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Techniques for the Cervical Region

Crow: According to Dr. John Fox, my mentor, and one of the founding members of the Cranial Academy, Dr. Sutherland became upset with some of his students, who he said were “decapitating the body” by doing only cranial manipulation. He emphasized that what he was teaching was “OSTEOPATHY in the cranial field.” In his 1947 course he taught what he learned from Dr. Still, while he was in attendance at the American School of Osteopathy. These techniques have been variously called BLT (balanced ligamentous tension techniques) or LAS (Ligamentous Articular Strain techniques). The techniques use balanced ligamentous tension to treat ligamentous articular strains.

West’s Lateral Cervical Technique

EXAMPLE: C3 dysfunction

PHYSICIAN: Standing behind the patient

PATIENT: Seated



STEP 1

1. Place your right hand on the patient’s C3. Your thumb and fingers are on the opposite articular pillars



STEP 2



STEP 3

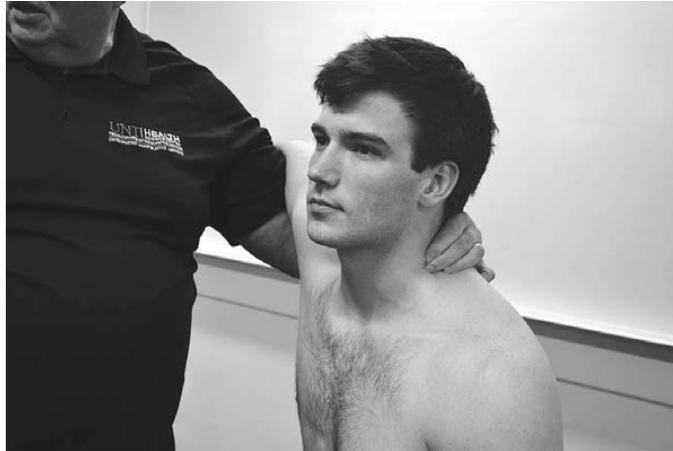
2. Take your left hand and place on the top of their head
3. Add mild compression and rotate their head in circles

West's Scalene Technique

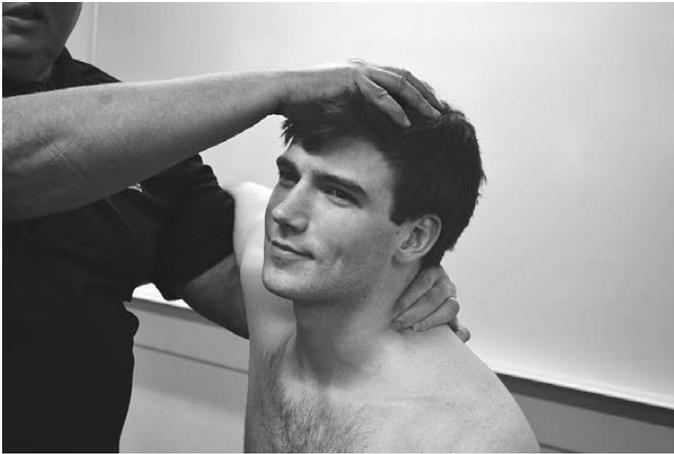
EXAMPLE: Left scalenes in spasm

PHYSICIAN: Standing facing the patient

PATIENT: Seated



STEP 1



STEP 2

1. Reach under the patient's right arm and place your left hand upon the tubercle of their left first rib, close to their neck, with your fingers directed anteriorly
2. With your right hand on top of their head, stretch their head back upon your knuckle. Rotate their head forward while moving their head slowly

