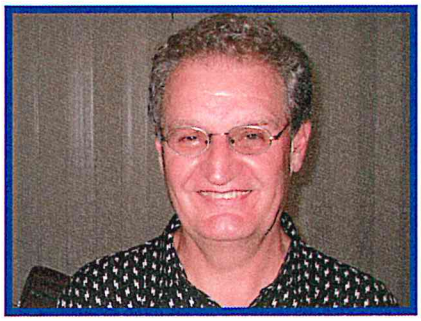
NOTES

Rational, Diversifed Manipulation and Philosophy Seminar



Dr. Leonard John Faye
DC, F.C.C.S.S (C) Hon., F.I.C.C

For more than 45 years, Dr. Leonard John Faye has led the transformation from the static, faith-based phase of chiropractic development to the dynamic, functional paradigm.
The author of hundreds of published articles, chapters and the book Good Bye Back Pain! (2008 Amazon.com; BookSurge Publishing), Dr. Faye has organized technique chaos into a biomechanical model. In addition to his published writing, Dr. Faye has also presented more than 300 seminars all over the world and delivered lectures to undergraduate and postgraduate students since 1967.
While an active chiropractor, speaker and publisher, his most influential work could be the 10-video series, Motion Palpation and Chiropractic Technique. In each video, Dr. Faye explains and demonstrates the dynamic chiropractic concept for specific areas. The videos in the collection have been valued resources for DCs and students alike.
Dr. Faye has become a world-renowned pioneer to the practice of chiropractic. After graduating from CMCC in 1960, he practiced in England for 15 years, Canada for 11 years and has been practicing in the United States for almost 25 years.

During his career, his expertise has been recognized through such achievements as:

- The Henri Gillet D.C. Award of Excellence given by the Belgian Chiropractors Association.
- The first chiropractor to be appointed by the Canadian Track and Field Team for the 1984 Olympics.
- The first chiropractor to present to the directors of the RAND Corporation in Santa Monica, CA.
- Co-authored chapters in well-known books: Foundations of Chiropractic, second edition by Meridel I. Gatterman; Fundamentals of Chiropractic by Daniel Redwood and Carl S Cleveland III; and Chiropractic Principles and Practice, by Scott Haldeman DC, MD, Neurologist.
- Author of Good Bye Back Pain!.
- Founder of ChiropracticMentor.com.

Copenhagen 2011 Seminar Agenda

Saturday ?

8:30 am Introduction: Philosophy of Chiropractic; Fact, Errors and Omissions.

Dynamic Principles and Rational Practice Concepts.

10:30 am Energy Break.

10:45 am The Cervical Syndrome: Facilitation of the Sympathetic NS.

Cervical / Upper Thoracic / Shoulder Girdle Kinetic Chains.

Twenty-one common symptoms.

Differential Diagnosis.

12:00 noon Lunch Break.

1:30 pm Lab demonstrations: diagnostic and adjustments to restore the Upper Thoracic, Cervical and the Shoulder Girdle Function.

3:15 pm Energy Break.

3:30 pm Continue Upper Thoracic, Cervical and Shoulder Girdle Adjusting.

5:30 pm End of Day

Sunday ? Lab Continues

8:30 am The Pelvis: A consensus of diagnostic tests and Adjustments Indicated.

10:30 am Energy Break.

10: 45 Lower Extremity, Hip, Knee and Foot Manipulation

1:30 End of presentations

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Non Surgical Shoulder Syndromes

The key to treating shoulder conditions is realizing you are treating the shoulder girdle.

Components of the shoulder girdle

- The Gleno-Humeral joint
- The Acromio-Clavicular joint
- The Upper Thoracic, Costo-Transverse Joints, especially the First Rib
- Cervical Spine, especially the Anterior to Posterior Rotation and Flexion of the lower Cervicals
- The Upper Thoracic Spine, especially the ability to glide anterior during neck extension and the ability to extend to as low as T-8.
- Scapular freedom on the Thorax

Biomechanical Insult

- The repetitive stress of compensation to a dysfunctional component of the shoulder girdle causes an inflammatory response.
- If the inflammation becomes a chronic low grade situation; it is only a matter of time before pathology develops in the Gleno-Humeral joint.
- Patients go for years putting up with “flare ups” followed by rest and N.S.A.I.Ds

One Traumatic Incident

- Even in these cases, with an obvious causative incident, the whole girdle needs to be treated.
- Most acute injury patients have pre-existing dysfunctions that need attention to obtain a full and speedy recovery.
- As an aside, this is true of most acceleration-deceleration injury patients. Pre-existing dysfunctions are as important as the injured tissues, for a full recovery

Ranges of Motion

- Active Ranges of Motion not just of the shoulder but of all the components of the shoulder girdle
- Passive R.O.M.
- Specific Joint Play not in the direction of active and passive ranges of motion.
- Recorded and discussed with the patient.

Patient Compliance

- The patient must learn to feel the loss of "Springy end-feel" of a "Manipulable Lesion"
- The pain response of a manipulable lesion is a non-lingering pain after eliciting a pain during palpating for the springy end feel we call Motion Palpation.
- Inflamed joints cause a lingering pain and lend themselves to a diagnosis.

