

04  
Foot Posture and  
Foot Orthoses—  
The Lost Connec-  
tion? Part I of II.



15  
The Cheapening  
of Chiropractic



20  
Colorful Olympic Tape  
for our Patients—  
Taping Movement,  
Not Muscles



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CHIROPRACTIC

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**CONTENTS:**

- 03** Research & Evidence
- 08** Business & Practice Tips
- 15** Editorial & Letters
- 16** BioPhysics Insights
- 20** Doctor Spotlight
- 23** News From Abroad

Your source of information for Chiropractic BioPhysics®—The Science of Spinal Health



Christopher J. Colloca, D.C.  
CEO and Founder of  
Neuromechanical Innovations

## Special Issue on Spinal Manipulation to Appear in the Journal of Electromyography and Kinesiology

At the invitation of Moshe Solomonow, PhD, MD (Hon), Editor of *The Journal of Electromyography and Kinesiology*, three prominent individuals in the forefront of spinal manipulation research were selected to serve as Guest Editors for a **Special Issue on Spinal Manipulation** appearing in the October 2012 issue of the Journal.

Guest Editors, Chris Colloca, DC, Joel Pickar, DC, PhD, and Malik Slosberg, DC, MSc were invited to compile related papers from the worldwide spinal manipulation field. Dr. Colloca is a Graduate Student in the PhD Kinesiology Program at *Arizona State University* and is also the CEO and Founder of the medical device company, *Neuromechanical Innovations* that manufactures the Impulse Adjusting Instruments. Dr. Pickar is a renowned neurophysiology researcher and Professor from the *Palmer Center for Chiropractic Research* who has received numerous Federal Grants for his work. Dr. Slosberg is a noted postgraduate chiropractic

See Special Issue on page 9

## CBP® Online Gets a Facelift & New Doctor Referral Directory

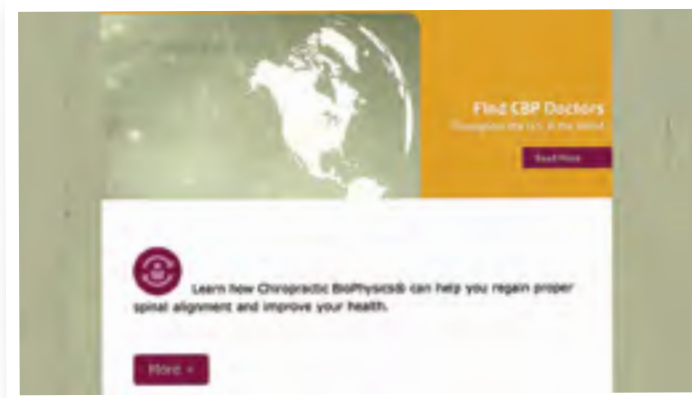
You asked for it, we did it. Recently, the Chiropractic BioPhysics' (CBP) website ([www.idealspine.com](http://www.idealspine.com)) received a professional makeover. According to Dr. Deed Harrison, President / CEO of CBP, "Dr. Joe Ferrantelli and I knew the CBP website was in a sad state of affairs. Simply put, we did not keep up with the technology for web development in the past several years and the result was that our website's functionality and look did not match our internal image and new marketing identity. Thus, I consulted and hired a professional web design team, whose custom chiropractic web design offerings were outstanding. I hired MyChiroPractice™

### The New Doctor Referral Directory

In addition to the new CBP website design, MyChiroPractice created

the new CBP Doctor / Patient referral directory. While this directory is still being developed, several of the features are currently live. CBP Chiropractors need to check their listings for accuracy to assist the process of debugging the content database. The criteria for listing on this new directory are as follows:

- Only chiropractors who have attended a CBP seminar in the previous 5

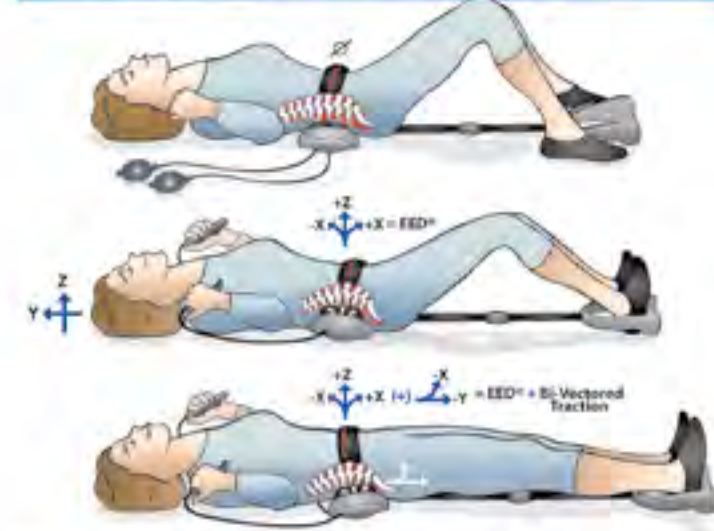


years will be listed on this directory; thus any Chiropractor not attending a CBP seminar since 2007 will not be listed;

- Chiropractors who have not attended a seminar in the previous 5 years, who practice various components of CBP Technique, and who

See CBP Online on page 21

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— Thank You, Dr. MM



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\*Other patents pending. Contact your health care professional before beginning any exercise program. Prices and colors subject to change without notice.

\*Please Note:  
It is entirely responsible to obtain the correct curve discoloration in Pre- versus Post MRI, especially if the shape of the subject disc changed. Therefore the Post MRI compression and displacement and are subject to interpretation. They are not and should not be used to determine EED™ effectiveness. Posture Pump.

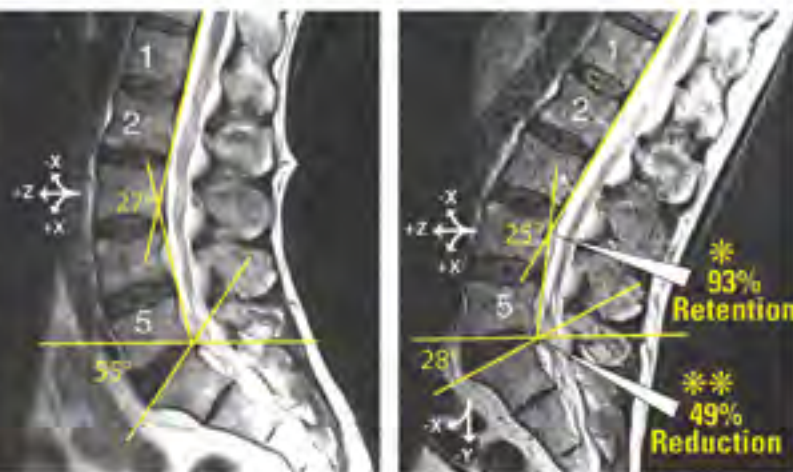


This difficult case exhibits disc compression, desiccation and bulging with osteophyte formation at various levels. Compare disc compression at L1/L2 and L4/L5 in this neutral image (no device applied) with disc expansion in the adjoining image of the same subject during application of EED™ with Bi-Vectored Traction™.

During simultaneous application of EED™ and Bi-Vectored Traction™ via Posture Pump™ Penta Vec™ 2500, high level joint expansion of 47% at L1/L2 and 43% at L4/L5 is attained by 5 simultaneous vectors of force! Carefully compare joint expansion with adjoining MRI of the same subject.

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Subject G with EED™ applied      Subject G with EED™ and Bi-Vectored Traction™ simultaneously applied



As EED™ was applied with the new model 2500; the expanded lumbar curve measured 27° with a sacral base angle of 55°. Carefully compare these angles with the adjoining MRI.

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## Suboccipital Headache

Dan Murphy, DC— Private Practice of Chiropractic; Diplomate American Board of Chiropractic Orthopedist; Faculty Life Chiropractic College West; Vice President ICA 2003-2009; ICA Chiropractor of the Year 2009

### INTRODUCTION

All headaches synapse in the Trigemincervical Nucleus.<sup>1</sup> See Figure 1.

The 4 suboccipital muscles are innervated by the posterior primary rami of the C1 nerve root.<sup>1</sup> See Figure 2.

Three of the suboccipital muscles are directly and firmly attached to the spinal dura mater.<sup>2,3,4,5,6</sup>

- Rectus Capitis Posterior Major (C2 spinous process to the occiput)
- Rectus Capitis Posterior Minor (posterior arch C1 to the occiput)
- Obliquus Capitis Inferior (C2 spinous process to the transverse process of C1)



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Figure 1

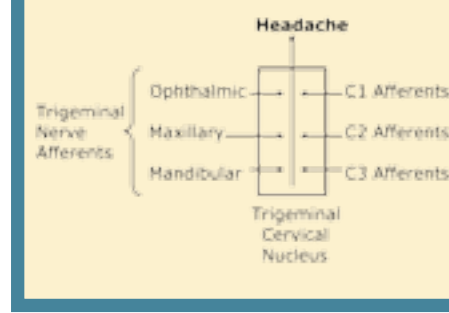
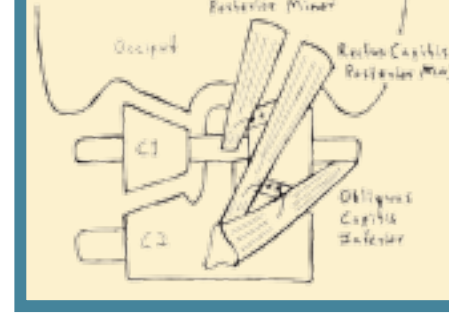


Figure 2



### DISCUSSION

The apparent function of the attachment of the suboccipital muscles is to prevent the cervical spine Dura Mater from being mechanically irritated, injured or inflamed during spinal motions.

The cervical spinal Dura Mater is innervated with pain afferents (nociceptors) from the upper cervical spine nerve roots.

Upper cervical spine nerve root nociceptors synapse in the Trigemincervical nucleus, and are therefore capable of initiating an electrical signal in the brain interpreted as being headache.

Mechanical dysfunctions of the upper cervical spine may compromise the ability of the suboccipital muscles to protect the Dura Mater from motion related stress, irritation, injury, and inflammation.

