CATEGORY FOUR – OCCIPITAL ANALYSIS

We thought the title of this article and the next four in this series, would grab your attention. Yes, its true. For a very brief moment in history there were not three but eight SOT categories. The year was 1970. In the 1969 manual, the three categories were discussed. Yet the eight category system was gone and forgotten by the 1971 manual. 1,2,3

How then did the situation arise where 5 areas of SOT study were elevated to category status only to see them relegated to the second division the following year? It wasn't that these subjects were unimportant, as you will see by the titles, but that in reality, they slotted into the three categories of the contemporary classification which over time has proven to be quite an adequate framework.

The five extra 1970 category listings are show in table 1.below

CATEGORY IV	Occipital Fibre Analysis
CATEGORY V	Trapezius Fibre Analysis
CATEGORY VI	Anterior Vertebral Subluxation
CATEGORY VII	The Oblique Sacrum
CATEGORY VIII	Occipito-Atlantal Syndrome

To give you a brief preview of coming attractions, first, the occipital analysis will be the subject of this article. The Trapezius fibre analysis will include some work of Dr David Denton and may require two "Expression" articles. The Anterior vertebral subluxations topic has been partially covered in "The anterior thoracic technique and SOT "(Expression, Autumn 2007) so we will limit our discussion in that article to lumbar and cervical involvement. The Oblique sacrum concerns the true short leg and how it affects the functional short leg that we experience with the three categories and last topic, the Occipito- atlantal syndrome is a subject that is woven into the fabric of all three categories of the current scene.

As you can see these topics are not merely being presented for their historical value but are currently applicable and will be described in the continuing theme and style of this article series, that being, information of practical use, hopefully adding to your understanding of SOT that you have gleaned from our SOTO Australasia seminar series attendance.

The historical account of the Occipital fibre analysis is most important as it is a key factor in the development of De Jarnettes enquiry into the nervous system which has become SOT, so let us get started.

Historical Perspective

As SOTO Australasia members you will recognize the source of many of the following facts as being the "history section" which is found at the front of your seminar

manuals 4. To give you a thumbnail sketch summary, De Jarnettes' techniques class lecturer at the Nebraska College in 1924, Dr Carl Hawkins, had taught that the occipital condyle subluxation was very important 5. De Jarnette stated that he noticed while palpating the occipital condyles that he would consistently find painful fibres on other areas of the occipital bone. By 1930, he came to realize that no mention of occipital fibres was made in any written treatise. Around this time De Jarnette had only one occipital line and working with Bings Laws of ascention he mapped out the interconnectedness between dorsal and lumbar sensory fibres and the nature of their reflex to occipital, cervical and sacral segments.

By 1949, the three separate occipital lines were described and it wasn't realized fully that line 2 concerned the viscera until 1953 and that line 3 concerned structural changes in the tissues collagen makeup until 1955. Whereas visceral techniques were discussed by De Jarnette as early as the mid 1930's, in Bloodless Surgery texts, the CMRT work, as we know it today, was first described and published as such in 1966 and most of the visceral techniques taught currently are sourced from the CMRT 1981 update 6.

That De Jarnette felt strongly about the occipital lines and fibres is evident. One can sense the disappointment he experienced with some in the chiropractic profession when he wrote that: "Doctors will spend months learning acupuncture points when in reality what they need to know and understand is the occipital defensive fibre (another De Jarnette statement is: the occipital fibre is "defensive", the trapezius fibre is "reactive" which will be discussed in greater detail in the cat 5 article) which is your body's way of telling you what the problem is, where it is located and its connection to the course of innervation" 7.