West's Anterior Cervical Technique

EXAMPLE: C3 dysfunction

PHYSICIAN: Standing behind the patient

PATIENT: Seated



STEP 1



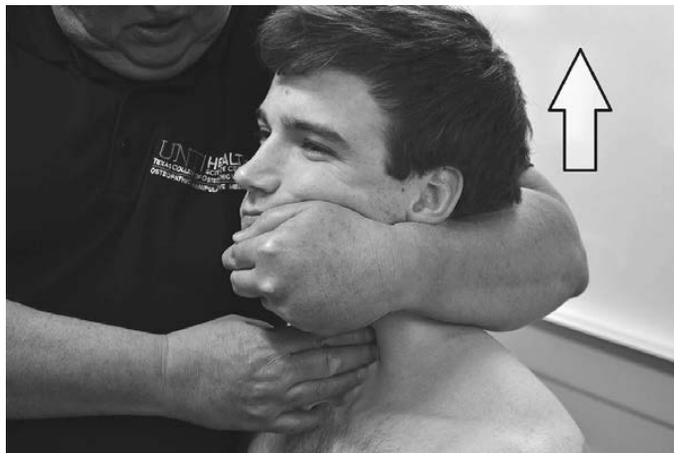
STEP 2

1. Place your right thenar eminence on their occipital protuberance and your long finger on the articular pillar of C3
2. Place your left fingers under their chin and your left thumb on the opposite articular pillar
3. Lift their head and add gentle pressure to the articular pillars with your fingers and thumb
4. Ask the patient to take a deep breath in and hold it until the cervical vertebrae release

Hazzard's Cervical Technique

PHYSICIAN: Standing in front of the patient

PATIENT: Seated



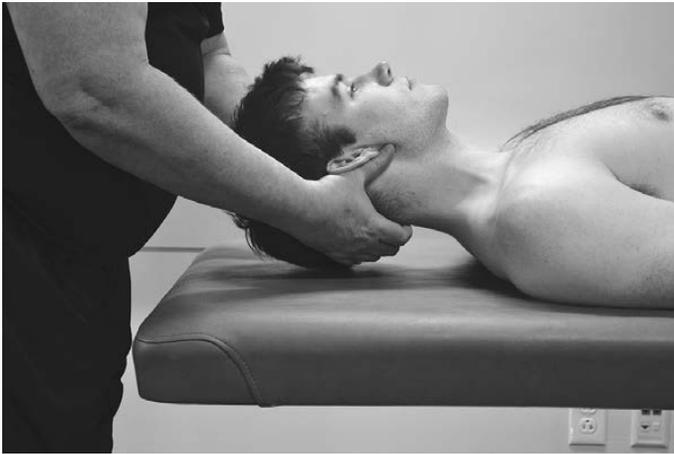
STEPS 1 – 2

1. Place your arm around the patient's neck so your elbow is just below their occipital protuberance posteriorly and with your hand beneath their chin
2. Their head is raised slightly
3. Palpate the cervical spine to find the area that is dysfunctional and then move their head to free the dysfunction

Hazzard's Technique for the Atlas #1

PHYSICIAN: Standing at the head of the table

PATIENT: Supine

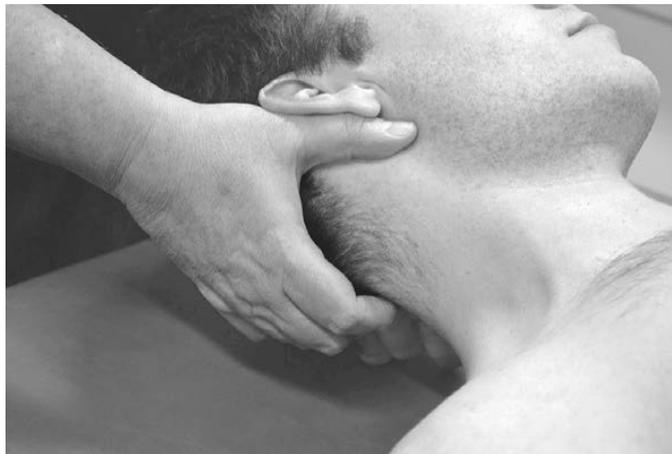


STEP 1



STEP 2

1. Hold their head between your hands, with your thumb or finger upon each transverse process of their atlas
2. Their head is now moved in a direction to exaggerate the lesion



