brevis: Base of the proximal phalanx of the thumb

Action:
• Longus: Flexes the thumb at the distal phalanx
• Brevis: Flexes the proximal phalanx of the thumb

Patient Position:
• Longus: Flexed and stabilized interphalangeal joint
• Brevis: Flexion of the 1st MCP joint

Stabilization:
• Longus: The hand making sure the IP is fixed
• Brevis: Stabilize the hand

Test:
• Longus: Pressure against the tip of the distal phalanx on the palmar surface attempting to extend the joint

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Opponens pollicis

Origin:
- Arises from the flexor retinaculum and the tubercle of the trapezium

Insertion:
- Attaches along the entire length of the radial aspect of the first metacarpal bone

Nerve Supply:
- C6 & 7, Median nerve

Neurolymphatic Reflexes:
- Anterior: Located over the pubes at the lower margin of the symphysis
- Posterior: Located between the transverse process of L5 and the posterior superior iliac spine

Neurovascular Reflexes:
- Located over the frontal eminence

Action:
- Contraction causes abduction, flexion and rotation of the first metacarpal bone. This motion opposes the thumb towards the little finger.

Indications:
- Chronic weakness is evidenced by marked atrophy of the muscle

Symptoms:
- Weak grip, difficulty in writing, loss of strength in doing fine work with the thumb and fingers like buttoning clothes

Body Part Position:
- The thumb is held straight and the patient is asked to oppose the thumb and the little finger

Stabilization:
- The hand is supported

Vector of Force:
- Pressure is then applied to extend, adduct and laterally rotate the thumb pulling it away from the palm

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Opponens Digiti Minimi

Meridian:
- Small Intestine

Origin:
- Arises from the hook of the hamate bone and the flexor retinaculum

Insertion:
- Attaches into the length of the 5th metacarpal bone on the ulnar side

Nerve Supply:
- C8 & T1, Ulnar nerve

Neurolymphatic Reflexes:
- Anterior: Located over the pubes at the lower margin of the symphysis
- Posterior: Located between the transverse process of L5 and the posterior superior iliac spine

Neurovascular Reflexes:
- Located over the frontal eminence

Action:
- Causes opposition of the metacarpophalangeal joint of the little finger

Indications:
- Chronic weakness is evidenced by weakness of the grip, failure to cup the hand, pisiform-hamate syndrome

Body Part Position:
- The patient is asked to oppose thumb and the little finger. The thumb is then returned to a neutral relaxed position.

Stabilization:
- The hand is supported

Vector of Force:
- The patient is asked to hold the little finger in opposition while pressure is applied to press the finger as to flatten the hand

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Pronator Quadratus

Origin:
• Arises from the medial anterior surface of the distal ¼ of the ulna

Insertion:
• Attaches to the lateral anterior surface of the distal ¼ of the radius

Nerve supply:
• C7 & 8, T1, Median nerve

Neurolymphatic Reflexes:
• Anterior: Lie just below the nipple on the chest wall
• Posterior: Lie just inferior to the inferior angle of the scapula

Neurovascular Reflexes:
• Located over the mid area of the lambdoidal suture

Action:
• Causes pronation of the forearm. Aids in flexion of the forearm.

Indications:
• Chronic weakness is evidenced by the arm hanging in a state of supination.
• Carpal tunnel syndrome
• Median nerve entrapment
• Wrist instability

Body Part Position:
• The forearm is flexed 135°. The patient is asked to fully pronate the forearm.

Stabilization:
• The elbow is supported

Vector of Force:
• Pressure is applied to move the forearm into supination

Notes:
Pronator Teres

Origin:
- Humerus head: Just superior to the medial epicondyle and the intermuscular septa
- Ulnar head: Medial aspect of the coronoid process of the ulna

Insertion:
- Lateral and middle surface of the radius

Action:
- Causes pronation of the forearm. Aids in flexion of the forearm.

Neurolymphatic Reflexes:
- Anterior: Lie just below the nipple on the chest wall
- Posterior: Lie just inferior to the inferior angle of the scapula

Neurovascular Reflexes:
- Located over the mid area of the lambdoidal suture

Indications:
- Chronic weakness is evidenced by the arm hanging in a state of supination, pronator teres syndrome, median nerve entrapment, elbow instability

Body Part Position:
- The forearm is flexed 45°. The patient is asked to fully pronate the forearm.