Whiplash extension injuries occur quickly, so that the suboccipital muscles do not have enough time to contract and pull the spinal Dura Mater to safety, resulting in injury and headache.

In chronic whiplash patients, injured suboccipital muscles may undergo atrophy and fatty infiltration, further compromising the ability of these muscles to protect the dura mater from irritation and inflammation during routine motions, resulting in headache.<sup>7</sup>

### SUMMARY

Chronic upper neck postural stress and distortions that invoke contraction of the suboccipital muscles may cause chronic stress on the spinal dura mater, resulting in headache. This is particularly important in postural techniques, such as Chiropractic Biophysics.

Mechanical dysfunctions of the upper cervical spine may also irritate/inflame the spinal cord and its blood

supply because the Dura Mater is attached to the vascular Pia Mater that surrounds the spinal cord.<sup>8</sup>

There is biological plausibility for upper cervical spinal manipulation, occiput-atlas-axis chiropractic alignment, postural improvement, and suboccipital muscle myotherapy to be utilized in the cervicogenic headache patient.

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See Suboccipital Headache on page 15

## Did You Know? By Dan Murphy DC.

# 59%

**In patients suffering from chronic pain subsequent to degenerative spinal disease, 59% can eliminate the need for pain drugs by consuming adequate levels of omega-3 essential fatty acids.**

(Surgical Neurology, 2006)

**Removing aspartame and glutamate from the diet for 4 months can eliminate chronic pain symptoms.**  
(Annals of Pharmacology, 2002)

# 4

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Dr. Dan, (DC)  
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Again, thank you!

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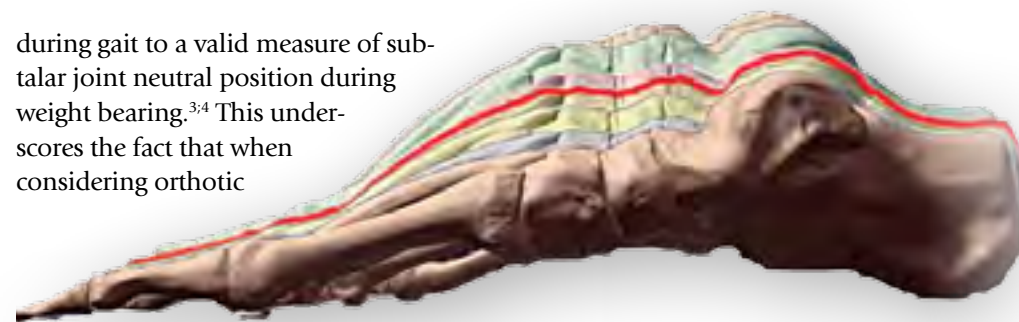
# Foot Posture and Foot Orthoses—The Lost Connection? Part I of II.

When considering these concepts within the scope of current popular foot orthosis intervention strategies, the question arises as to why these concepts have not been applied to the foot to any significant degree. Although clinicians may consider these concepts in their clinical evaluation, it seems that these ideas have lost traction when it comes to foot orthosis design and correctional model. In many common models, emphasis is less on correcting foot posture that may have deteriorated and more about shifting tissue stresses and forces. Although shifting tissue stresses may provide pain relief, it may be too narrowly focused and not provide the most complete preventative solution to the problem.

## DISCUSSION

The Podiatric concept of basing a foot orthosis around the tenet of subtalar neutral has been called into question. Investigations have demonstrated the lack of correlation of rear foot motion

during gait to a valid measure of subtalar joint neutral position during weight bearing.<sup>3,4</sup> This underscores the fact that when considering orthotic



intervention to affect dynamic function, the subtalar joint neutral position cannot be relied on to predict the corrected position. In addition, the ability and degree to which a custom orthosis can even control rearfoot motion is debatable. Davis et al showed that there are few differences between a custom and a semi-custom device in the ability to control the rearfoot<sup>5</sup> and that foot orthotic devices do not produce significant change in rearfoot-tibial coupling.<sup>6</sup>

Measurements of the rearfoot to forefoot relationships in the static position have been the foundation for a clinical rationale. Investigations into the assumptions behind these measurements have shown that the goniometric measurement of the forefoot to rearfoot relationship is unreliable regardless of clinical experience.<sup>7</sup> In addition, one study revealed that when comparing groups of doctors casting for foot orthotics (inexperienced, experienced and "expert") there is a 16.5 degree variation in the measurement of frontal plane forefoot to rearfoot angulation across the groups.<sup>8</sup> This relationship is the major determinant of arch height. When considering the degrees involved in the strategy of posting the rearfoot (i.e 4-10 degrees) this variability casts doubt on the practicality of rearfoot control with a posted orthosis. Foot type analyses that involve primarily frontal plane static measures may have less to offer than more dynamic and robust analyses. Clinical measures of static foot structure that have included subtalar range of motion and calcaneal eversion and inversion, have been shown to have poor interrater reliability.<sup>9</sup> Moreover,

these rearfoot measurements are poor predictors of dynamic rearfoot motion.<sup>10</sup>

To review, if these static measurements are unreliable, and unrelated to the function of the patient's foot in motion, then any skepticism on the part of the clinician regarding these types of foot posture measurements, is warranted. However, abandoning the concept of foot posture altogether because the rearfoot measurements don't correlate, does not help with the great incongruity that exists - we generally accept the concept of an ideal architecture to the rest of the human body, so why should this not apply to the foot?

## SUMMARY

In contrast to the clinical murkiness of the measurements discussed above, we do know that

there are statistical differences in the biomechanical function between the planus and rectus foot.<sup>11,12</sup> It is thought that changes in foot structure affect dynamic function<sup>12</sup> and foot morphology has been implicated in a variety of lower extremity overuse injuries.<sup>13,14</sup> A pronated foot posture is thought to be a factor in various pathologic conditions of the foot; for example the excessively pronated foot has been cited as a cause of limited dorsiflexion at the first metatarsophalangeal joint during gait.<sup>15,16</sup> Munteanu et al also postulated that people with pronated feet are more likely to exhibit limitation of dorsiflexion at the first MPJ during gait, and found that orthoses focusing on the forefoot to rearfoot relationship (Blake-style inverted) did not significantly change the range of motion.<sup>17</sup> Could this be due to the focus of this type of intervention on

The Podiatric concept of basing a foot orthosis around the tenet of subtalar neutral has been called into question.

See *The Lost Connection* on page 23

Dr. Ed Glaser, DPM  
Dr. Glaser is the President and developer of Sole Supports orthotics.

## INTRODUCTION

Chiropractors rely on the study of human form and posture to determine deviations from normal and apply appropriate corrections to the underlying structure. It is commonly accepted that departures from correct form, posture or structure, either through acute trauma or insidious degradation, affect function. Muscles exert their pull and force more efficiently across joints and the human body is better able to counteract the effects of gravity and the ergonomics of

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Chiropractic Biophysics Non-profit, Inc. is a 501(c)(3) nonprofit corporation dedicated to the advancement of chiropractic principles through scientific research. Dr. Don Harrison (deceased) and his second wife Dr. Deanne LJ Harrison (deceased) founded CBP research foundation in 1982; it was registered as CBP Non-Profit, Inc. in 1989 by Dr. Sang Harrison (Don's 3rd and final life's love). Through this organization Dr. Don and colleagues have published 140 peer-reviewed spine and Chiropractic research publi-

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cations. Further, CBP Non-Profit, Inc. has funded many scholarships as well as donated chiropractic equipment to many chiropractic colleges; always trying to support chiropractic advancement and education. Dr. Don Harrison was the acting president of CBP Non-Profit, Inc. since 1982. Currently, Dr. Deed Harrison (Don's son) is the President of CBP Non-Profit, Inc.

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- Validity of the measurements and evaluation of patients,
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- Case studies evaluating technique outcomes,
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Eric Huntington, DC  
Co-Owner Developer of the Chiropractic Business Academy  
drhuntington@chirobizacademy.com

## Keys to Success that Most Chiropractors Don't Apply

clearly differentiating it from what most practice owners do on a daily basis. An owner may wear OTHER hats, such as the doctor hat, the ROF hat (sales), the Insurance hat, or any other hat within the organization.

But the true owner hat in a chiropractic practice encompasses things such as goal setting, determining plans of action, handling legal and compliance issues (at least overseeing them), managing key staff (not all the staff), and Public Relations (not marketing)—among other things.

**Goal Setting:** The owner determines where the organization is going, short-term and long-term. This is a crucial and should be done on a regular basis. However, most owners wear this hat for only a few months prior to opening the clinic and then drop it for the rest of their career.

Prior to things such as the internet and devices such as cell phones, the chiropractor of yesteryear operating a slow practice, probably used the agonizing hours between patients to dream up the future—and ways to get there. Today, it's easy to fill that time text messaging friends, or surfing the net. It's important to recognize that there is a big difference between wishing one had more money or a better practice and actually determining goals and figuring out the best

strategy to achieve them.

Unknown to most, there are very effective tools you can use to define exactly what you want to achieve. The Chiropractic Business Academy helps chiropractors apply these tools daily.

• **Determine the Purpose(s)**

There could be many reasons why you want to achieve your goal(s), or maybe there is just one. That's up to you. *But the main driving force behind most activities in life is the purpose.* It's the reasons one is going for the goal(s).

The purpose behind ANY activity is SO IMPORTANT, that some practice building gurus have packed huge conference rooms offering ONLY one thing—helping chiropractors find or establish a purpose to practice. Despite the fact that focusing exclusively on purpose is rather narrow in scope for a “practice building” seminar it nonetheless can achieve dramatic results.

It's so powerful that purpose alone, with hardly the application of any other administrative skill, has built some very large chiropractic practices. Albeit, these practices that operate on purpose alone may lack other important components leading to doctor burnout, overworked staff, and low fees, the fact remains that purpose is near the top of the list when it comes to the driving force behind success.

Defining the purpose(s) of the organization and its activities as well as figuring out ways to invigorating the staff with that purpose is part of the owner hat.

The Chiropractic Business Academy helps chiropractors to establish, reestablish or further define their purpose so as to help unleash the fire which drives practice and personal success.