STEP 3

3. Add traction and rotate their head until the atlas begins to move into place. Then add pressure upon the articular processes until their atlas is forced toward its correct position

Hazzard's Technique for the Atlas #2

PHYSICIAN: Stands with one foot on the table

PATIENT: Seated facing you



STEP 1

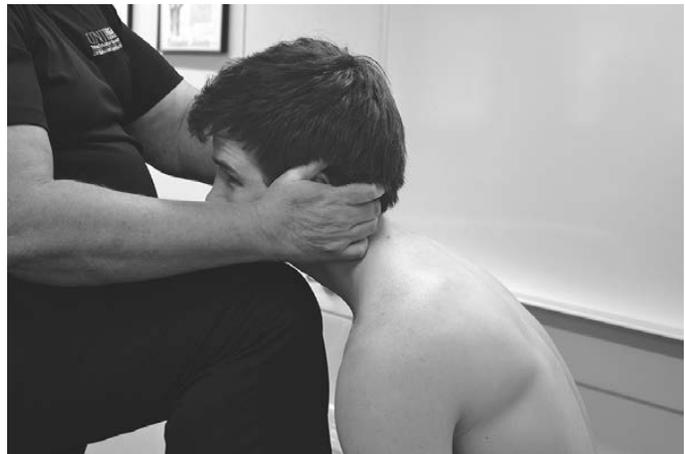


STEP 2

1. Place one knee beneath the patient's chin
2. Grasp the sides and back of the patient's head with your fingers firmly pressed upon the lateral arch of their atlas on each side



STEP 3



STEP 4

1. Their head is now moved in a direction to exaggerate the lesion
2. Add traction and rotate their head until the atlas begins to move into place. Add pressure upon the articular processes of their atlas



STEP 5

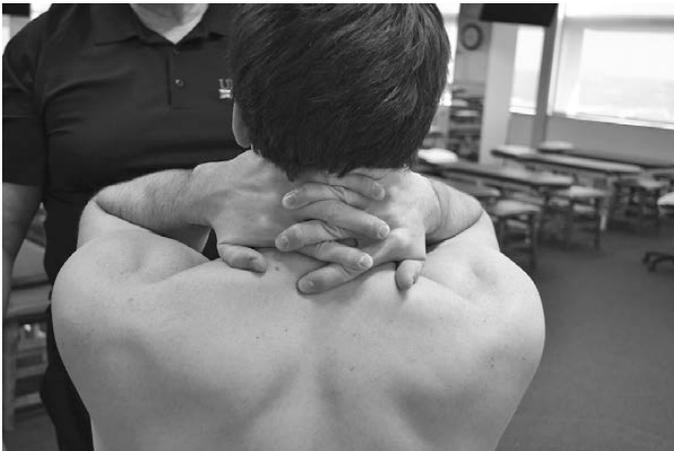
1. Their chin is slightly raised and drawn forward by the motion of your knee beneath their chin
2. The head is rocked upon the atlas gently, the requisite pressure being made upon the lateral arches to press the bone back to its position

Hazzard's Technique for the Atlas #3

Hazzard: Dr. Still uses the following movement in setting the atlas.

PHYSICIAN: Standing in front of the patient

PATIENT: Seated



STEP 1



STEP 2

1. Ask the patient to clasp their hands behind their neck, just below the skull. Press their pisiform bones firmly against the lateral arches of their atlas
2. Rotate their head to the affected (lesioned) side



3. “Sink it down” upon their spine (press their head downward) and press their atlas into place

Ernest Eckford Tucker on Cervicals

Lesions of the cervical vertebrae are found to be in all directions. These are bilaterally posterior, unilaterally posterior, directly lateral, unilaterally anterior, and rarely bilaterally anterior. In the bilaterally posterior position it is evident that both articular surfaces have become separated from those below. This is a primary lesion of one side leading to a secondary gapping of the opposite side. This is also found in sacral lesions.