Stabilization:
- The elbow is supported

Vector of Force:
- Pressure is applied to move the forearm into supination

Nerve supply:
- C6 & 7, Median nerve

Nerve Entrapment:
- May cause entrapment of the median nerve

Notes:
Supinator

Origin:
- Lateral epicondyle of the humerus, radial and annular collateral ligament, supinator crest of the ulna

Insertion:
- Lateral anterior surface of the proximal ⅓ of the radius

Nerve Supply:
- C5 & 6, Radial nerve

Neurolymphatic Reflexes:
- Anterior: Located in the 6th intercostal space from the mid-mammillary line to the sternum on the left
- Posterior: Lies in the intertransverse space between T6 & 7 on the left

Neurovascular Reflexes:
- Located over the frontal eminence

Action:
- Causes supination of the forearm

Indications:
- Supinator syndrome, entrapment of the radial nerve

Body Part Position:
- The forearm is flexed 90°, upper arm is held firmly against the chest wall with the forearm supinated

Stabilization:
- The elbow is supported

Vector of Force:
- Pressure is applied to move the forearm into pronation

Nutrition:
- Cataplex B, G, HCL products

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Wrist Strain

Falling on an outstretched hand can cause partial or full dislocations and possible fractures. Most often the patient will land on the hand in an extended position which will open the volar surface of the carpals. The force of the body is transmitted down the forearm into the lunate and causes strain or rupture of the ligaments supporting the lunate and cause a volar subluxation of the lunate. This may cause a disturbance in the median nerve. If the injury is severe enough, there may be accompanying subluxation of the pisiform and hamate resulting pressure one the ulnar nerve.

Remember back to session one and two when we were talking about shearing vs compaction injuries. Use that diagnostic tool with the muscle that you have just learned to treat these symptoms.

Notes:
Carpal Tunnel Syndrome

- Tunnel is formed by the flexor retinaculum crossing the volar surface of the carpal bones and the distal radius and ulna
- Transverse carpal ligament crosses from the hamate and pisiform to the scaphoid and trapezium

The tunnel contains:
- Tendons of the flexor digitorum profundus and superficialis
- Flexor pollicis longus
- Flexor carpi radialis
- Median nerve

Superficial to the tunnel
- Ulnar nerve and artery

Carpal Tunnel Symptoms

- Numbness/tingling in the palmar surface of the thumb and the radial two and ½ fingers
- Symptoms are worse at night
- Weak grip, fine motor coordination problems and clumsiness
- Thenar atrophy

Etiology

- Trauma
- Falling on hand
- Pushing or holding objects with wrist in extension
- Repetitive stress
- Computer mouse work
- Using hand tools
- B-6 deficiency

Additional Tests

- Phalen’s
- Reverse Phalen’s
- Tinel’s Sign
- Grip strength
- Test flexor digitorum profundus I & II. If weak - pronator teres syndrome

Differential Diagnosis

- Hidden cervical disc
- Peripheral nerve entrapment on torso
- Anterior scalene
- Costoclavicular syndrome
- Pectoralis minor syndrome
- Pronator teres syndrome
- Ileocecal valve syndrome

- Treatment
- Test/correct pronator quadratus
- Challenge carpal bones
- Manipulate carpal bones
- Approximate radius/ulna
- Support carpal bones
- Test for B6 deficiency
- Test for ligament nutritional support
B6 Deficiency
- Standard conservative care alone provides 14% improvement
- Addition of B6 at 100mg twice a day increased this to 68%
- Dose reduced to 50 - 100 mg/ day for maintenance - Kasden & James
- Pyridoxine must be converted to pyridoxal-5-phosphate - cofactors:
  - Magnesium
  - Zinc
  - Riboflavin
  - Phosphorus

Treatment Procedures
- Cervical manipulation - C6/7
- Travell treatment to supinator
- Balance wrist flexors/extensors
- Exercises for pronators
- Physical therapy for wrist

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Pisiform Hamate

Etiology:
Wrist Strain:
Partial or full dislocations and possible fractures can occur when a patient falls on the outstretched hand. These types of injuries are common and may produce avascular necrosis. Typically, landing on the hand in an extended position will open the volar surface of the carpals. This may disturb the median nerve. If the force is severe enough there will be subluxation of the pisiform and hamate resulting in disturbance of the ulnar nerve.