• **Making a Plan**

Once you have your goals clearly defined, backed up by YOUR reason for achieving them, the next step is to figure out the plans needed to achieve the goal(s).

You may find it easiest to break up the plans by area of the organization, such as a plan for the marketing, a plan for improving patient care, a plan for improving your report of findings, a plan for training your staff, etc. The key is to determine the general concept of what you want to ac-



complish and put it into word—, such as “establish a marketing campaign to bring in 10 new patients per week”.

In most cases, you would have several of these plans all which will coordinate to bring your practice from where it is today, to where you would like it to be at some specific point in the future.

As a practice grows, the owner would need to constantly update these plans, and determine new plans to continue the practice toward its goals. Plans need to change for many reasons. Some plans are completed—brought all the way to full execution. Other plans need to be altered because new situations arise. Still other plans need to be dropped all together based on new data.

Establishing and reworking plans is an ongoing process, at least monthly. Monitoring the steps taken to carry out these plans should be a daily and weekly activity of an owner.

The Chiropractic Business Academy helps practice owners establish the exact plans needed to achieve the goals set by that doctor. In fact, one of the first

See Keys to Success on page 23

Special Issue—cont'd from page 1

lecturer from *Life College of Chiropractic West*. Together, they formulated an outline for paper submissions based upon the following topics: The Basis for Spinal Manipulation; Epidemiology; Clinical Research; Kinesiological Research, and Neurophysiological Research.

Through their our own personal contacts within the research community and keyword searches of the Pubmed database using ‘spinal manipulation’ together with relevant categorical terms researchers and research groups who had published on these topics were identified. Original and review paper submissions from thirty-one individuals representing twenty-five institutions who were identified as lead researchers or department heads and who were considered authorities within a given topic on spinal manipulation. Consistent with the pro-

fessional diversity of spinal manipulation research, scientists with backgrounds in chiropractic, osteopathy, physical therapy, manipulative physiotherapy, and rehabilitative medicine were sought. In addition to these professional associations, submissions were sought from individuals within the disciplines of anatomy, biomechanics, biomedical sciences,

education, epidemiology, engineering, kinesiology, medicine, neurology, and public health. Eighteen paper submissions were received. Manuscripts went through the Journal's peer-review process ultimately yielding seventeen papers included in the special issue.

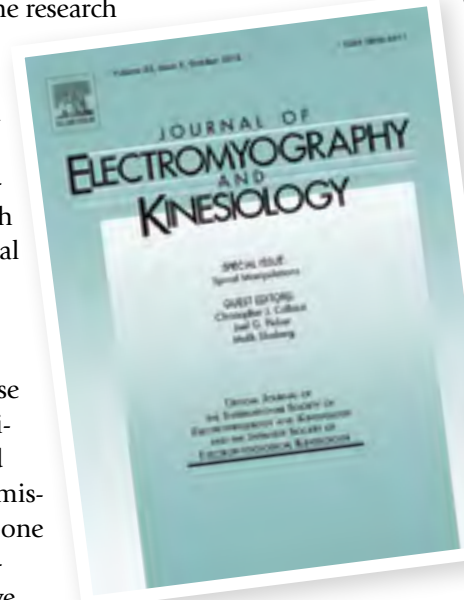
When asked about how this Special Issue came to be, Dr. Colloca said, “I first met Professor Solomonow at the International Society for the Study

of the Lumbar Spine (ISSLS) conference in 1999 in Kona, Hawaii. He won the Volvo award that year in Spinal Biomechanics for his work in ligamentomuscular reflexes, so I made it a point to reach out to him and introduce myself. Over the years at

conferences, I had the opportunity to chat with him and we published a paper in the *JEK* in 2008. Ultimately invited him to speak at our International Spine Research (INSPIRE) Foundation symposium that we hold in Phoenix each year. Dr. Solomonow spoke to our group twice and got to see

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first-hand the chiropractic research that our group was conducting. The idea for a special issue on chiropractic research stemmed from these discussions. Dr. Solomonow knew well of Dr. Pickar's excellent work in neurophysiology and he felt Joel would be an perfect candidate to assist in reviewing the many papers as a Guest Editor for this issue. Dr. Slosberg had also reached out to Professor Solomonow to discuss some research projects that he had an interest in and in seeing how well read Malik was made a natural fit for him to participate. Dr. Solomonow will



INTRODUCTION

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**INTRODUCTION**

I receive many calls from Chiropractors all over the country who have been with different management groups. I realize many management groups are all different variations of the same thing.

The different variations are dependent upon the personality of the founder(s) communicating traditional chiropractic. What does this mean? Although there is benefit from every group, they all teach us to speak ABOUT a subluxation TO a person rather than speaking TO a person WITH a subluxation.

Truthfully speaking a subluxation, whether globally subluxated by posture or segmentally within an abnormal curve, a subluxation is still a FACT. Since the general public does not typically see a subluxated posture as a life or death

**Stop Speaking ABOUT a Subluxation TO a Person and Start Speaking TO a Person WITH a Subluxation.**

decision like cancer, which they are familiar with, it is up to us, chiropractors, to help them see this fact. The question is, "How do we help patients FEEL the same URGENCY about a subluxated spine and posture as they would cancer?"

The challenge is people make decisions according to how they FEEL, not what they think. Showing a patient an x-ray and telling them ABOUT a subluxation does not create the urgency or the understanding of a life or death decision. Do you know how your patients FEEL about their condition? Do you ask?

Since the general public does not typically see a subluxated posture as a life or death decision like cancer, which they are familiar with, it is up to us, chiropractors, to help them see this fact.

A person WITH a subluxated posture is an emotional being. Speak TO that individual and understand how they FEEL with a condition that will threaten their life. First of all, **DO YOU BELIEVE IT WILL THREATEN THEIR LIFE!** They will believe proportional to the amount you are convicted to your belief. An example of speaking TO a person WITH a subluxation is, "Mrs. Jones, how do you FEEL that you've lost the curves in your spine causing extreme stress and tension on the spinal cord shutting down the energy to your organs progressively weakening your immune

system, your digestive tract, reproductive organs and slowing your metabolism? In fact, your body is aging faster every day as your spine continues to collapse? How does that make you FEEL?" It is the FEELING that will inspire her to commit. You would then ask her spouse, "Mr. Jones, how do you FEEL knowing your wife's metabolism is getting weaker every day as her weakened spine and posture collapses? She is wearing her body out? How does that make you FEEL?" His answer regarding his emotion is the key to his commitment to help his wife. ALWAYS use the spouse's feelings to influence patient commitment.

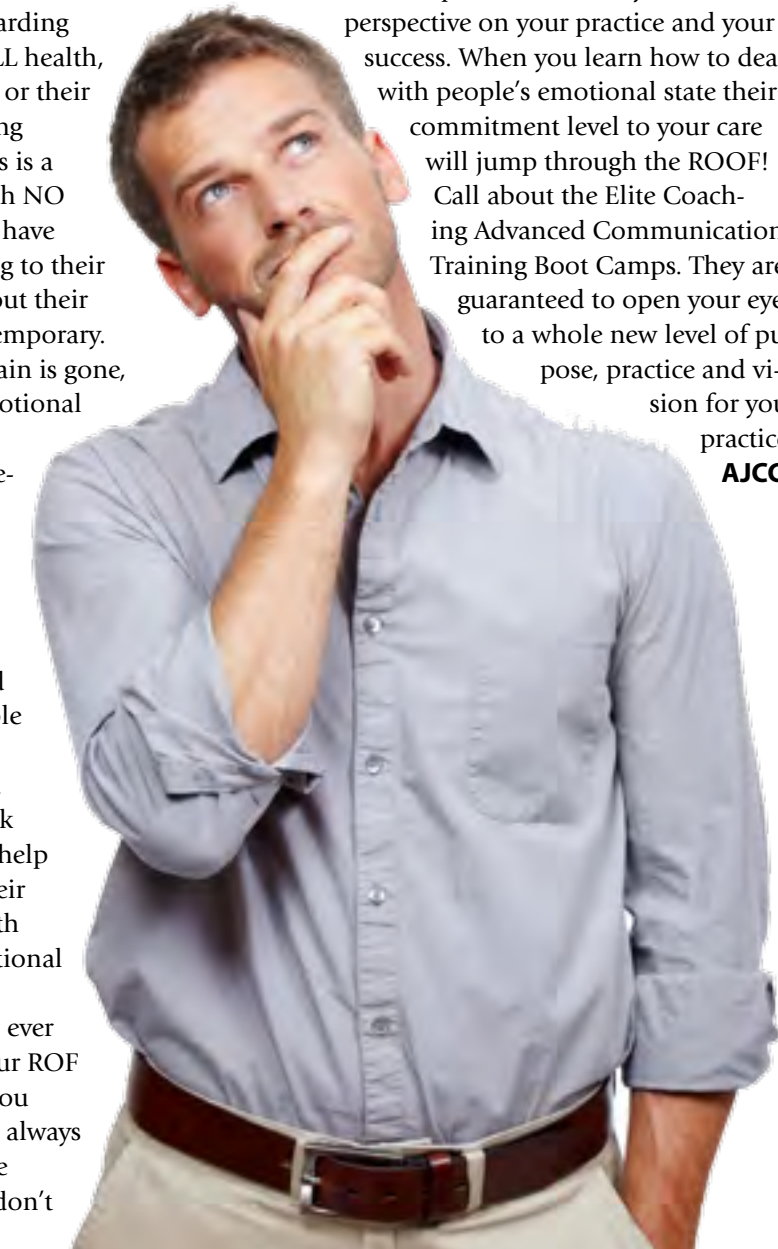
Since people are emotional beings making decisions from an emotional perspective, we need to learn advanced communication to speak to different types of personalities and emotions regarding their OVERALL health, NOT arthritis or their PAIN. Speaking about arthritis is a condition with NO urgency, they have time. Speaking to their emotions about their pain is very temporary. When their pain is gone, so is their emotional attachment. Many management groups attempt to build value on these two conditions. Both will lead to some people walking out of your office. We must think BIGGER and help people see their ORGAN health from an emotional perspective.

