

HIATUS HERNIA

The Hiatus hernia problem which we see as part of a Category II is one of the most common problems found in patients of all ages. The test and correction description which takes up a mere three lines in our current SOTO Australasia Seminar notes (1) perhaps does not do justice to this most useful and helpful procedure.

On the topic of hiatal hernia, De Jarnette states “Next to the TMJ, the hiatal hernia is the most prevalent overlooked problem in Chiropractic (2)”. In SOT Seminars of the early 80’s, the term PHH or pseudo-hiatal hernia came into usage. The reason was that the only medically (and insurance company) acceptable diagnosis of the “diaphragmatic hernia” or ‘hiatus hernia’ was the barium X Ray. Perhaps a better description may have been ‘subclinical hiatus hernia’ or ‘subacute hiatus hernia syndrome’. As a subacute condition and one the patient most often fails to mention, ‘reflux’, (psuedo- hiatal hernia, subclinical hiatus hernia, subacute hiatus hernia syndrome , diaphragmatic hernia, hiatus hernia) and the techniques to handle it are an important part of your SOT protocol.

Clinical Indicators

Dr Ralph Failor (3) has suggested four indicators. These are:

1. Position-wise, the hiatus is at about the vertebral level of T10. Failor’s suggestion is that palpatory tenderness will be found more on the left of T10 vertebra.
2. Palpatory tenderness is noted in the supine patient just to the left of the xiphoid process pressing gently upwards and towards the patients left shoulder.
3. Tenderness at the 3rd intercostal space. (SOT Cat II protocol).
4. Palpatory tenderness at the intercostal space directly down from the axilla on the left lateral side of the thoracic cage.

De Jarnette reminds us that the HH can be ‘part of the Category II or no category today (4) and has stated, “when this is a health problem, mind language is perhaps the best way to detect its presence. (5)

In recognizing HH as being part of the fifth thoracic dural port closure, Dr Rees also suggested that these patients have had and may still have a liver problem (6). (Liver technique is fully described in your CMRT notes).

On this subject, Dr Rees did a pretty good job of describing the HH. In his words, “The vitality to the gastro-oesophageal vestibule, also called the gastric antrum or antechamber of the stomach, which is that portion situated

just before the cardiac orifice of the stomach, is in dire straits and needs your immediate help to clear the 'reflux esophagitis' (pseudo hiatal hernia) symptoms that are scaring the daylights of your patient who just knows he is having a heart attack" (7).

Symptoms

Symptoms may or may not be present which is the nature of the viscera and its nerve supply. The indicator systems of SOT and CMRT serve as a wonderful system to determine the status of the viscera.

Having stated this, Failor (8) gave a long list of the possible hiatal hernia syndrome symptoms, included here:

1. Fatigue The patient will get up in the morning more tired than when he retired.
2. Lack of mental acuity The patient will complain of just not being able to think clearly. Students will have difficulty in obtaining passing grades.
3. Appetite limited The patient is often able to eat only small meals and in a matter of two hours will be hungry.
4. Keep breath curtailed The patient is unable to take a deep breath, usually only about one third of the average.
5. Exhaustion The patient will become exhausted on the slightest exertion.
6. Spare tyre The patient will have a 'spare tyre' bulge across the upper abdomen, just below the rib cage.
7. Pseudo Goitre The patient may experience a full feeling at the base of the throat as if there were a goitre.
8. Heavy Chest The patient will have a constant heavy feeling in the chest as if something was pressing on it.
9. Regurgitation The patient will experience a regurgitation of the eaten food many times. Or, it may go part way down to the stomach and stop, giving discomfort and pain.
10. Darting Pains A large majority of patients will experience slight to heavy darting pains across the upper thoracic cage at intervals, especially after a large meal.
11. Tickling Cough The patient will have a tickly cough at the base of the throat. However, the cough will produce nothing.
12. Sensitive Waist The patient will not be able to stand anything tight around the waist, the sensitivity being more pronounced after eating.
13. Flatulence The patient will have so much gas at times which can become so severe, that the clothing will have to be loosened.
14. Colourless Face The patient will evidence a lack of normal colouring in the face, due to the lack of oxygen resulting from restricted and shallow breathing.

Causes

The term hiatus comes from the Latin meaning 'window' so we have a window in the diaphragm whose sole purpose is to allow the hollow musculomembranous canal, or the oesophagus to carry food from the mouth to the stomach (Oesophagus from the Greek, comes from two words 'to carry' and 'food').

Causes suggested for the malposition of the stomach are a direct blow to the stomach, landing on the stomach while making a dive or a severe and heavy lift but as SOT practitioners, we need to examine cause mechanisms in terms of the craniosacral mechanism.

At some time, a slip separation of the weight-bearing portion of the sacroiliac joint has occurred. The instability of this Category II situation invokes imbalance in the psoas and latissimus muscles and a diaphragm imbalance ensues, which sets the stage for the oesophagus stomach interface or gastric antrum to rise (Diag. 1)

Diagrams 1 & 2

The anatomy of the stomach valves is governed by survival factors. The lower valve, the pyloric valve is a strong valve which prevents matter from returning to the stomach. The cardio-oesophageal valve is purposefully weak to allow vomiting (this valve hardly receives a mention in some anatomy texts). While this ensures you don't die the first time you eat a piece of 'bad pork' from the takeaway, it means as a trade-off, you can develop an HH.