Symptoms:
Atrophy of the hypothenar eminence, weakness of the flexor digiti minimi

Correction:
Adjustment of lunate. Often times there is a disturbance of the ligaments and surgery may be needed

Elbow
The elbow consists of three articulations, between the radius and the humerus, the ulna and the humerus and between the ulna and the radius. The main functions of the elbow are flexion, extension, and rotation of the forearm. The integrity of the elbow is partially dependent on the ligaments and mostly on muscular stabilization.

Treatment:
• As with all joints
  1. Alignment
  2. Nerve supply
  3. Muscles
  4. Ligament
  5. Holographic subluxation
  6. Skin
  7. Emotions
  8. Nutrition

• Specifically to the elbow,
  • Check all muscles around the joint
  • TL and challenge for any subluxation
    • Supinator = Posterior radial head
    • Articularis cubiti = Medial olecranon

Many times you will find a weakness of the adductors and or abdominal obliques

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Biceps
Meridian:
  • Stomach
Origin:
  • Short head: Tip of the coracoid process of the scapula
  • Long Head: Supraglenoid tubercle of the scapula
Insertion:
  • Inserts into the radial tuberosity
Nerve Supply:
  • C5 & 6, Musculocutaneous nerve
Neurolymphatic Reflexes:
  • Anterior: Located in the 4th intercostal space starting three inches from the sternum
  • Posterior: Lies over the lamina of the axis
Neurovascular Reflexes:
  • Located over the frontal eminence
Action:
  • Flexes the elbow. Aids in forearm supination. The long head aids in holding the humeral head in the glenoid cavity.
Indications:
  • Weakness may be shown by the arm hanging excessively straight. Shortening of the triceps.
Body Part Position:
  • Short head: Bend the elbow to 80° and place the forearm in supination
    • Stabilization: The elbow is supported.
    • Vector of Force: Imagine a circle formed by the rotation forearm. Place your testing forearm at a tangent to this arc. Pressure is applied against the forearm at this angle.
  • Long head: Bend the elbow to 90° and place the forearm in supination
    • Stabilization: The shoulder is supported
    • Vector of Force: Imagine a circle formed by the rotation forearm. Place your testing forearm at a tangent to this arc. Pressure is applied against the forearm at this angle.
Nutrition:
  • Zypan, Betaine HCL, Zinc, Chlorophyll

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Brachioradialis

Meridian:
- Stomach

Origin:
- Upper ⅔ of the supracondylar ridge of the humerus and the lateral intermuscular septum

Insertion:
- Into the lateral side of the styloid process of the radius

Nerve Supply:
- C5 & 6, Radial nerve

Action:
- Flexes the elbow. Assists in pronation when this motion is resisted.

Indications:
- The arm hangs with the elbow in full extension. This muscle becomes involved when the extensor carpi radialis becomes involved.

Body Part Position:
- Bend the elbow to 80° and place the forearm in a neutral position between pronation and supination

Stabilization:
- The elbow is supported

Vector of Force:
- Imagine a circle formed by the rotation forearm. Place your testing forearm at a tangent to this arc. Pressure is applied against the forearm at this angle.

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Pronator Teres Syndrome

Etiology
This is an entrapment syndrome of the median nerve as it passes between the ulnar and radial heads of the pronator teres muscle. After the nerve passes the pronator teres, it divides and supplies the wrist flexors and hand EXCEPT for the flexor carpi ulnaris and the ulnar portion of the flexor digitorum profundus.

Symptoms:
The patient reports loss of strength throughout the hand, difficulty writing, paresthesia throughout the hand specifically in the palm

Test/Correction:
Muscle testing will reveal weakness of the finger flexors that resolves when the radius and the ulna are approximated just distal to the pronator teres

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Supinator Syndrome

• Entrapment of the Radial nerve as it travels beneath the supinator muscles
• This occurs most often with repeated throwing motions of the forearm, this may include, pronation, wrist flexion and forearm extension, resulting in hand weakness

Test:
• Test the extensor carpi ulnaris
• If found weak, the nerve is likely entrapped at or around the radial head and will need to be adjusted

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Ulnar Sulcus Syndrome
The ulnar nerve travels down the posterior surface of the forearm and passed through a sulcus on the medial epicondyle of the humerus. The epicondylo-olecranon ligament stabilizes the ulna and the humerus. It also stabilizes the ulnar nerve at the sulcus and prevents it from moving during motion of the forearm. If this ligament is hypertrophied or stretched an entrapment of the ulnar nerve may occur.