Have you ever noticed in your ROF the patients you resonate with always sign up vs. the patients you don't know how to

connect with almost never sign up? This is a personality dependent practice and will keep you a prisoner of your practice.

Do you know how to communicate with a victim, someone who is hopeless, someone who always has to be right, someone who doesn't like chiropractors, a timid person vs. a AA, CEO personality, etc. These are all examples of different types of emotions people walk in your office with that may not be committing to your care because you have not been trained how to communicate effectively with them. Speaking ABOUT a subluxation to these people may not work and they walk out of your office. In reality, they desire to live a subluxation free life too.

Communication training applied to Chiropractic will shift your whole perspective on your practice and your success. When you learn how to deal with people's emotional state their commitment level to your care will jump through the ROOF! Call about the Elite Coaching Advanced Communication Training Boot Camps. They are guaranteed to open your eyes to a whole new level of purpose, practice and vision for your practice. **AJCC**



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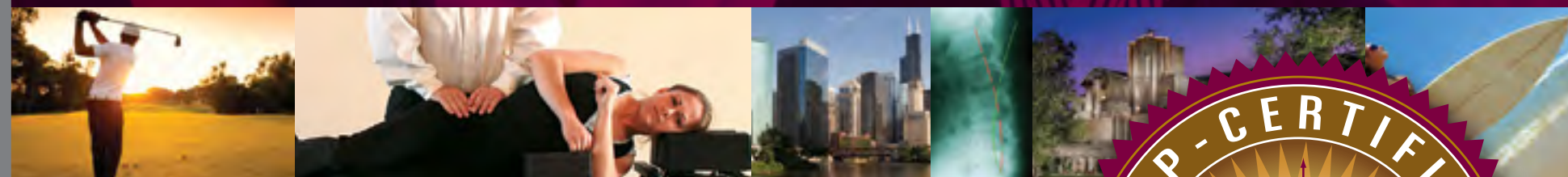
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ing the health of patients. CBP is practiced the world over, and taught in numerous chiropractic colleges. And it's continually upgraded through ongoing clinical trials, improved equipment, and refined techniques.


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 <b>Deed Harrison, DC</b> President of Chiropractic BioPhysics (CBP). Deed is one of the most published researchers in the the Chiropractic profession.	 <b>Jason Jaeger, DC</b> Developed the Universal Traction System. Co-manages patients with Neuro-Surgeons, Pain management specialists, etc.	 <b>Dan Murphy, DC</b> Undergraduate faculty member at Life Chiropractic College West. Expert in various Neuro disorders and injuries.	 <b>Don Meyer, DC</b> Developed numerous Ambulatory, Vibratory and Motorized dynamic postural/structural corrective devices.
 <b>Bob Berry, BS, BS, DC</b> Founder of Berry Translations and creator of the Berry Lateral Translation Traction unit; used in CBP offices around the world.	 <b>Jason Haas, DC</b> Researcher, board member of CBP NonProfit, Inc. Co-developer of the CBP Business Seminar Series.	 <b>Joe Betz, BS, DC</b> ICA board member, Vice President of CBP NonProfit. Principal investigator on two Chiropractic guidelines.	 <b>Cindy Boyd, DC</b> Owns a CBP focused health and wellness facility in Alameda CA. CBP Technique instructor at Life Chiropractic College West.
 <b>Joe Ferrantelli, D.C</b> CEO of PostureCo, CTO of CBP Seminars. Lectures on technological advances in technique, and biomechanics.	 <b>Evan Katz, DC,</b> Published studies in <i>Spine Journal</i> , <i>Journal of Pain Physician</i> and others. Served on various health care boards.	 <b>Shirlene Harrison, DC</b> 14 year owner/clinician of a practice in Nevada. Currently a dedicated instructor in all aspects of CBP Technique.	 <b>Paul Oakley, MSc., DC</b> Researcher and board member of CBP NonProfit. Masters of Science in the field of Biomechanics.
 <b>Sandy Haas, DC</b> Instructor for CBP technique. Co-developer of the CBP Business Seminar Series (Ideal Practice Performance).	 <b>Jennifer Brandon, DC</b> Has used CBP techniques in her family practice for 20 years. Author of several peer reviewed pediatric articles.	 <b>Jean-Guy Daigneault, BS, DC</b> Practiced clinical nutrition. CBP instructor at the University of Quebec at Three Rivers.	 <b>Pete Lope, DC</b> Board member of CBP Non-Profit. Manages the CBP Case Consultation on call service. Maintains a private practice in NJ.

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Oct. 20-21**	Ideal Practice Performance, Module 3	Windsor, CO	Drs. Jason & Sandy Haas' Clinic	970-744-1084
Oct. 27-28	Whiplash Trauma	Orlando, FL	Hyatt Regency Grand Cyprus	888-421-1442
Nov. 10-11**	Ideal Practice Performance, Module 3	Windsor, CO	Drs. Jason & Sandy Haas' Clinic	970-744-1084
Dec 1-2	Cervical Rehab	Las Vegas, NV	Red Rock Resort-Casino	866-767-7773
Dec 7-9°	Basics X-ray & Posture	Eagle-Boise, ID	Hilton Garden Inn	208-938-9600
Jan 25-27°	Drop Table Adj. & Lower Extremities	Eagle-Boise, ID	Hilton Garden Inn	208-938-9600
Feb 22-23*	Scoliosis Module 1: CBP Analysis & Mgmt	Park City, UT	Hotel Park City	435-940-5010
March 1-3°	Upper Cervical & Posture Instrument Adj.	Eagle-Boise, ID	Hilton Garden Inn	208-938-9600
March 9-10	Pediatric Analysis & Adjusting	Marietta, GA	Life University	TBA
April 12-14°	Cervical Rehab	Eagle-Boise, ID	Hilton Garden Inn	208-938-9600
April 27-28	Whiplash Trauma, Analysis Management	Morristown, NJ	Hyatt MorrisTown	888-421-1442
May 17-19°	Lumbar Rehab	Eagle-Boise, ID	Hilton Garden Inn	208-938-9600
June 21-23°	Thoracic Rehab	Eagle-Boise, ID	Hilton Garden Inn	208-938-9600
June 29-30	Basics X-ray & Posture	Dearborn, MI	TBA	TBA
July 12-14°	Posture Neurology & Health-Dr. Murphy	Eagle-Boise, ID	Hilton Garden Inn	208-938-9600
July 26-28***	CBP Hands On Workshop	Eagle-Boise, ID	Hilton Garden Inn	208-938-9600
Aug 16-18	35th CBP Annual	Chicago, IL	TBA	TBA
Sept 20-22°	Biomechanics of the Spine	Eagle-Boise, ID	Hilton Garden Inn	208-938-9600
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Nov 15-17°	Scoliosis Module 2: Mirror Image Bracing	Eagle-Boise, ID	Hilton Garden Inn	208-938-9600
Dec 6-8°	CBP Functional Rehab & Mirror Image	Eagle-Boise, ID	Hilton Garden Inn	208-938-9600

Welcome to the brand new Ideal Spine Health Center. You may have noticed that most of the upcoming CBP seminars are now held at this facility. It has always been challenging to train Chiropractors in the technicalities and nuances of CBP Technique in hotel conference settings without the necessary equipment. We've solved that problem as well as being able to demonstrate how a full scale CBP office looks, feels, functions, and operates.



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Figure 1: PostureScreen Mobile example of an AP postural analysis.



Figure 2: Sample Mirror Image® Exercise for Thoracic to Pelvic Postural Subluxation.



Figure 3: Video Clip of a cervical translation resistance exercise. Unique to the WebExercises platform is online streaming video tutorial so your patient can learn exercises while at home.

Oct 12

aicc

Editorial & Letters



Randall Hammett, DC  
Private Practice of Chiropractic

## The Cheapening of Chiropractic

### INTRODUCTION

Its funny how in tough financial times, especially for healthcare professionals, dermatologists are opening medical spas, orthopedic surgeons are opening exercise and PT clinics and chiropractors are adding all types of non-chiropractic services to make a living. In 33 years of practice I have experienced three large economic downturns in the United States, during this economic upset I have watched chiropractors and other professionals make strange choices in increasing their incomes. Recently a chiropractor was sentenced for importing and prescribing HCG for his patient's weight loss scheme. Another is sentenced for billing services without rendering them, and another is sentenced for practicing outside his limitations. Another chiropractor is offering \$10 adjustments as a spinal screening, no examination or x-rays needed. On and on it goes with the unusual solutions to financial woes.

Unfortunately, chiropractors for far too long have been potty trained by the insurance industry,

the government and the public on what their care is essentially worth. We've been told by PPO's that we are worth a certain amount and we become to believe this

as a fact... Medicare tells us that an adjustment is worth a certain amount of money and we begin to believe that also. The poor mentality permeates the profession like the black plaque in Europe did. On a daily basis chiropractors ask themselves, what will the government think? The board?

The PPO? In fact many chiropractors spend much time thinking about what others think, they forget to think about themselves and that my fellow chiropractors is death in your practice.

Chiropractic consultants around the country profess that they have your answers. Really then why are they not in practice full-time earning a living that they profess they're going to teach you? The general wonder if BJ Palmer or Clarence Gonstead had a practice management consultant. Doubtfully. What they did have was an innate sense of what public needed and wanted and provided that to them in an expert, economical manner.

First, the insurance war is over, we lost! You get the crumbs of third-party reimbursement and nothing more. Second, the good news is you're still in charge of your own business or practice to a certain extent. Success in your practice is still about you and what you care about. Face facts, it was you who sat through all the thousands of hours of schooling, sat through

state and national boards in humiliation. It was you who tried to make every detail of your office patient friendly and economical. It was you who looked over

everything so that you could improve your family's lifestyle. It was your ability to help others achieve health and mastering that alone improved and increased your practice volume. Think about this as your true worth from your lifesaving, life improving spinal adjustment worth \$18.75? Is it worth

charging \$10 a spinal screening special? Think! Gee have a brain. What is your time and talent worth in your community?

It was your ability to help others achieve health and mastering that alone improved and increased your practice volume.

