Dynamic Chiropractic

BACK PAIN

An Enigma: Left-Sided Cervical Fixation Patterns

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Over the last 20 years, I have examined the spine in a number of ways: x-rays; nervoscopes; thermometers; neurometers; left checks; therapy localization; static and motion palpation (MP). Ultimately, MP seemed the most tangible and reliable method of analysis.

This lead to the question of how to examine the spine by motion analysis. Dr. Gillet and Dr. Faye recommended the use of an upright posture; others utilized prone positions for the lumbar and thoracic regions, and the supine position was used for the cervical spine. In principle, all were proper and better than anything else because function was being tested. I preferred the use of all three positions, but I only used the supine position for the neck, because it seems easier, more relaxed, and more versatile in what can be tested. In the supine position, any combination of cervical positions could be achieved and tested easily. An adjustment would also be an easy succession to the diagnostic procedure.

As I examined and treated more people, I perceive patterns: not everyone fit into discrete patterns, but patterns often were present. I kept trying to prove myself wrong by evaluating over and over again. Most of the time, I was in denial of the possibility for patterns to exist because I so disliked technique systems which based their corrections on patterns. So, often I ignored what I perceived and treated as I was taught. I would treat the left side and the right side to balance the spine. Ultimately, I was sorry for taking this typical approach to treatments. In my observations with supine MP of the neck, I would find the major fixations occurring on the left side most often. Marginal fixations appeared on the right side, for the most part. Although this is not universally the case, major left-sided fixes and marginal-to-absence of significant right- sided fixes were a common finding. Trying to balance the spine by adjusting the right side of the neck after the left side did create some problems. I put myself in the position of forcing adjustments on marginal fixations. The result often would be scary signs: dizziness, disorientation, and increased discomfort. Often I was reminded of signs suggestive of cerebrovascular accident. However, these signs never appeared with my left-sided adjustments, unless I adjusted a hypermobile joint by mistake.

When motion palpating the cervical spine in the supine position, very frequently I am alerted to certain specific findings:

1. More left-sided rotational fixes in quantity and degree, more often seen in the upper cervical spine, and next in the extreme lower cervical spine.

2. More left-sided lateral flexion fixes, especially in the upper cervical spine, and secondarily in the lower cervical spine.

There are different ways to test supine rotation and lateral flexion at intersegmental levels. Lateral flexion is best tested by slightly flexing the neck and laterally bending at each articulation. Another

good method is to slightly rotate each segment, then lateral bend to access the coupled effect. Rotation is best tested in slight flexion, then rotating each segment. In general, the left sided fixes were predominant over the right side. The predominance was located at C-1/C-2, C-2/C-3, C-6/C-7, C-7/T-1, O/C-1, C-3/C-4. This is not to say that major fixes cannot be found elsewhere. Associated with the above fixes was an emerging monster fixation, the right-sided anterior atlas fixation, which is as common as the left-sided atlas fixation. Left-sided fixes usually were combinations of left lateral flexion and left posterior rotation fixes.

Often, the entire left cervical spine was found to be rigid in lateral flexion combined with slight rotation. A major fixation had to be assigned. C-1/C-2 was usually the major; next in order was C-2/C-3; third was C-6/C-7; fourth was a toss up between C-7/T-1, C-3/C-4, and occiput/C-1. These are the observations from my clinical memories. In releasing the left-sided lateral flexion and rotation fixation on the left side at the major level, the remainder of left cervical joint regions would loosen or release, giving more overall normal function. Sometimes, there would be two major fixes. The most important would have to be taken, then the next. It could be done on different days, or the same day at different times. Or, both fixes could be adjusted simultaneously.

The right cervical spine did have its problems too, but not as frequently. The right side often would hurt, but the solution could often be found on the left side: most frequently, compared to the left side, it was hypermobile or normal in its mechanics. Rarely did I perceive what I regarded as a major fixation as compared to the left side, when considering quality and quantity. For the most part, the right side consisted of marginal fixations; intermittently, a right major would appear to keep me alert and avoid me accepting patterns. Right-sided disc or radicular patterns were also intermittently observed. I am, and have been, referring to lateral flexion and rotation fixation patterns, where lateral bending and posterior to anterior rotation were being evaluated. Right anterior to posterior fixations on the right were more common.

Both the left and right sides of the neck need to be carefully examined, but exercise caution before adjusting the right side if you are dealing with a marginal fixation as compared with the left side. Especially be careful of the upper cervical spine at C-1/C-2, where so much motion is possible, and where there is consequent increased danger of damage to the vertebral arteries, ligaments, and nervous tissues.

My adjusting procedures usually combine lateral flexion with rotation in slight flexion. The degree of each has to be determined by feel and practice.

The most significant finding I can relate, regards the upper cervical spine. Specifically, the C-1/C-2 articulation. It is a common and unique situation, often unrealized and uncorrected. It can masquerade as right-sided migraine headaches, right-sided neck and head pain, right-sided throat pain and others. It is the C-1 posterior rotated and laterally fixated lesion with a C-1 right-sided anterior fixated position. When examining the C-1/C-2 articulation, you will see:

1. C-1/C-2 lateral flexion restriction, left side.

2. C-1/C-2 rotation restriction on the left, going posterior to anterior. That is, the left C-1 side does not move easily in rotation towards the right.

3. C-1 on the right resists anterior to posterior motion and is fixed anterior on the right.

In common language, C-1 is posterior on the left and anterior on the right, and does not side bend well on the left. I perform my own techniques in evaluating these fixations, which are quite simply performed by anyone.

Dangers in this fixation pattern are real and hazardous. Pain can be right or left, or both. Pain can be in the head or neck, shoulder, eyes, forehead, or temples. When pain is on the right side, it is most dangerous because it may cause a spasm or increased tension, and the DC may attempt to adjust the right side P to A. That is a big mistake. The muscle tension appears to be a posterior fixation, but there is an anterior fixation present, already too far anteriorward. A right-sided P to A thrust would cause it to move and more intensely fixate anteriorward. This would cause increased stress on an already stressed vertebral artery, ligaments, and nerve tissues. This could cause an accident. Even if the pain is not on the right side, and it is elsewhere, a serious accident could occur if C-1 right is adjusted further to the anterior. However, further inspection can reveal C-2/C-3 or occiput/C-1 right fixations. At times, if these fixes are significant, and if the doctor is precise, the right sided occiput or C-2 can be adjusted with good results.

The correction of this posterior left and anterior right fixation subluxation is to correct it solely from the left side. The correction is usually done in slight flexion, slight to moderate lateral bending, and slight to moderate rotation from the left. It is a combination of vectors, as based upon feel. What is felt is the greatest amount of resistance, and that is the angle. Simultaneously, a second imperative contact is taken behind the right side of C-1. The index or middle finger takes a tissue pull behind the right C-1 arch or TP. As mentioned above, you rotate, flex, and laterally bend on the left until the tension feels maximal and proper. The thrust takes care of left lateral flexion restriction, left rotation (going from left to right) and the right tissue pull does pull the C-1 right anterior fixation to the posterior, causing a release of all three fixations: left lateral flexion, left rotation, and right rotation (anterior to posterior).

In the above example, if there were no significant lateral flexion fixation, a pure rotation could be taken without lateral bending.

The result of the above adjustment is usually dramatic, with an overall immediate improvement in all complaints.

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