Below the ligament, the muscles innervated by the nerve supplies the flexor carpi ulnaris, the ulnar portion of the flexor digitorum profundus, the interossei and the hypothenar muscles, adductor pollicis and the deep head of the flexor pollicis brevis.

Symptoms:
Pain, paresthesia over the ulnar nerve distribution and weakness of the above muscles

Testing of the above muscles in flexion and extension may uncover this entrapment, adjustment and support of the ulna will be indicated.

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Shoulder

Anatomy

• Clavicle
  • Functions as a strut to prevent the shoulder from dropping anteriorly across the chest. It maintains a constant distance from the humerus to the midline of the chest.

• Scapula
  • Provides a broad movable base for muscular attachment. Glides across the muscles of the thorax and arm.

• Sternoclavicular Joint
  • This is the only bone to bone contact in the shoulder. The joint integrity is ligaments that bind the clavicle, 1\textsuperscript{st} rib and sternum together.

Shoulder motion

• A/C Joint
  • Plane joint, allows limited gliding and rotation between the clavicle and acromion
  • There is a disc in this joint

• Glenohumeral joint
  • Ball and socket joint
  • Muscular instead of bony socket which allows for much greater range of motion but decreased stability
  • The actual bony joint is a small, saucer shaped joint between the neck of the scapula and the head of the humerus. The glenoid joint serves as a small base for stabilization as the humeral head is so much larger than the glenoid surface. Ligaments only help prevent anterior displacement of the humerus.
  • Major support for the joint comes from the rotator cuff muscles
    • Teres minor
    • Infraspinatus
    • Supraspinatus
    • Subscapularis
  • Anterior support is provided by the subscapularis tendon
    • As with all joints, muscles act to hold the joint together during active/normal ranges of motion

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Ranges of motion
• Abduction
  • 0-60° is performed by the supraspinatus and the deltoid and is supported by the infraspinatus, subscapularis and teres minor
  • 60-120° scapular motion is accomplished by elevation of the clavicle by the upper trapezius and rotation of the scapula by the anterior serratus. Clavicle rotation is controlled by the subclavius. The antagonist of this action is the rhomboid and pectoralis minor.
  • Full abduction is allowed by the spinal motion and lateral curvature of the spine
• Flexion
  • The first stage of flexion is accomplished by the anterior deltoid, coracobrachialis, pectoralis clavicular and biceps
  • The next phase of flexion is performed at the shoulder girdle by the anterior serratus and upper trapezius
  • The final stage of flexion is allowed by motion of the spine
  • Lowering from 180-120° of flexion is done by straightening the spine
  • Lowering from 120-60° of flexion is done by the rhomboids, levator scapula, lower trapezius and pectoralis minor
  • Lowering from 60° is done by the teres major, latissimus dorsi and pectoralis major
• Extension
  • Accomplished by first raising the arm in the shoulder joint by the posterior deltoid, teres major, teres minor, latissimus dorsi
  • The second is abduction and rotation of the scapula by the lower trapezius and the rhomboids

Clavicle
Muscle attachments
• Sterno-cleido-mastiod
• Pectoralis major clavicular
• Subclavius
• Deltoid
• Upper trapezius
• Sterno-hyoid

Shoulder Treatment
Muscle
• Subclavius - Sternoclavicular
• Deltoid/Upper Trap - Acromioclavicular
• Serratus Ant - Inf. Scapula/Scaphoid
• Rot Cuff Muscles - Glenohumeral
• Subscapularis - Axillary lift
• Long Head Bicep - Slipped Bicipital Tendon
• Coracobrachialis - Acromioclavicular II
• All muscles weak - Dislocation
A/C Sprains

This injury is one of the most frequently overlooked injuries in the body. I find that almost all persons who are driving and involved in an accident have this injury due to the stress applied to the joint at impact. Any person who has fallen and caught themselves with their arm or anyone complaining of ache or pain in the upper trapezius would be considered a candidate for this injury. Classically, I find that the upper trapezius will exhibit trigger points as well as a decreased cervical rotation and lateral bending. The muscle weakness pattern will be, at minimal, a weakness of the posterior deltoid but may include all of the muscles of the rotator cuff. In severe injuries, the palpable pain in the trapezius will extend down the spine to the fibers of the middle and lower trapezius and weakness in the hand may be found due to a thoracic outlet syndrome created by the over contraction of the shoulder muscles as they compensate for the injury of the ligaments at the acromioclavicular joint.