The cheapening of chiropractic starts on the inside of each of you, just as the answers are inside of each of you. The coming of national health insurance, ever limited third-party coverage should paint a picture of what you're doing right now with your practice and your mindset as far as the finances of your practice. Place your focus solely on the best patient care you can provide as well as charging correctly for the services that you provide and you will survive, step out of these bounds and you will parish. Till next time. **AJCC**

### Suboccipital Headache—cont'd from page 3

- 2011; Vol. 36; No. 25, pp. E1612-E1614.
- 7. Hallgren RC, Greenman PE, Rechten JJ; Atrophy of suboccipital muscles in patients with chronic pain: a pilot study; Journal of the American Osteopathic Association; 1994 Dec;94(12):1032-8.
- 8. White AA, Panjabi M; Clinical Biomechanics of the Spine; Second edition; Lippincott; Philadelphia; 1990. **AJCC**

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Deed E. Harrison, DC  
President CBP Seminars, Inc.  
President CBP Non-Profit, Inc.  
Chair PCCRP Guidelines  
Editor—AJCC

## Combining Specific Chiropractic Adjusting Techniques with CBP Corrective Care Techniques

bility, posture mobility, and reduce pain and muscle hyper-activity by reflexo-genic inhibitor effects, then this statement holds some merit. However, certain specific segmental adjusting techniques have more research validating this statement than others. For example, using the Gonstead Technique system of analysis and adjusting, Nansel and colleagues<sup>1</sup> found statistically significant improvements in cervical lateral bending motion responses following one specific adjustment to the restricted side of the cervical spine.

In contrast, if we assume that what is meant by 'works' is that all techniques are able to improve the alignment of generalized abnormal sagittal plane curvatures, then this statement does not hold merit. For example, using the same Gonstead Technique system of analysis and adjusting, Plaugher et al<sup>2</sup>, found no measurable change in the cervical and lumbar lordosis in 50 patients receiving several adjustments. Regarding CBP Technique corrective methods, statistically significant improvements in sagittal plane alignments have been identified in several clinical control trials examining patients suffering from chronic low back and cervical spine disorders.<sup>3-6</sup>

So what does the above information indicate? In our opinion, the above indicates that the astute Chiropractor should

become skilled at administering both a segmental specific adjustment technique and a full spine corrective technique like Chiropractic BioPhysics (CBP). In this manner, patients will experience the benefits of segmental motion restriction improvement and the restoration of proper full body and spine alignment. The case presented herein attempts to provide initial rationale for the combination of two uniquely distinct, but complimentary full spine Chiropractic Technique systems.

### Case Study

Approximately, 6.5 years ago (in 2006), a 74 year old female presented to one of the author's (T.P.) practices seeking care for the relief of functional disabilities related to a chronic low back condition. At this time, the Chiropractic clinician (T.P.) exclusively adhered to and utilized the Gonstead Technique system of analysis and adjusting for identified spine subluxations including:

1. Abnormal temperature differential patterns (nervo-scope / tempo-scope).
2. Static palpation data indicating the presence of edematous tissue around the injured segment.
3. A decrease in motion of the segment in question, as compared to the surrounding area.
4. Palpable muscle spasm or splinting

around the area in question.

5. Visualization of the area (looking for presence of pitting edema, asymmetry in the tissues, etc).
6. Then, consulting the 3-shot, digitally stitched, AP full spine x-ray and the lateral (2 shot) full spine x-ray to analyze the "foundation principle" and relate this to the examination findings.

At this time, the patient was recommended and consented to a program of care consisting of Gonstead adjustments at a frequency of 3 times for 2-weeks, 2 x per week for 4 weeks, and then 1 x per week for 6 weeks. At this point the patient was improved to some extent (not completely) and was placed on a Chiropractic maintenance schedule consisting of 1-4 x per month sessions of adjustments over the course of 6 years. Through the course of this 6-year time period the patient would have episodic acute flare-ups of her chronic low back conditions that would improve with Chiropractic. The patient averaged a minimum pain intensity of 4/10 over the course of these 6-years with flare-ups reaching 8/10 on a numerical rating scale.

### Feb 2012 Findings:

In February of 2012, the Chiropractor

See *Adjusting Techniques* on page 17

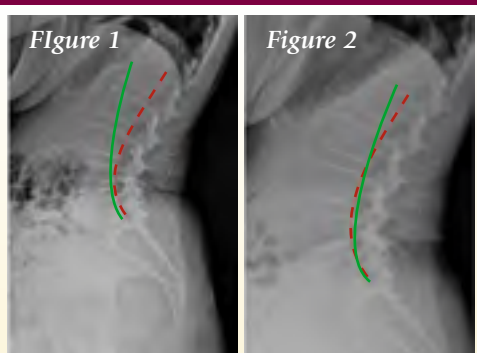
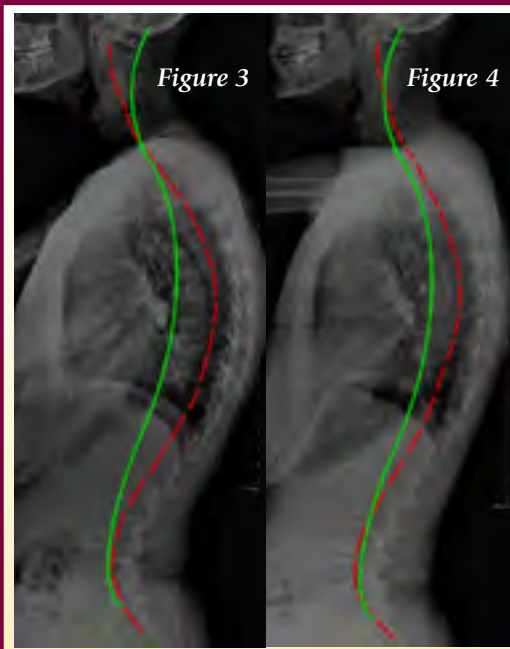
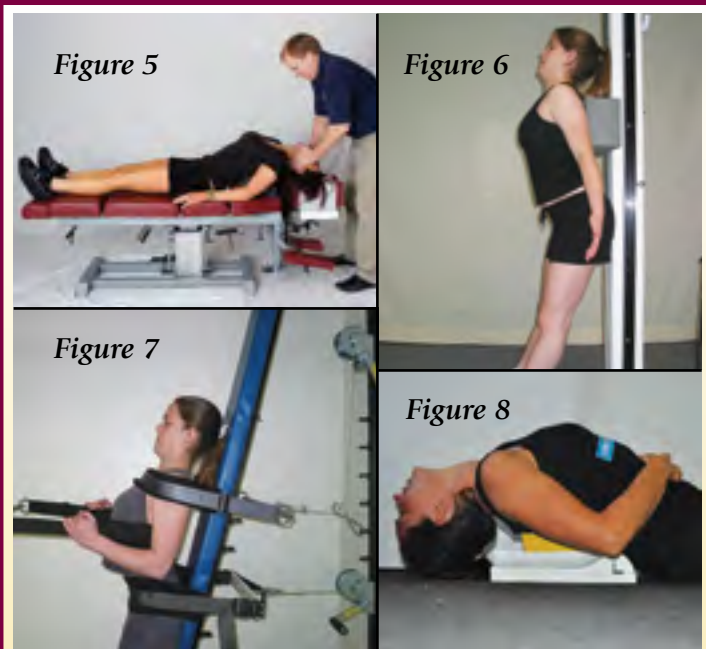


Figure 1. Initial full spine lateral radiograph taken in February of 2012 following 6-years of Gonstead segmental adjustments. The radiograph taken 6 years earlier showed the same spine displacement patterns.

Figure 2. Follow-up full spine lateral radiograph taken in May of 2012 following 3-months of CBP corrective care. Note the considerable improvement in alignment.



Figures 3, 4. Initial and Follow-up lateral lumbar spine radiograph taken in February and May of 2012. Note the improved alignment of the follow up radiograph.



### Adjusting Techniques—cont'd from page 16

(T.P.) informed the patient that he had learned a new approach to full spine corrective Chiropractic (CBP Technique) and that he believed she was a candidate for this 'new' system. The patient was recommended and consented to a 36 visits, 3-month, corrective care program consisting of the combination of Gonstead Technique (segmental adjusting applied to the cervical, thoracic, and lumbo-pelvic regions) and CBP Technique. Her pain scale was a 7/10, she reported difficulty walking more than 1/4 mile distances without severe thoraco-lumbar pain, fatigue, and spasm, all while wearing a back brace.

### Radiographic Findings

**Lateral Full Spine Radiograph:** In February, 2012 a new digital full spine lateral radiograph of the patient was obtained. See Figure 1. The radiographic analysis was done using the PostureRay computerized radiographic measurement system. Qualitatively, the patient's radiographic displacements are shown in Figure 1 as the path of their posterior vertebral body margins from C2-S1 relative to an idealized spine model in upright stance developed by Harrison and colleagues.<sup>7</sup> The patients follow up full spine lateral radiograph after 3-months of CBP Technique is shown Figure 2. Note the remarkable improvement in alignment, whereas previously, for 6 years no such improvement was identified with Gonstead Technique alone.

**Lateral Lumbar Spine Radiograph:** In February, 2012 a digital lateral lumbar radiograph was obtained. See Figure 3. The radiographic analysis was done using the Posture Ray computerized radiographic mensuration system. The patient's radiographic displacement values are shown in Figure 3 and are compared against normal.<sup>7</sup> The patients follow up full spine lateral radiograph after 3-months of CBP Technique is Figure 4. Note the remarkable improvement in alignment where for 6 years no such improvement was identified with Gonstead Technique alone.

### Interventions

The primary course of interventions included CBP mirror image<sup>®</sup> adjustments, exercises, and traction to reduce her full spine postural and spine displacements. The treatment frequency was 3 times per week for 40 visits over approximately 12 weeks. The Patient presented to and actively participated at all appointments. Each visit consisted of mirror image adjusting, mirror image exercises and traction to reduce her abnormal posture displacements.

**Mirror Image Adjustments:** The pa-

tient was administered mirror image adjustments to correct posterior thoracic translation with hyper-kyphosis and anterior head translation with head flexion postures. See Figure 5.