Discussion

Two aspects of SOT, which we learned as rules in the early 1980's, were: rule 1 – you don't mix the categories and rule 2 – you don't add "this and that" to your procedure. The first rule meant you didn't add a few moves from the Category III procedures thrown together with some Category II stuff and next visit, check the dollar and crest signs – that is you didn't do this unless you wanted a real mess. The second rule, which was drilled into us by Drs Parker, Bastian, Power and Power, Postles, MacPherson, Leyonhjelm and Co (early SOTO A/Asia instructors) was aimed at the overzealous chiropractor; to discourage him or her from doing as many different adjustments as they had learned at college or seminars, thus complicating the Category III or II – also resulting in a real mess.

So how does the Occipital analysis fit into the SOT framework of Categories? The Occipital fibre system is specifically compatible to the category one. Its relationship to the category two is less pronounced yet with a Category II patient who is non-responsive, with continual upper fosse failure despite all efforts, you may find it worthwhile to turn your patient prone find a line 1 fibre that is reactive, swollen and painful and neutralize it. Occipital fibre systems relationship to Category three may be

more direct as many so-called symptomatically involved sciaticas and neuralgias are related reflexly to a diseased viscus.

In reading this section on the Categories, the curious reader may wonder what would be their findings if they did do an occipital analysis on a newly arrived Category II patient. The Category II is likely to have multiple fibres present and active due to the involvement of liver, pancreas, spleen, stomach and yes you could get lost in the maze of these if you just jumped straight in. Your priority is to stabilize the Category II, allow those 42 days for the stabilization, start checking your crests and dollars, base plus and minus and then you will have arrived. Years ago, we heard Dr Joe Flescia of Renaissance talk about the "Onion skin" effect of Chiropractic adjustments. As the patient moves forward with their Chiropractic course of care new underlying things are discovered. (For newer graduates, Renaissance was started in the 1970s and was the forerunner to Quest – an educational alliance of Drs Guy Riekeman and Joe Flescia who did much to move chiropractic out of the "why should I go to a Chiropractor, I don't have a bad back? And further, "why should I come back to a Chiropractor, my back feels better?" mentality.

No truer is the onion skin effect the case than in an SOT practice. Your 'occipital fibres' and the time to examine them is with Category I, likewise cranial work save for the sutural work of Category II. De Jarnette named the time to check the occipital fibres the "fourth block technique visit" and this was done on day ten in cat 1 protocol 8.

Occipital Lines

The three lines of the occiput had been designated different names by the late 1940's. Thus line one is termed the cerebrospinal fluid line, which indicates any interference to the normal flow and pressure of the cerebro spinal fluid which has reflexed to one of the seven areas on each side of the superior occiput, fourteen areas in total the presentation of such is dependent on the level of the fluid interference.

The thing to know about line one fibres is that they are always present, that is , unlike lines two and three which have no normal fibre formations. That is to say, that fibres felt on lines two and three are formed upon reflex action, line 1 fibres can always be felt which makes them good starting points for the work.

Line two is designated the Viscus reflex line and this line will exhibit a raised and painful fibre when a specific viscus is delivering an over abundance of sensory impulses to the spinal cord at that involved level.

Line three is the Structural line and becomes involved when any of the tissues of the body undergo pathological changes due to any cause. 9 In more detail…

Line 1 Mechanism

Any irritation within the meninges will excite the nervous system connected to that part and will then reflexly affect the occipital aponeurotic tissues as those tissues relate to the Golgi tendon organ muscle protective mechanism.

Occipital line one does contain fourteen aponeurotic fibres, seven on each side from the temporal mastoid suture groove to the lateral nuchal border. The fibres are sensitive to any reflex affecting the pressure of the cerebrospinal fluid at the levels of the thoracic or lumbar spine.

Although Occipital fibres 1 to 7 relate to cervical levels 1 to 7 it must be remembered that the stair stepping and rocking procedures are the cervical methods of choice. De Jarnette proposed the mechanism that the cervical spine disrelationships were one of over motion, thus the constructive application of compressing the pre and post zygapophyseal joints and shortening of the posterior ligament proves to be beneficial clinically.