The Double Diagnosis

- As chiropractors we need to be very conscious of the double diagnosis model.
- We need a biomechanical assessment and a pathological assessment to guide our treatment plan.
- We need a prognosis for both as well, because the inflammation often clears up before we establish normal biomechanical function. For example normalizing recruitment and strengthening shoulder muscles, comes after the joints of the shoulder girdle are able to function.
- This paradigm is what makes us unique.

Demonstrations

MPI Lumbar & Pelvis

- Types of Thrust:
- Impulse vs Fast Hands
- Recoil
- Body Drop a la Carver
- Dropping your body a la side posture “Roll”
- One arm Body Drop

Motion Palpation

- Quick Scan isolates level to be specific
- Patient sitting in Neutral posture
- Sacral Nutation and S/I Springy
- L5/S1 wave motion up to Occiput
- Glide Occiput anterior on Atlas
- Identify Manipulable Lesion Pain Response Challenge. Pain but no lingering pain
- Lingering Pain sign of Inflammation

Building a Consensus

- Doctoring is about Differential Diagnosis and building a consensus opinion, as to what procedures, to deliver to a patient.
- Basing a treatment on one test, is not a good idea
- MPI encourages attendees to become critical thinkers not disciples of a Guru.
- You must learn to judge the patients response visit to visit

Henri Gillets' S/I Palpation

- Patient stands and doctor places crooked thumbs on PSIS and 2nd Sacral Tubercle.
- The patient lifts a bent leg on the same side and "feels" the innominate flex with the flexing hip joint.
- If these few mm. of movement are "restricted" there will be visible, associated compensation to this "Flexion Dysfunction"
- The other knee flexes and/or the pelvis tilts

S/I Extension Restriction

- With our "crooked" thumbs in the same position we ask the patient to lift the other leg to determine if the sacrum can flex against the fixed, weight bearing innominate.
- This the same action as extension on the side we are palpating. Restriction forces a visible compensation at the weight bearing knee and/or the pelvis to tilt. Subtle but visible

Inferior S/I Joint ?

- Gillet taught that the S/I joint could form an axis of rotation in the upper or lower part of the joint because of its' auricular shape.
- He adjusted the upper and lower portions individually and followed with stretches to affect the Syndesmotic portion of the joint.
- Therefore there were eight possible S/I adjustments and an assortment of stretches

Other S/I Tests

- Side posture gapping for Joint Play
- Vleeming supine 4” Straight Leg Raise
- Parallel Lateral Sway
- Standing SLR
- Sensitive S/I Dorsal Long Ligament

Side Posture S/I Adjustments

- Mimic the positive palpation posture
- How you determined the restriction is one way to increase the lost motion.
- Remember we restore the joint function with a series of adjustments and have the pro-active patient stretch and exercise to maintain the gain.
- Lab Demo 8 possibilities. Ref: DVD Set, Dr Faye

Alternative S/I Manipulation

- Supine to increase Flexion with drop mechanism
- Extension using leg drop patient supine
- Symphysis dysfunction test and adjustment
- Squat stretch
- Figure 4 stretch
- Fencers' Stretch

Hip Consideration For LB

- Long axis Joint Play
- Internal and External Rotation with the patient prone and supine and the knee flexed.
- Adjustments prone and Supine with and without drop mechanisms.

Specific Lumbar Motion Palaption

- Leads to Rational Diversified Techniques
- Gang Sign Orthogonal Co-Ordinates
- Joints move in both Positive and Negative Theta ranges of motion.
- All adjustments are Rotations in a Positive or Negative Theta direction or Translation along an axis and can be coupled.

Thoraco-Lumbar Junction

- Maignes' Syndrome and Lumbar S.G.C.
- Supine Flexion
- Supine Extension
- Prone Extension Cross Bilateral
- Rotation / Counter Rotation
- Lateral Flexion
- Long Axis Distraction patient standing
- Motorized Distraction, prone adjustment
- Anterior Lig. ? Prone

Lumbo-Sacral Junction

- Nehri Disc Test
- Mennells' Springing Test for Post. Joint Infl.
- Lumbo-Pelvic Rhythm Test
- Side Posture Spondylolithesis Test
- Skin Roll Test
- Hyper Aesthesia Pin Test
- Quadratus Lumborum Test
- Jandas' Recruitment Order test
- Adams Scoliosis Test

Mid Lumbar Joints Side Posture

- Posterior Joint Extension
- Posterior Joint Flexion
- Lateral Flexion
- Posterior to Anterior Rotation
- Anterior Ligament Hyper Extension
- Long Axis (Y) translation patient standing

Must Read List

- Chiropractic-A Philosophy for Alternative Health Care by Ian Coulter, PhD pub by Butterworth / Heinemann
- Why Zebras Don't Get Ulcers by Robert M. Sapolsky 3rd Edition. Pub Henry Holt N.Y.
- DVD set Complete Full Spine & Extremity Adjusting Course L.J. Faye D.C., F.R.C.C.S.S. (Can.) Hon., FICC
- Go from this base and add to Subluxation Complex Components' heuristic model

Never Forget

- The Spine and Pelvis is part of a Closed Kinematic Chain called the Locomotor System.
- It adapts to its' own biomechanical, soft tissue and muscular faults and can be influenced by our Emotions and Viscero-Somatic Reflexes and the legacy of previous trauma.
- Never isolate or think you are treating one region, motion unit or muscle component.