**Mirror Image Exercises:** The patient was administered mirror image adjustments to correct posterior thoracic translation with hyper-kyphosis and anterior head translation with head flexion postures. See Figure 6.

**Mirror Image<sup>®</sup> Traction:** Mirror Image traction care was administered to the patient. The patient received traction in the standing posture as shown in Figure 6. In addition the patient was instructed in the use of the denneroll thoracic orthotic and was advised to do this 5-7 times per week at home. See Figures 7-8.

### Case Outcome

Subjectively, at the end of the 1st month of corrective care, the patient was remarkably improved; NRS = 1-2 / 10. Her low back condition improved to where she was able to walk 3-miles without the use of a low back support and without debilitating pain. According to the patient, in her own words, "I do know that I'm experiencing a life change for the better...I'm singing the praise for the treatment (CBP Technique—added for clarity) and how great I feel".

### CONCLUSION

The authors' opinion is that the patient's improvement is directly related to the spinal corrective procedures applied using CBP Technique. Accordingly, for optimum patient response, traditional Chiropractic adjustments would seem to be enhanced by the addition of spinal corrective procedures as in CBP. In the end, it is the positive response of the patient that should dictate this combined approach of classical Chiropractic care, with more contemporary corrective Chiropractic systems.

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# Strong Extension-Based Exercise of the Cervical Spine— A Case Series



Don Meyer, DC  
Private Practice Huntington Beach, CA  
President Circular Traction Supply  
CBP Instructor

## INTRODUCTION

In a recent paper published in the Journal of Rheumatology, the Cervical Overview Group conducted a large-scale meta-analysis of existing literature concerning the management of mechanical neck disorders, including radiculopathy.<sup>1</sup> The categories of evidence ranged from strong evidence, to moderate evidence, to limited evidence, to evidence of no benefit. The only regimes that managed to make it into the highest level of evidence were [combined]

stretching/strengthening exercise and mobilization/manipulation. Medical prescriptive interventions failed to make the cut.

So now that we know that along with manual manipulation, a stretching/strengthening exercise program is one of the most evidence based therapies we can provide a post-acute or chronic patient with mechanical neck problems. But what is the best method to apply these exercises?

Applying a strong anterior load into the posterior cervical region while the patient actively performs extension-based range of motion neck exercises is a relatively new and unique concept within the healing arts. Exercise straps have been invented that recommend a “gentle” resistance to various neck range of motion exercises and assist in stretching the neck.<sup>2</sup> These devices

were not designed to provide a strong progressive anterior load into the user’s neck. A more recent exercise device uses a spring-like design to apply a strong extension load to the posterior neck muscles, but again recommends only a mild anterior load (4-6 lbs.) be applied into the posterior

Category	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6	Case 7
Sex	Male	Female	Male	Female	Female	Female	Female
Age	53	62	68	54	49	47	32
DJD Stage	Moderate	Severe	Severe	Severe	Severe	Mild	None
Increased ROM with Pro-L Neck Exercises?	Unknown	Unknown	Yes	Yes	Yes	Yes	Yes
Increased ROM with Pro-L Neck Exercises after Active In-Office Rehab?	N/A	Unknown	Yes	Yes	Yes	Yes	N/A
Pain Relief with Pro-L Neck Exercises?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Pain Relief with Pro-L Neck Exercises after Active In-Office Rehab?	N/A	Yes	Yes	Yes	Yes	Yes	N/A
Decreased ADL Restrictions with Pro-L Neck Exercises?	Yes	N/A	Yes	Yes	No	No	Yes
Decreased ADL Restrictions with Pro-L Neck Exercises after Active In-Office Rehab?	N/A	N/A	Yes	Yes	No	No	N/A
Improved Cervical Curvature with Pro-L Neck Exercises?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Improved Cervical Curvature with Pro-L Neck Exercises after Active In-Office Rehab?	N/A	Yes	Yes	Yes	Yes	Yes	N/A
Relief of Radicular Symptoms with Pro-L Neck Exercises?	N/A	N/A	Yes	Yes	N/A	N/A	N/A
Long Term Relief of Symptoms with Pro-L Neck Exercises?	Yes	Yes	Yes	Yes	Yes	Yes	Yes

cervical region.<sup>3</sup> In fact, it is designed to prevent a strong anterior pull from being applied into the neck by the posterior spring assembly.

In the early 2000’s, Deed Harrison, D.C. started instructing Doctors of Chiropractic at CBP® seminars how to take a padded strap and forcibly pull the upper thoracic and lower cervical spine

into flexion while actively extending the head and upper cervical spine.

I took Doctor Deed Harrison’s idea of extension exercising of the neck with a padded strap and extrapolated upon it. I added Theraband™ resistance tubing offered at three different resistance levels, padded hand grips and a rehabilitative program of eight isotonic ranges of motion and posture corrective exercises. See Picture 1. I first used this new exercise device on myself and then offered it to six of my chronic neck pain patients to try out at no cost. Three of these patients had completed postural/structural corrective in-office treatment and were on monthly maintenance care. What follows are the result with my own cervical condition as well as the six other participants. Pre and Post pain questionnaires, lateral cervical radiographs and computerized range of motion findings are provided with most cases.

## DISCUSSION

The Table illustrates that of the seven cases, four had severe DJD, one moder-

See Extension Based Exercise on page 23



Picture 1: Pro-Lordotic Neck Exerciser



Supine neutral lateral cervical



On Denneroll lateral cervical

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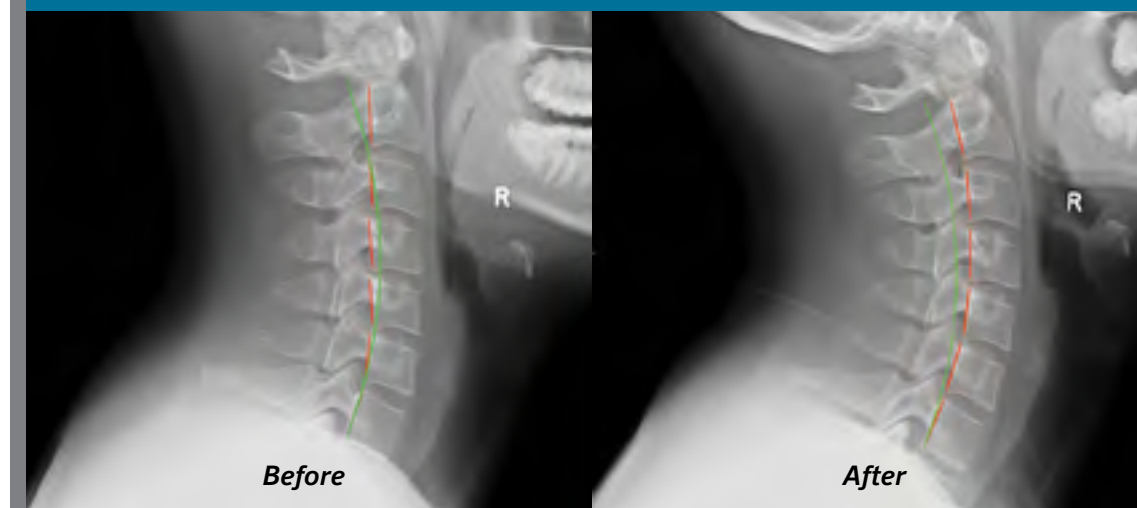
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## Colorful Olympic Tape for our Patients— Taping Movement, Not Muscles



Steven Capobianco D.C., DACRB, CCSP  
Medical Director, Rock Tape.  
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It was apparent that world-class athletes were seeking an alternative to managing pain and maximizing recovery potential at the 2012 London Olympic Games. Practitioners and spectators alike witnessed athletes, from the diving platform to track and field, wearing colorful tape in intricate patterns and with questions of what it was, word began to spread. While the use of kinesiology tape is often associated with athletes, the reality is that kinesiology tape is effective for a wide variety of problems, not just sports injuries.

The evidence supporting the role of kinesiology tape still lacks high-level clinical trials, but if you spend the time to research further you will start to see a trend. This trend was spearheaded by Thibaud (Feb 2011), and reported the effects of taping the skin in subjects

that are compromised, either fatigued or injured. They found that the skin acted as an auxiliary kinesthetic system providing the brain with postural awareness when the compromised muscle/joint receptors were fatigued.

Kinesiology tape, developed and refined for the past 35 years, attempts to mimic the qualities of the skin in its elasticity and thickness. With these qualities in mind, the tape is applied to the skin in certain patterns to enhance certain physiological processes. Once applied to the skin the elastic capacity of the tape provides a light shear augmenting the mechanoreception of the area addressed. This same elastic recoil aids in pulling the epidermis and dermis layers of skin away from the underlying fascial compartments, thus improving fluid dynamics (acute/chronic edema) (Ya-Hui Chou). Both of the above processes have a substantial benefit in down-regulating nociception (pain), in return improving movement patterns in accordance to the area addressed with tape. Lastly the tape in its ability to enhance kinesthetic awareness through skin stimulation, can improve postural dysfunction. Careful application of tape along "fascial strain lines" has been shown to improve common postural dysfunctions such as upper and lower cross syndromes, hyper and hypolordosis, anterior/posterior tilting of the pelvis, and more. See Figure 1.

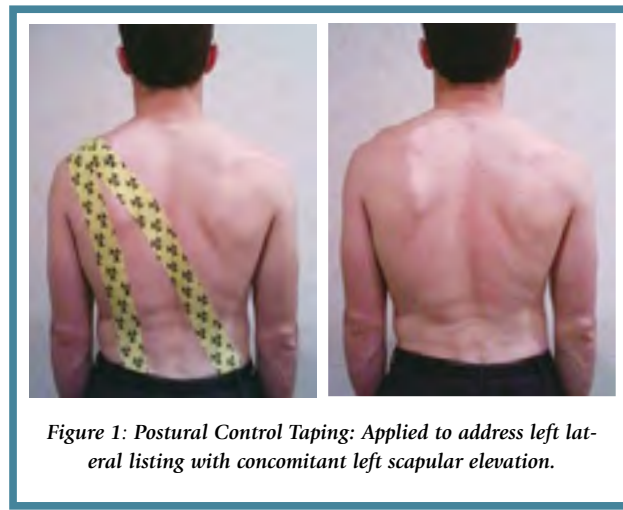


Figure 1: Postural Control Taping: Applied to address left lateral listing with concomitant left scapular elevation.

