Dynamic Chiropractic

DIAGNOSIS & DIAGNOSTIC EQUIP

Prioritization tools - Finding the Primary Subluxation

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When we assess our more difficult patients, we need to ask: "What is the cause? What is the key link?" Our profession denigrates allopathic medicine for treating symptoms, but do we really get to the cause? I'll outline specific prioritization tools, including inhibition, indicator testing and listening, to help you get to the underlying pattern and get patients well faster.

Priority Testing

We know that we can find multiple restricted areas in most of our patient's spines. If we add the cranium, anterior structures, extremities, and viscera, the number of restrictions continues to climb; at some point, this becomes a dilemma. By default, most practitioners tend to assess and treat where the patient hurts. This may work on acute or mild problems, but will not solve more difficult conditions. If we adjust the priority segments, the body will respond much better than to a shotgun approach. A priority approach is essential for chronic pain, for our difficult cases, and for patients tending toward fibromyalgia.

I clearly remember Leonard Faye,DC, at a motion palpation seminar in 1981 saying, "Find the most restricted segment, and adjust that one." Finding the primary restriction is perhaps the Holy Grail of chiropractic analysis. Until recently, I never felt that I had a definitive set of tools to find the dominant subluxation.

The working assumption here is that the body has enormous capacity to adapt to stress and trauma. It adapts by creating restrictions, by twisting and turning, by tightening certain muscles, and by allowing atrophy in others. As the body further adapts to restricted areas, it creates additional restrictions. I believe that there is no logical way to figure the exact adaptation patterns the body has chosen. The best way to unwind the pattern is to "listen" to the tissues and let the patient's body guide us. If we correct only the adaptation, we will not solve the problem but only require the body to readapt. These prioritization methods share a common assumption, that the body knows where the problem is, and that the body can help us prioritize our corrective sequence.

Inhibition Testing

Inhibition, or inhibitory balance, was first introduced to me by Paul Chauffour,DO, author of *Mechanical Link*. First, you must find areas of restriction via palpation. To use inhibition, compare the give at the various spinal and rib levels. As you press simultaneously on two spinal levels (or other restrictions) that were both restricted, one will "give way," or soften, and also become less tender. The area that remains rigid is more primary; the one that softens is secondary or adaptive. Our intention is to determine, via a relatively objective test, which level is most fixated. Remember to trust your first impression. Compare level-to-level, finding the one that stays rigid, while the others soften. You are

sequentially eliminating secondary segments, comparing two at a time, continuing to use the one that stays rigid until you find the highest priority segment. I often use both the objective feel of release or softening at the secondary area, and the patient's subjective, immediate decrease in tenderness at the secondary area.

This procedure shouldn't take long. Once you've found the priority lesion, you evaluate that segment specifically for its exact listing, its exact directions of restriction, adjust it, and then go back and test the other levels. Correct what is primary, and the secondary areas will often resolve or loosen spontaneously.

Inhibition is a great reality check tool. If I have frozen shoulder, I will use inhibition in the spine to find my dominant subluxation, and then "inhibit" the dominant subluxation by engaging that area, and see if the ROM of the shoulder improves. I could do the same thing with an Adson's maneuver, a straight leg raise, or a tender spot. In other words, once I find what I think is primary, I want to pre-test whether it will change my objective findings.

Indicator Testing

Indicator testing was developed by George Roth,DC of Tensegrity (matrix-repatterning). You are basically testing compliance or "give," by gently pressing inward over an area of soft tissue or a compliant part of the trunk. The indicator zone can be the lower rib cage, or over a large muscular area, such as the gluts, quads, pecs or upper trapezius regions. Get a feel for the resistance and compliance at these areas. If the area feels very stiff, don't use it as your indicator, as it may be a significant restriction, and won't give you information about other areas. As you scan or engage each level or region of the spine (or the extremities, cranium or viscera), simultaneously press over your indicator. When you are engaging significant restrictions, the indicator will have a substantially increased give. You are using two simultaneous contacts: one on the area we are evaluating; the second over our chosen indicator.

Using the indicator has some wonderful features. First, it has the same baseline of compliance or give each time, unlike the spine or any other structure we are testing, where the normal give varies from region to region and vertebrae to vertebrae. Second, unlike muscle testing, it does not give strictly a digital yes or no signal, but functions as an analog mechanism, a continuum. More give means more significance. Minimal or slight give means a secondary problem that you can ignore. I tend to use indicator testing to find three or four major areas, which I will then further prioritize with inhibition testing.

Listening

Listening is directly from Jean Pierre Barral's visceral manipulation work. Local listening is done by running the palm of your hand along the area of the body that you are interested in, and see what attracts you, what your hand is pulled toward. Your best sensor will be between the palm and the heel of your dominant hand. If we are listening to the spine, we'll have the patient prone or sitting, and we'll slowly move our hand down the midline of the spine. Think of your hand as a Geiger counter, or magnetic metal finder. As you get closer to the lesion, the pull or sensation will increase. If you slowly go past a significant spot, you will begin to be pulled back toward the lesion. I'll always use motion palpation to confirm and localize further my specific restriction, the listening just speeds my scanning process. The key to successfully listening is to get out of the way, quiet your conscious mind, and listen with your greater awareness. This is not a sequential, logical left-brain activity, but accessing your and

the patient's inner knowing. This is obviously a more subtle tool than the others we have described. I wasn't immediately good at this, but I have found it worth the investment of time to develop. Listening is an incredibly powerful tool, which allows me to cover enormous territory in a quick manner. Follow your listening with palpation to give yourself a reality check.

Using These Tools

A patient presents with persistent headaches. The obvious restriction is at C2, and I've corrected it on her first two visits. The patient returns without any lasting changes, as the symptoms have recurred, and she's still locked up at C2. I will do a careful palpation exam and local listening over the entire cervical and upper thoracic spine, and assess the shoulder and chest. Besides C2, which has recurred, I find restriction in the sternoclavicular joint, and a left anterior C6 (C6 is translated anterior, and resists flexion and left lateral bending). I use inhibition testing and find that the sternoclavicular joint is the primary. I adjust this with recoil, and C2 immediately softens up. I then correct the remaining subluxation at C6, using muscle energy (I don't like to correct the anterior part of the neck with articular adjusting), and the whole region now feels clear. On the next visit, the patient states that she has had far fewer headaches. Instead of hammering unsuccessfully on the same segment over and over, we've used prioritization to find the dominant subluxations, facilitating the healing process.

I recognize that I have taken on a Herculean task in trying to describe and teach sophisticated technique concepts via the written word only. I hope I have at least given you an appetite for more information.

Resources

- Mechanical Link courses, levels 1-4, Paul Chauffour, 1996-2001.
- Tensegrity (matrix repatterning) seminars with George Roth, DC, 1999, 2000, 2001.
- Visceral manipulation courses, Upledger Institute, 1996-2001.
- *Visceral Manipulation*, Jean-Pierre Barral, Eastland Press, 1988.
- Framework 1 and 2 courses, Marc Heller, DC, 2000, 2001.

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