Examination begins with observation of the normal motion of the shoulder. When the acromioclavicular joint is involved, there will usually be instability of the clavicle and/or of the scapula. This causes what is referred to as reversed glenohumeral rhythm. This is the elevation of the shoulder along with the humerus. Normally, the shoulder should stay in a horizontal position while the humerus is abducted. Elevation of the glenohumeral joint by contraction of the upper trapezius indicates a possible injury to the subclavius and/or the serratus anterior. These muscles are frequently found injured and respond to the strain counter-strain procedure.

Palpation of the patient will reveal trigger points in the upper trapezius that will be dramatically reduced when the acromioclavicular joint is approximated. There will usually be additional trigger points in the posterior deltoid and the infraspinatus muscles.

All muscles of the rotator cuff should be examined and tested if possible. The most common muscles found weak are the posterior and middle deltoid, the supraspinatus and the infraspinatus. An interesting observation is that the infraspinatus will frequently strengthen when the first rib is statically challenged from superior to inferior.
Slipped Bicipital Tendon

The tendon of the long head of the biceps brachii travels from the supraglenoid tubercle and passes over the head of the humerus passing through the intertubercular groove. It is held in place by the transverse humeral ligament and by the fibrous expansions of the pectoralis major muscle. The tendon may slip off the groove with only slight trauma, especially if the patient has a weak division of the pectoralis muscle or if the patient is ligament lax. Yergason’s test or sign can be indicative of ligament laxity of the transverse ligament or tendonitis of the long head of the biceps.

Diagnosis: Often times the long head will test weak on manual muscle testing. Confirmation of the medial slippage of the tendon is by using a static challenge, pulling the tendon medial to lateral.

Treatment: The tendon can be manipulated in the seated or supine positions
1. The elbow is held at 90° while the tendon is tractioned in the challenge direction
2. The shoulder is extended into full extension while the tension is held on the tendon
3. Slowly externally rotate the humerus while making sure to maintain the tension on the tendon
4. With the tension still on the tendon, the shoulder is abducted, you may feel the tendon slip back here if so slowly return to the original position.
5. Once you have reached full extension and external rotation of the humerus, you quickly “snap” the tendon back into place with a two handed thrust with your thumb on the tendon and by quickly internally rotating and adducting the humerus to the body
6. You may have to check the short head for a trigger point: Jone or Travell
7. Check for ligamentous problems in the transverse humeral ligament. Also don’t forget the organ relation to both the PMC and the biceps.

Nutrition: Zypan, Zn, also Ligaplex II

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Suprascapular Nerve Syndrome

This is a very commonly overlooked syndrome that can lead to atrophy of the infraspinatus and the supraspinatus muscles. The suprascapular nerve traverses through the suprascapular fossa and the scapular notch to arrive at the supraspinatus fossa. After supplying fibers to the supraspinatus muscle, the acromioclavicular joint and the subacromial bursa, it twists around the base of the spine of the scapula and enters the infraspinatus fossa. Due to this tortuous path, the nerve is stretched as the scapula moves if there is any scapula instability.

Symptoms, reported by patients, will run the gamut from diffuse shoulder pain that is hard to localize to complete atrophy of the infraspinatus first and then the supraspinatus muscles. Symptoms are usually aggravated by any activity that requires extensive motion of the scapula. In most cases, there is no overt weakness pattern. However, if the scapula stabilizers are weak, especially the serratus anterior or rhomboids, the infraspinatus will test weak if tested with the arm flexed to 90° with anterior rotation of the shoulder. This position creates additional torsion on the suprascapular nerve and if the scapula has inadequate support, the infraspinatus will weaken.

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Bursitis

Bursitis is hallmarked by pain worse at night. The synovial fluid becomes thick like toothpaste. This is really a relative protein deficiency where the body is utilizing proteins from synovial membrane. When looking at blood work you can determine if a patient currently has or is at risk for bursitis.