### SUMMARY

The refinement of kinesiology taping has extended from the traditional anatomical (muscle) applications to the more integrated fascial (movement based) applications. This innovative way of taping has revised some new and improved taping applications that have shown to improve movement dynamics, such as postural sway associated with compromised environment like pain and fatigue states, as dis-

cussed earlier in the science of taping. Athletes, such as those in the Olympic Games, are interested in the advancement of taping technology. With this added interest in "legal" performance enhancement which doesn't involve drugs, athletes and coaches are looking for an edge in other alternatives including kinesiology tape. By enhancing our body awareness via movement taping, we can improve the length-tension relationships of the associated muscles, and, in turn, improve the neuromuscular efficiency of the intended activity.

Recently, the Garmin-Barracuda professional cycling team has implemented this model of taping to improve postural position on the bike to optimize power outputs during long cycling time trials. The team's physicians believe that the tape, applied in specific patterns, improves form which translates to a faster time with less incidence of injury. This all translates into improved performance without the use of illegal enhancements. Future studies on the effects of stimulating the largest organ in our body (the skin) via kinesiology tape is a new direction to investigate with regards to improving proprioception, posture and performance.

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See Taping Movement on page 21

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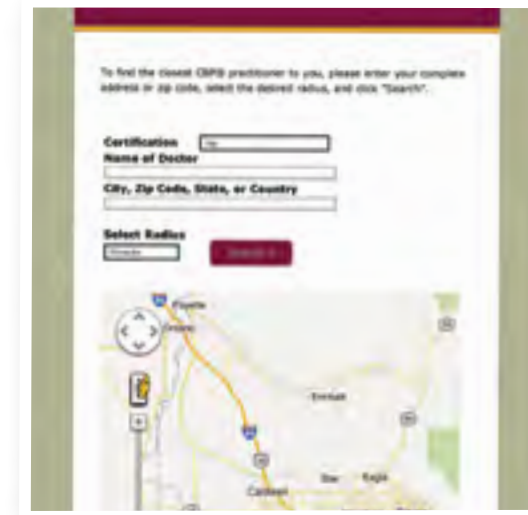
### CBP Online—cont'd from page 1

- wish to continue to be listed, will be charged a monthly fee. Contact info@idealspine.com or annie@idealspine.com for information.
- Chiropractors who are CBP certified, but who have not attended a seminar in the previous two years to keep their certification active, will still be listed, but their certification status will be dropped. Once a seminar is attended, their certification status will be reinstated.

A quick list of functionality options for the new directory at www.

chiropracticbiophysics.tv/directory/ is shown in the figure. And here's the pointed description of how to use the database:

- Doctors or patients can select for which level of CBP certification for a doctor that they are interested in.
- By selecting 'any', all CBP Chiropractors who have taken a seminar since 2007 will show in the specific region. By selecting 'instructor' only CBP instructors will show, etc...
- For more accurate searchers, the selection criteria for doctor's name or city, zip code, etc...should be selected.
- If no CBP doctors show after the search, you should increase the area of radius you are searching. Currently, new features are being developed daily and a list of items



still to come include:

- Patient friendly content explaining the CBP Chiropractic difference and why they might benefit from selecting a CBP trained chiropractor.
- Introductory video on how to use the CBP referral directory; what CBP certification entails, and why they should consider a CBP Certified chiropractor as their first choice of a chiropractor.

Future content updates for www.idealspine.com will be ongoing. However, one the largest updates will occur, hopefully, by the time your reading this article:

The new CBP product store for doctors will debut. Check www.idealspine.biz for this update. **AJCC**

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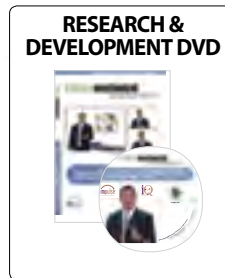
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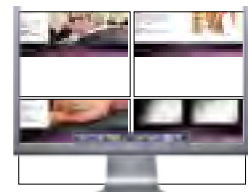
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## News From Abroad

### CBP Seminars Sponsors Life West Mission Trip for Select Club Officers

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#### Extension Based Exercise—cont'd from page 18

ate, one mild and one had no DJD. One patient was in their early thirties, two were in their late forties, two in their early fifties and two were in their sixties. There were two males and four females. All the individuals had chronic neck pain.

In two of the cases, pre/post ROM studies were not performed. But in the five cases where pre/post studies were performed, they all showed improvement with regular use of the Pro-Lordotic Neck Exerciser. Case five achieved higher than normal ROM values even with severe degenerative joint changes.

All of the cases experienced some degree of pain relief from regular use of the Pro-Lordotic Exerciser. Case one and two experienced a complete relief

manipulative rehab achieved higher levels of pain relief through the continued use of the Pro-Lordotic Neck Exerciser.

Four of the seven cases reduced their ADL restrictions with the regular use of the Pro-L Neck Exerciser. One case had no ADL restrictions and two cases ADL restrictions did not reduce. Two of the cases that were on monthly maintenance care of spinal manipulation only saw their ADL restrictions further reduce with regular Pro-Lordotic Neck Exercises.

All seven of these chronic cases achieved some degree of cervical curvature correction with regular use of the Pro-Lordotic Neck Exerciser. Cases two and four achieved more correction with this home exerciser than what they were able to accomplish in-office with expensive cervical curvature traction devices. Case three started his curvature correction in-office and was able to continue correcting it with the home exerciser. Case five and six had lost some of their in-office corrections over time and were able to retain some of this lost curvature with the home exerciser. Case seven achieved all of her correction with the home exerciser.

Cases three and four were the only two cases to have true radicular symptoms all the way into their hands. Both of these cases were able to either completely or almost completely resolve these symptoms with regular use of the Pro-Lordotic Neck Exerciser.

Most importantly, all seven of these cases received enough relief of pain and increase function to what to continue their home use of the device for long periods of time. All of the cases reported being able to control their condition, to some degree, with regular use of the Pro-Lordotic Neck Exerciser.

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#### Keys to Success—cont'd from page 8

actions CBA does with a new client is to sit down and interview them to find out EXACTLY what that doctor wants to achieve. From the data gath-

ered in that interview, we help the client determine the plans needed to achieve the overall goals. Then we work with that client to develop an exhaustive, in-sequence series of steps needed to carry out the plans.

**Monitoring the steps taken to carry out these plans should be a daily and weekly activity of an owner.**

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#### The Lost Connection—cont'd from page 4

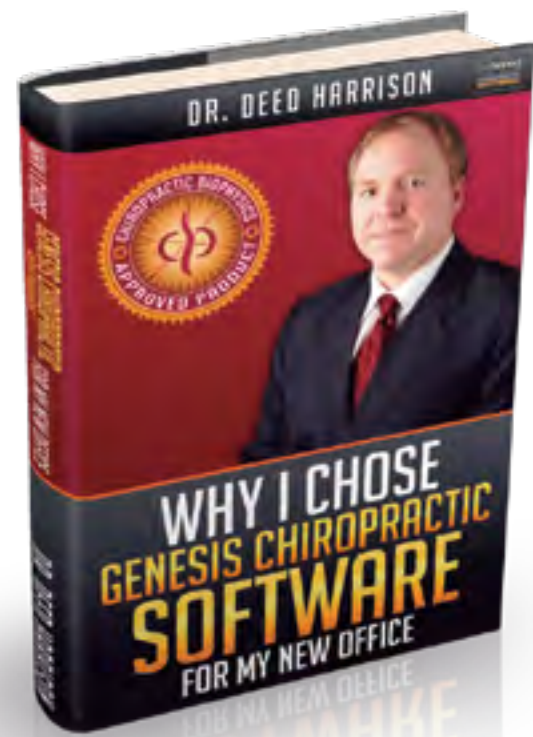
subtalar rotation, rather than on restoring proper orientation or posture to the entire foot?

Since the days of Merton Root, single axis position (subtalar "neutral position") has been the goal of orthotic intervention. It is clear the relationship of these measurements to the improve-

ment of the human gait cycle is questionable. Part II of this article (January 2013, *AJCC*) will advance these topics presented herein.

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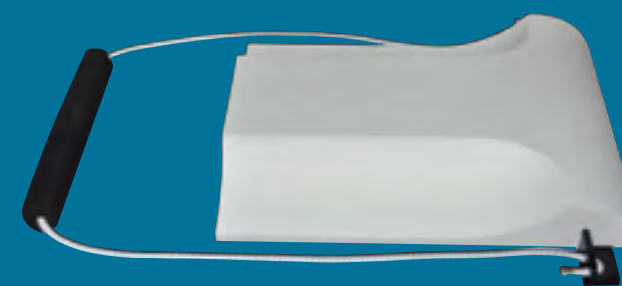
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**To reduce thoracic kyphosis and anterior head posture while increasing cervical lordosis and anterior thoracic cage translation, some must push and some must pull.**



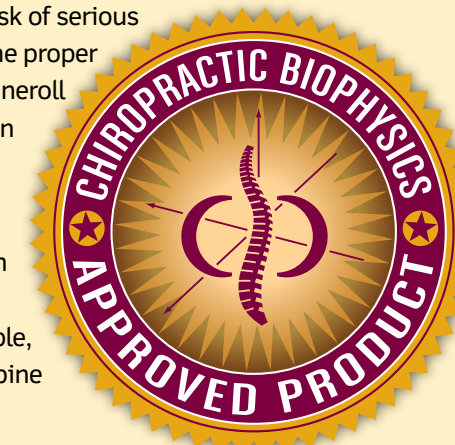
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Patent Pending—Thoracic Denneroll Component:  
Canadian Application No. 137759, US Application No. 29/577,954



No matter what makes lumbar lordosis abnormal, Denneroll can help get it back to normal.