In our last article in this series, anterior thoracic subluxation, we made mention of the impossibility of the thoracic vertebrae subluxated in a true anterior position and that the palpated or observed dishing was either an extension malposition and fixation (Fligg) or a rotary inferiority combination (Pettibon). De Jarnettes line 1 vertebral malposition is one that has not developed to this extent biomechanically but is a slight flexion or extension that causes cerebrospinal fluid pooling at that level. (Perhaps a future article could be written on the differing mechanisms of the vasomotor subluxation, trapezius analysis adjustment, anterior dorsal and the articular subluxation).

Line 2 Mechanism

If that “tippage mechanism” that is a line 1 fibre involvement is not corrected by the spinal pump procedure the involved vertebral level will either become arthritic or rotate. Muscle response at the involved segmental level is such that it contracts excessively unilaterally causing the rotation. That the line 2 is visceral involvement and involves the sympathetic through the rami communicantes is seen in that the reflex is of far greater intensity than would be a muscle reflex. A cord impulse is then extended into the cervical column of a greater intensity than the one producing the original occipital area swelling and we now have an extension of the fibre formation into a line two. (In accordance with this articles title ‘Category IV’ and a naming system which would have become unwieldy, De Jarnette also had a system of A, B and C fibres in the 1950s thus a line 1, type C fibre, a line 2, type B fibre and a line 3, type C fibre – too complicated, much easier to say a line 2 fibre 5). The line 2 of course is the indicator for the chiropractic Manipulative Reflex Technique work.

Line 3 Mechanism

Whereas the line 2 we could say involves a situation of a viscus bordering on pathology, line 3 is indicative of the full-blown pathological changes in the organ innervated from that vertebral segment. 10

Practical Application

Two aspects of Occipital fibre analysis are very useful in learning the work, the banjo strings analogy and the use of a foot long plastic ruler. 11 Each in turn.

The Banjo Strings

The occipital fibre formation on the left and right would be comparable to two seven string Banjos. You could identify the position of each string by finger touch. This is true of the occipital fibres. Use the nail points of the index finger to explore line one and the nail points of the middle fingers to hold line two. Each is done at the same time. When your index finger locates that painful fibre on line one, it is then easier to move that finger inferior onto line two, following the fibre you just located, and test it for a modulation. If this fibre extends one quarter inch inferior it will be on line two. The line one fibre extending to line two is simply a larger fibre than would be one which did not include line two, but was exclusive to line one. The index fingers do the fibre search. The middle fingers keep the skin tight so you do not lose your position when the index fingers move to the next fibre space. Should this same fibre be longer than that one quarter of an inch then it is extending further and probably will end up as a line three. This is all very complex. But so is the lack of ease, or dis-ease.

The One Foot Ruler

Using a foot ruler with elevated marking is an ideal way to train your index finger to detect the involved occipital fibre. The quarter inch marks are longer than the sixteenth inch marks, so they represent line two while the smaller elevations represent occipital line one.

Conclusion

That the topic of Occipital palpation and fibre analysis which De Jarnette commenced in 1930, after finding and reviewing his Dr Hawkins class notes, remained of interest to him throughout his clinical years is contained in his 1981 statement that:
‘what you do by use of the occipital analysis can be the most important step you take in chiropractic care, when what you do is predicated on sound and thorough pelvic block procedure’……. Occipital palpation is a task requiring patience, practice and understanding. The more you practice, the greater your understanding.

The final word on the subject from De Jarnette 12:
‘The chiropractors who do not learn occipital analysis will not ever learn the kind of chiropractic that will survive’. We take it that he would have wished that the work be

continued to be applied by SOT practitioners. We look forward to your company at this year's CMRT seminars.

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URGENT FAX MESSAGE

TO: Averil Crebbin SOTO Magazine

FROM: Dr John Kyneur

Dear Averil,

Here is the next John and Peter Article.

Could you please proof read.

Love,
John K