Adjustments

Several techniques to help the hiatal hernia have been developed including two methods by De Jarnette, those offered by Byron White and Ralph Failor and the method popularised in SOT by Dr Rees, known as the Allen flip which is taught currently in the basic series by SOT A/Asia.

The term CMRT, Chiropractic Manipulative Reflex Technic is a term used by De Jarnette from the 1960s. Earlier works such as those from the 1930s, 1940s and 1950s were known as Bloodless Surgery. From the 1936 Volume of Bloodless Surgery entitled "Reflex Pain" comes the first technique for hiatus hernia. De Jarnette suggested sitting behind the patient encircling the patient's body and lifting the entire ribcage ceiling-ward. This freed the 'stuck' lower end of the oesophagus so that it could move freely with respiration (10). (This works but it's a bit like holding the light bulb still while you get those fifty Celtic gentlemen to turn the house).

De Jarnette's more recent approach can be found in either of the last two printed SOT manuals (we have often referred to these final two SOT manuals in this series of articles. The final edition SOT 1984 is available at the seminars or through SOT Australasia).

The De Jarnette Technique:

The patient's left hand is made into a fist and placed over the gastric area just inferior of the sternal xiphoid process, the palm side next to the skin. Doctor's contact is a flat hand laid over the patient's closed fist and that hand is supported by the doctor's free hand. (Diag 3)

The adjustment is performed with consideration of the respiratory cycle, thus, both Doctor and patient can inhale together. When inhalation is in process, pull down slightly onto the patient's closed fist and hold for five seconds; patient exhales and so does the doctor. Patient inhales alone, deeply as the doctor continues to pull posterior and slightly inferior.

The Thrust – doctor releases his contact, patient inhales deeply, while doctor now moves patient's closed fist firmly against sternal xiphoid. With Doctor's hand pressure onto patient's hand, patient exhales rapidly and with force as doctor gives a quick thrust posterior at termination of exhalation (11).

Dr Byron A White's techniques are credited to his associating with Viennese Orthopaedist, Dr Adolph Lorenz. By way of background, at the beginning of the twentieth century, orthopaedists and gynaecologists in Germany, France, Austria, Sweden and other European countries were the manipulation of the body's soft tissues. Dr Lorenz was one of Austria's leading Bloodless Surgeons of this time. On one of his visits to America he taught the work to Oregon Chiropractor, Dr Byron White.

Dr Ralph Failor associated with Dr White and described the work in 'Three generations of Healing Secrets' (1975).

The Failor Technique:

A similar contact as that shown at SOTO Australasia Seminars to contact the hiatal area is made, that is, one hand usually the right, overlaid and reinforced by the left hand with the fingers cupped. White and Failor started with a sweeping, circular movement going very lightly and gradually increasing with the purpose of relaxing the abdominal muscles in a preparatory manner.

Then with the slightly curved finger tips of your right hand, reinforced by the fingertips of the left hand contact the lesser curve of the stomach, which will be positioned quite high, exert a light but deep pull straight forward for two inches (5 cm) and then continuing with your move, curve it slightly to the patients left side, just below the costal margin for another inch or two. (Diag. 4)

Failor suggested following the correction with a method he termed 'Ballooning the stomach'. This is performed by placing the heel of the right hand on the lesser curvature of the stomach and once again the left hand reinforces the right and making a few clockwise rotary thrusts to reinforce the earlier correction. (12) (Diag5)

Dr M L Rees is known for his tempero-sphenoidal work, the palpatory tender areas that can be used as a way of verifying findings with the occipital fibre analysis.

The Allen's flip technique came to SOT practitioners from Dr Leonard J Allen of Margate, Kent who had visited Dr Rees in the late 60s to learn the TS work. In discussing and exhibiting techniques, Dr Allen shared his 'stuck oesophagus' technique which Dr Rees demonstrated at SORSI's Omaha homecoming in 1969. (13)

The Allen Technique:

You go in under the xiphoid with both hands overlaid (in a similar manner to Failors Technique) as the patient takes three deep breaths. You are gaining and holding your contact on each breath. At the end of the third exhalation you simply let go-you flip your fingers out. This elicits ligamentous stretch reflex and causes immediate recoil for the antechamber of the stomach to retain its motility.

Dr Allen suggested an alternative approach to the flip technique. A Racquetball, placed in the palm of your left hand and reinforced by your right hand is used. The grip of the ball is, in our experience, quite effective in attaining the drag needed especially with those patients possessive of tight diaphragmata.(14)

In conclusion, we have discussed several variations to the HH correction. The common theme, as is the case with all bloodless surgery type methods is to go gently. The important thing is the De Jarnette comment to not exclude this most valuable approach to your daily patient care.

References

1. SOTO Australasia Seminar notes 2006
2. De Jarnette MB SOT 1984
3. Failor RM Three Generations of Healing Secrets
4. De Jarnette MB SOT 1983
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6. Rees ML Sorsi Despatcher 1974
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10. De Jarnette Reflex Therapy 1936
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13. Rees ML SORSI Despatcher 1974
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