Unilaterally posterior lesions are the most frequent. There is not found to be necessarily a corresponding anterior displacement of the opposite side. More often it is the reverse. The point of engagement is some point of bony contact, of the lateral lip on that displaced side with the lip of the corresponding vertebra. A flexion lesion on the opposite side may bring about a separation posteriorly on the affected side, with the engagement of the transverse process against the superior edge of the articular process below. The mechanics of these very frequent lesions are not perfectly clear. It may be necessary to abandon the bony contact theory, and to adopt a view of the mechanics of these lesions based on passing the dead-center of the ligaments. Consider also the much slighter restraining power of simple friction, effective only because the tension of the ligament moves away from the load of the vertebra above.

Unilaterally anterior lesions, if maintained by points of bony contact, must be maintained by a catch of the superior border of the articular process of that side against the surface above. This causes a subsequent flexion of the vertebral column. There are no other points of bony contact in anterior lesions.

Directly lateral lesions, the least frequent of these, are maintained evidently by a catch of the lateral lip against the tissues at the base of the bone.

Tucker's Posterior Cervicals

EXAMPLE: C3 posterior right

PHYSICIAN: Standing at the head of the table

PATIENT: Supine



STEP 1



STEP 2

1. Place the proximal joint of your right index finger behind and below the prominent portion of the patient's C3. With your other fingers support their neck, with the patient facing straight ahead in the midline
2. Hold the patient's articular pillars of C4 with your left hand



STEP 3



STEP 4

3. Side-bend their neck to the right without raising their head. Do not rotate their head until all of the tissues of the left side are on tension



STEP 4

4. Turn their face to a forty five degree angle and at the same time draw their head back slightly. Press with your finger across their C3 in the direction of their nose—parallel to the plane of the articulation. In the average patient a very slight pressure is sufficient to reduce the lesion
5. At the moment of reduction the arches of their C3 and C4 are drawn by the pressure of your finger into two straight columns. The cervical vertebrae below are drawn taut and straight while still holding the patient's C4
6. The complete extension of the left side makes this side serve as a fulcrum

Tucker: Caution: The reduction of cervical lesions is always attended by a conscious shock for the patient. This is sometimes unpleasant and often unexpected by the patient. The word 'care' was invented to apply to techniques for cervical lesions. Preparatory stretching is especially advisable here. Aside from the tensing of the ligaments on the opposite side, which must be maintained throughout, all motion must be focused on moving the bone in the lesion. By means of the leverage of the tensed ligaments and the pressing finger, which limits motion in the plane of its natural motion, all your attention should be focused on the reaction of the patient to avoid unnecessary shock. The force used must be so graduated as to go no further than the point of correction. Indiscriminate 'cracking' of the neck without a definite plan for the correction of a lesion is a danger and often damaging to the patient. This should be regarded as little short of criminal.

Tucker's Anterior Cervical Techniques

EXAMPLE: C3 right anterior

PHYSICIAN: Standing at the head of the table on the patient's right

PATIENT: Supine



STEP 1



STEP 2

1. Place the palm of your left hand beneath their occiput, holding the patient's head in as low a position as possible
2. With your right hand move their sternocleidomastoid muscle out of the way and gently press down on their prominent right C3



STEP 3

3. Side-bend their head to the left and to the physiological limit of motion. Without turning their head rotate their face slightly to their left. With your left thumb press down gently on the most prominent portion of the lesion
4. With a quick motion of your left hand turn their occiput to the left and their face to the right

Tucker: The effect of this technique is as follows, carrying the head to the limit of motion to the left locks all of the bony processes on that side against further motion. This makes that side of the cervical column the fulcrum for any further motion. At the same time the ligaments of the right side are all tense, tending to separate the bones in the lesion. Allowing the patient's face