To determine a relative protein deficiency

- Serum globulin fraction is normally between 1.5-2.9
  - Total protein – Albumin = Globulin Fraction
  - S.G(Globulin fraction) is greater than 3.0 there is a protein metabolism problem:
    - 1. Dietary inadequacy
    - 2. Dysfunction of stomach (HCl Decreased)
    - 3. Dysfunction of pancreas
    - 4. Dysfunction of small intestine
    - 5. Inability of liver to re-synthesize amino acids

• Nutrition:
  - Cal-amo 1 every 15 minutes until the patient starts yawning
  - Then one every hour
  - Also, test HCl, Protefood, and digestive enzymes (multizyme and zypan II)

Diagnosis:
See protein calculations above
Also Symptoms should be present

- Pain and tenderness to the touch
- Decreased range of motion

Treatment:

- **Acute**
  - Ice pack 20 minutes on - 40 off
  - Immobilize the joint, NSAID’s
- **Standard treatment**
  - Cortisone injections
  - Later therapy to increase range of motion
- **Meridian Therapy**
  - ST 41, SP 5, GB 40
  - Fix what you find on diagnosis (pulse points)

Nutritional -

- Primary - no salt diet low oxalic acid
- EFA’s - omega 3 and 6 - zinc, calcium 1500mg/Magnesium 750 mg
- Tumeric

Homeopathic

- Arnica -
  - Most important first 24 hours
- Ruta gravelones
  - For tender ligaments and tendons
- Rhus tox

- Dull ache that increases with activity
- Swelling of the bursa
  - If joint is stiff and improves with motion
  - Calcarea phosphorica
    - Pain in the bones and nerves along with neck discomfort
  - Causticum
    - Chronic condition - feel better in rainy weather
  - Guaiacum
    - Stiffness relieved by ice or cold compress
  - Hypericum perforatum
    - Sharp shooting pains

Herbs

- Increasing flexibility & reducing inflammation
  - Aloe vera, yarrow, devil’s claw
- Diuretics
  - Dandelion, corn silk and parsley
- Reduce inflammation
  - Application of wintergreen oil

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Reproductive System

Female:

**Estrogen Dominate:**
- Large breasted
- Heavy flow
- Short cycle
- Easier to get pregnant
- Ovex increases progesterone

**Progesterone Dominate:**
- Small breasted
- Scanty flow
- Long cycle
- Easier to maintain pregnancy
- Ovatrophin PMG increases estrogen
Ovary
The ovaries produce two major hormones, estrogen and progesterone. Estrogen is produced by the theca interna cells of the ovary. Progesterone is secreted by the follicle after ovulation.

- Second highest concentration of iodine in the female body
- Ovaries and thyroid are on a “teeter-totter”
- Treatment of the ovaries should be directed at balancing the steroidal hormones
  - Specifically estrogen and progesterone
  - Test B3, A, C, E, Zn and WGO against ovary related muscles
  - Muscles that are related to the ovaries:
    - Gluteus medius/minimus
    - Gluteus maximus
    - Piriformis
    - Adductors
  - Also, you must check the liver for sluggish break down of the steroidal hormones
  - Don’t forget the pituitary and hypothalamus

- It takes progesterone to maintain a pregnancy, along with a healthy thyroid
  - If patient has problems maintaining pregnancy, check iodine status, thyroid and remember that the parotids de-iodinate the food

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Estrogen:

The physiologic form of estrogen is estradiol. Estriol and estrone are the metabolites of estradiol. The ovary is controlled by two separate pathways. Estrogen is stimulated by FSH, and progesterone is stimulated by LH. However, some LH is needed for estrogen production and estrogen is also used as a feedback inhibition loop for progesterone.

Physiology:

• Regulates the menstrual cycle and female sex behavior, maintains secondary sex characteristics, affects antibody properties

Deficiency Symptoms:

• Delayed maturation, regression of secondary sexual characteristics in the female, decreased female behavior, menopause

Excess Symptoms:

• Tumors, sterility, inhibition of the male gonads

Synergists:

• Prolactin, corticoids, growth hormone, thyroxin, insulin, relaxin

Biosynthesis:

• From progesterone which is derived from cholesterol

Catabolism:

• Broken down by enzymatic activity of the liver

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**Progesterone:**
Predominately prepares the uterus for implantation and helps maintain the pregnancy. Thyroid function is necessary for its production. Released in the secretory phase.

