

Headaches and the Unresponsive Atlas Subluxation

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This situation presents itself clinically as a failure to most attempts for correction. The patient presents with suboccipital pain on the left or right side. There is often radiating pain into the left or right face, especially the forehead, temple, or eye region. Examination by static, visual and motion analysis reveals a C-1/C-2 articulation that is fixated in rotation, and lateral flexion on the left side. This means that the left side of C-1, when rotated to the right, exhibits restriction. C-1 also is restricted in lateral flexion on the left. The right side palpates freely.

When the doctor tries to adjust the atlas from the left side, nothing happens: no sound, no release, no correction, and probable increased soreness. You try again, but the atlas remains tight and unmoveable, yet clearly a hypomobile fixation. The title of this article calls this a subluxation, but it is actually a subluxation and fixation. The atlas is clearly malpositioned, as determined by static and visual analysis. To confirm this, while the patient is supine, press over the atlas lying under the SCM, bilaterally. You can feel the more anterior position and resistance of C-1 on the right side. The left side of C-1 from the anterior will palpate with less resistance.

Stop banging on the atlas and go to the right side. Do not bang on the right side of C-1, which can be very dangerous under any condition. Evaluate the ability of the occiput on the right side to rotate to the left, laterally flex on the right, and extend during rotation to the left. A common finding in these C-1 unresponsive headaches is a right-sided occipital fixation pattern. Occasionally, you may encounter a left-sided occiput rotation fixation. The most common finding with unresponsive left C-1 problems and responsive C-1 left fixations is a right-sided fixation of occiput on C-1.

You can encounter some combination of occipital problems involving rotation, lateral bending and extension. With one adjustment, you can free all the restriction problems just by incorporating correctional vectors to your corrective thrust. To rectify the extension or backward nodding problem, incorporate occipital extension in your thrust, combined with rotation. If you do not combine extension with rotation, correcting extension alone will be very difficult and can feel like you are punching the patient.

The result of correction to the occipital fixation dysfunction will be a release to atlas motion, overall cervical increased movement, and a gradual reduction in symptoms. "Migraine" type headaches often are associated with this right-sided occipital fixation pattern. Even if C-1 is responsive to adjusting on the left side, you commonly still encounter the right-sided occipital fixation. You also may encounter a simultaneous lateral bending and extension hypomobile fixation at C-2/C-3 level. You may correct this with a simultaneous contact at the occiput and C-2. The corrective thrust induces some rotation, lateral bending, and extension simultaneously. The rotation is not full, rotation and does not take C-2 to completion, which is necessary. C-2 will tend to favor rotation from right to left, and full rotation of C-2 from right to left can exacerbate the headache.

In summary, I advocate the following forms of analysis:

- visual analysis, especially supine; observe position of SCM tissue bilaterally;
- static palpation while supine to the posterior and anterior aspects of the cervical spine bilaterally;
- static palpation of each cervical level anteriorly/posteriorly (joints and segments); extend palpation (tissue challenge); then push on tissues to feel for resistance. You will be surprised when you combine the palpation and challenge to anterior and posterior elements.
- motion palpation applied to the anterior/ posterior sides of the cervical spine in the supine position. This is easier and has more clear results than doing it seated. In this procedure, you have to bring each cervical segment and joint to tension, and beyond, with posterior and anterior contacts. There are two ways to do this, but a description of the technique has to be a separate article.
- Motion palpation to the anterior and posterior aspects of the occiput.

I guarantee that if you take the time to be more thorough in your palpatory examination of the cervical spine, you will become more accomplished in your diagnosis and understanding of cervical mechanics and patterns, including the occiput. Even beyond this, you will discover things that you have been doing wrong and must to change. You will be surprised at what you find if you force yourself to become more thorough, examining every angle of motion. You may not agree with my findings. You may say, "I've been practicing for 20 years and have had no problems, so why should I change?" Just try to be more thorough and see for yourself.

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