**Physiology:**
- Prepares the uterus for implantation, regulates female sex accessory organs, maintains pregnancy, represses ovulation, and sex activity
- Made in adrenal cortex, placenta, corpus luteum and CNS
- Stored in adipose tissue

**Deficiency Symptoms:**
- Decreased ovulation, loss of normal cyclic changes, acne, uterine bleeding

**Excess Symptoms:**
- Inhibition of uterine growth, increased sodium and potassium excretion

**Antagonists:**
- Aldosterone, testosterone, estradiol, oxytocin

**Synergists:**
- Prolactin, cortisol, growth hormone, thyroxin, relaxin

**Biosynthesis**
- Derived from cholesterol

**Catabolism**
- Through urine as pregnanediol

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Daily Temperature for one month are shown in graphs above:

- The temperature should be taken under the arm with a Hg thermometer and should be done first thing in the morning before the patients feet before hit the floor
- Pineal type of temperatures are up and down throughout the month
- Low progesterone type only slightly dips at ovulation
- Low estrogen type dips significantly at ovulation but the temp doesn’t come back up
- Low thyroid type is very low through the month
- Normal is shown with the dip at ovulation
- Notice that estrogen and progesterone have opposite effects on the temperature and normally the temperatures should be roughly the same before and after ovulation

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PMS and Dysmenorrhea are not the same thing.

Premenstrual Syndrome:

PMS refers to the symptoms that appear during the seven to the 10 days before menstruation and disappear with the start of the menstrual period. There is a great disagreement to the nature, timing, pathogenesis, treatment and even the existence of the disorder.

**Physical symptoms:** Can include bloating, breast swelling, and discomfort, pelvic pain, headache, ankle swelling and bowel changes

**Psychological symptoms:** Irritability, aggressiveness, depression, anxiety tension and changes in libido

The women who tend to have more pronounced PMS symptoms, also tend to smoke, drink lots of coffee, eat chocolate and have blood sugar issues. Keep in mind any person with rapid shifts of mood, think blood sugar and liver. In short, if they have PMS they are toxic.

Remember that the liver conjugates estrogen through phase II of detoxification - sulfation reaction. If sulfation is overwhelmed (which can happen in obese people) glucuronidation pathway can be utilized. Remember that the liver’s main job is to detoxify the lower bowel. So make sure you check the liver and colon with any patient that has PMS.

**Clinical signs:** Can include altered absolute levels or ratios of gonadal steroids, steroid induced variations in neurotransmitters, and hormone induced changes in salt and water balance.

**Treatment:**

There are four different and distinct types of PMS. To effectively treat this condition, a number of factors have to be considered. It must be noted that you have to treat the patient while they are in their cycle. The muscle test is not predictive of how the patient will present when they are in their cycle. The patient must be treated during their cycle to determine the best course of action for their treatment plan.

- Have the patient take their axillary temperature every morning for a month. This should help determine where the hormonal imbalances are occurring due to the relationship between the thyroid and ovarian hormones and temperature.
- There is a balance between adequate hormone levels, prostaglandin production and liver detoxification of the sex hormones.

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Dysmenorrhea:
- Dysmenorrhea refers to the cramps and other physical discomforts that accompany ovulatory cycles in many women. Cramps reflect the effect of prostaglandins produced and acting in a progesterone rich environment. Balancing the prostaglandins with essential fats like GLA, EPA, DHA and BCSO (GLA) will help with the cramping and breast tenderness. Dysmenorrhea usually equates to low progesterone, ovex may help.
- For pain in the “back”, use B6 niacinamide, testing the scalenes
- For pain in the front, use zinc (zinc liver chelate, chezyn, trace minerals B12), testing teres major
- For severe cramps check against Ca+ and or Mg+
  - Ca should be given at a rate of one every 15 min until pain improves then one per hour
  - Vitamin D, E, F should also be checked
- ICV should be checked for all endocrine and female problems, especially endometriosis
- Sugar metabolism should also be checked
- Liver and large intestine should also be checked
- Spinal and pelvic subluxations
- Also check viceroptosis of the uterus

Notes:


Amenorrhea:
- Check pineal, hypothalamus, pituitary, ovarian and liver imbalances
- Also, protein or fat deficiency, lack of body fat, low cholesterol (160 is area for concern but really this is a relative number), anemia should also be considered
- Change the diet, get them eating fats, balance the body, fix what you find
- Also consider tumor or persistent lutein tissue

Notes:
Menopause:
- When the ovaries senesce the adrenals are supposed to take over production of estrogen and progesterone
- Most women that suffer from menopausal symptoms are adrenally stressed
- To fix menopausal symptoms, fix the adrenals
- With hot flashes check for cataplex F tablets. This will normally get rid of the hot flashes within 30 days.
- Test adductors (climacteric)
  - Nutrition is Symplex F/M
- Female normal climacteric time is 42-52

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Uterus
- Ptosis of the uterus
  - Contraindicated if the patient is on their period or pregnant
  - The indication is nothing at all, bowel or bladder incontinence, dysmenorrhea, PMS, inability to get or stay pregnant, loss of muscular control during intercourse
  - The body language of a dropped uterus is WIDE open eyes
  - Weak piriformis and other pelvic muscles
    - Especially pelvic floor muscles
- Challenge:
  - Static challenge about 1” below the umbilicus pushing inferiorly
    - If weakens a strong indicator
- Correction
  - Lift up 3 times while the patient exhales and lifts arms over head and knees to the chest
  - Check base posterior sacrum
  - Remember that the uterus is suspended by the broad ligament which is susceptible to ligament stretch
  - Always correct the pelvic floor muscles afterward

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Session 6

- Pelvic Floor Muscles:
  - Coccygeus
  - Iliogoccygeus
  - Pubococcygeus

Notes:

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Vagina

- Vaginitis
  - Fix the colon
    - Congaplex 1 per hour for 3 days
  - Sugar metabolism
  - Shower instead of baths
  - Loalsan - TPCS www.tpcsdirect.com
  - Mold yeast SF 722, Kapracidin-A

- Getting Pregnant
  - Generally unhealthy
    - Toxicity
    - Balance the body and pregnancy will happen
  - Protein back in the diet
  - Make sure the man gets checked
  - Sometimes, the inability to get pregnant is an incapability of body fluids
    - Check to see if the woman weakens to the man’s sperm
      - Use your imagination

- Birth Control Pills
  - If you get the right pill, they should be able to tolerate it, but if they are having symptoms, it will be sometimes negated by B6 (P-5-P)
  - Have the patient get samples of the pills and test it out
    - If they weaken to all or some of them, find the reflex that negates the weakening and treat it. Structurally, nutritionally, chemically, homeopathically.

- Dry Vagina
  - Painful intercourse
    - Mix iosol (TPCS) and water
  - Soak a dental plunge in the iodine solution. Have the patient insert it vaginally to let the walls soak up the iodine. This should give immediate relief.

Notes:

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Breast

- Breast soreness (tenderness in the actual breast tissue and not at the origin/insertion point of the serratus anterior) is normally a toxic colon. Work the chapman reflex for the TFL and get the patient off of caffeine and sugar.
  - Rarely, you will have to use Mammary PMG if nothing else has worked
  - Breast cancer, most common cause is excess estrogen or deficient progesterone
    - Ovex is used to bring up progesterone and decrease the estrogen, also check Wheat Germ Oil, Niacin, Mammary PMG… etc)
  - In all cancers, Zymex and I3C can be very helpful

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Diet:

In general, women need to be even more diligent than men concerning their diets because of their estrogen levels. This places an even greater load on the liver thus they are much more susceptible to toxicity symptoms than most men. Alcohol, drugs, caffeine, cigarettes, etc. really tend to mess women up (they mess almost everyone but especially women). I am sorry its not my fault :)

Male

Prostate

- Zinc Liver Chelate, Chezyn against gluteus medius, maximus and piriformis
- Prost-X, Super-EFF, Wheat Germ Oil, High Dose E, Symplex M, Orchex
- Check to see if they need “uterine” lift technique
  - Check pelvic diaphragm

Impotence / Andropause

- Check toxicity and liver

Erectile dysfunction / Loss of libido

- Check adrenals
  - Change diet get rest
  - Test any muscle against arginine (see Nitric Oxide)

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