From lifting injuries to poor posture, falls to awful ergonomics, abnormal lordosis affects a lot of people. And that means pain, muscle tension, and more pain. In the end, abnormal lordosis has been linked to a reduced quality of life and poor health.

With Chiropractic BioPhysics® techniques and the Lumbar Denneroll, you can provide relief and improve health for back-pain patients.

Designed by chiropractors and endorsed by CBP®, The Lumbar Denneroll provides a gentle, but effective, stretch to coax the lumbar spine back to its ideal curvature, or lordosis. Which relieves pain and reduces the risk of nerve, ligament, and muscle damage.

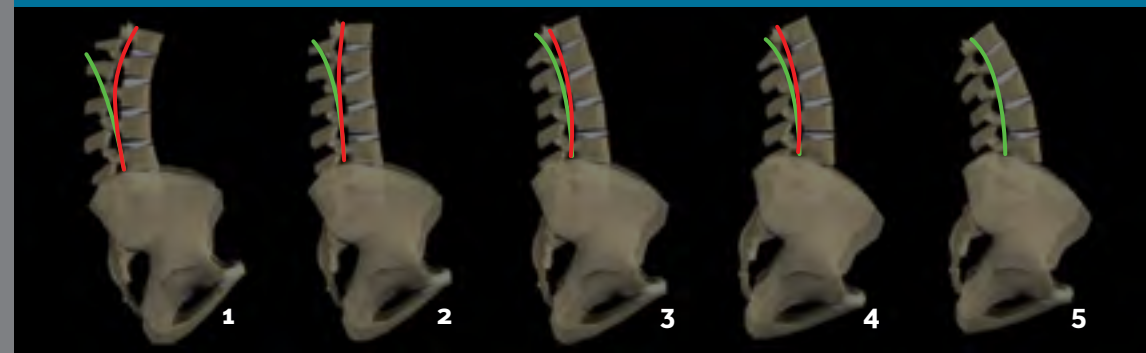
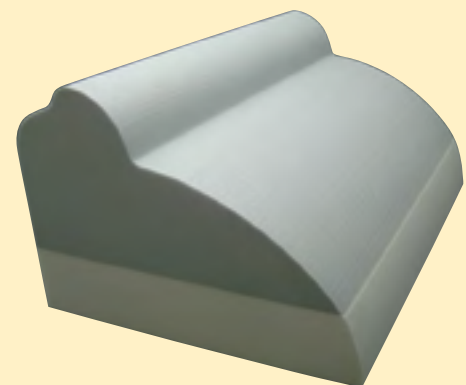


In certain cases, the Thoracic Support Block System makes spinal treatment more effective. Contoured to allow the scapula and shoulder region to roll back into slight retraction and external rotation, the device reduces posterior thoracic cage translation at the same time the Lumbar Denneroll improves lordosis.

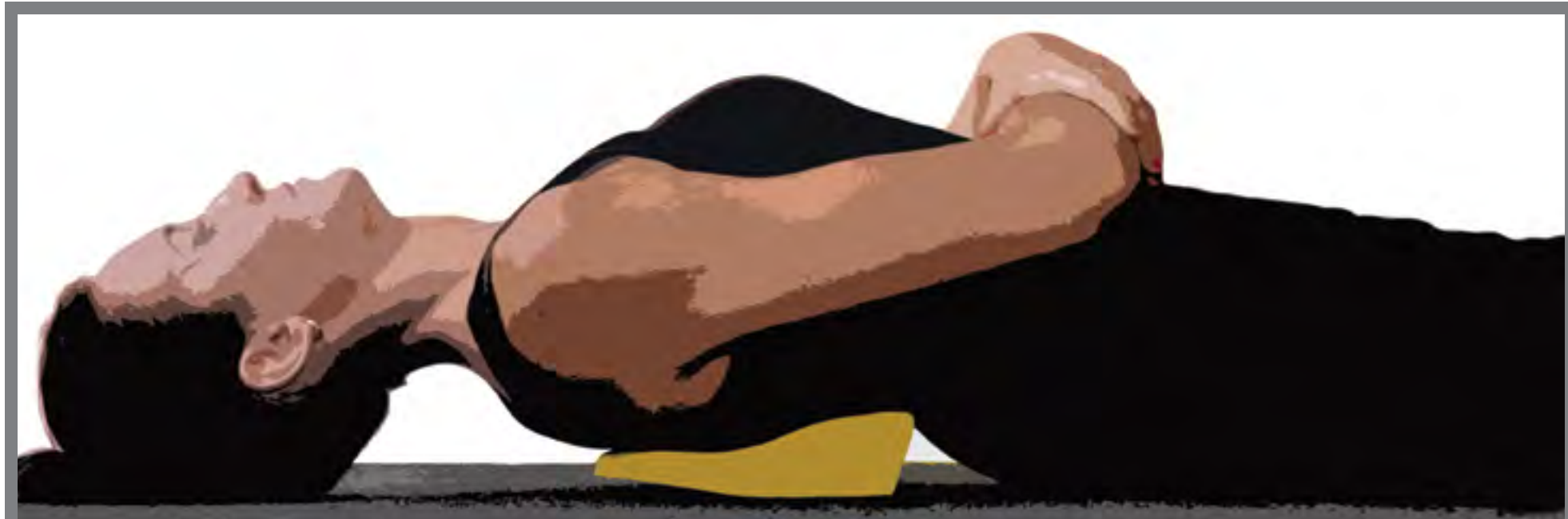
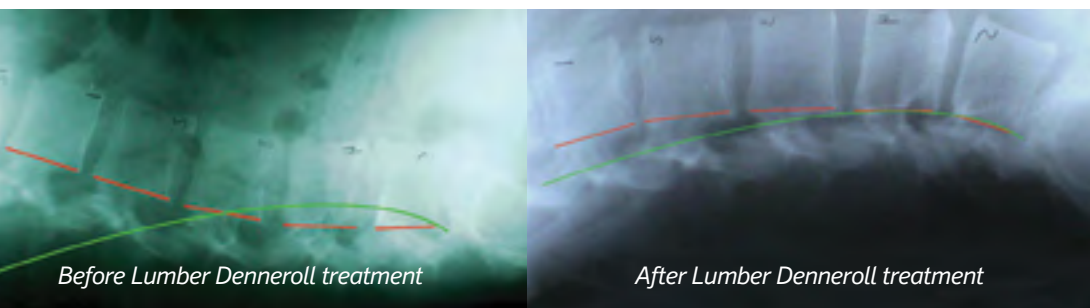
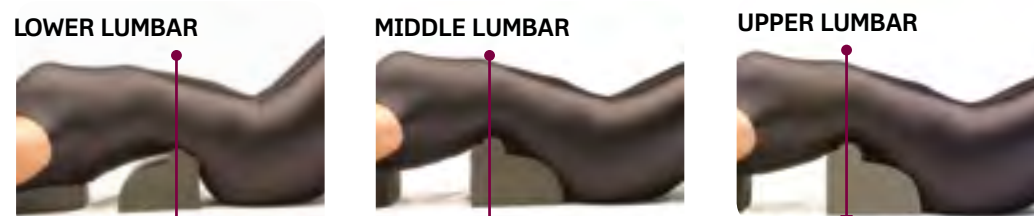
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Patent Pending - Lumbar Denneroll: Canadian Application No. 137758, US Application No. 29/377,956



ABNORMAL LUMBAR LORDOSIS CURVES (RED LINE) → NORMAL LUMBAR LORDOSIS CURVES (GREEN LINE)



Correcting thoracic kyphosis is a stretch. The Thoracic Denneroll provides it.



As you know, the thoracic segment of the spine should have a natural, ideal shape, or kyphosis, to its curvature. But, thanks to lifting injuries, falls, poor posture, poor ergonomics, and other abuse, abnormal kyphosis is altogether too common.

Which causes pain and suffering, along with added risk of nerve, ligament, and muscle damage, loss of function, and the potential of more serious back injury and poorer health.

The Thoracic Denneroll, developed by chiropractors and endorsed by Chiropractic BioPhysics®, provides a gentle but effective stretch that assists in the correction of abnormal thoracic kyphosis. And that means relief from pain, improved posture, reduced risk of further injury, and improved health.

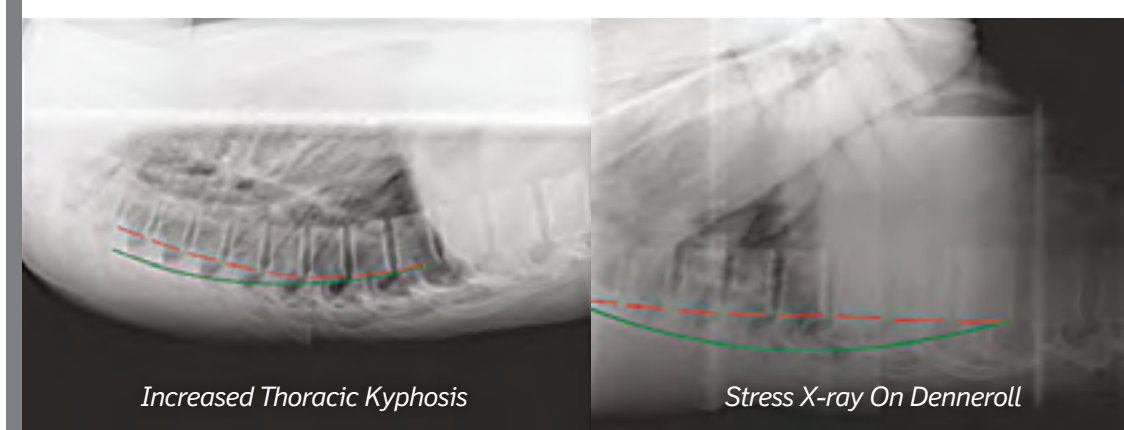
When indicated in certain cases, the new Thoracic Support Block enhances the effectiveness of treatment. Its unique design helps reduce posterior thoracic cage translation in combination with increased thoracic kyphosis.

Put Denneroll to work for your patients—with cervical, thoracic, and lumbar devices available, you can improve the spine from top to bottom.



THORACIC KYPHOSIS

ABNORMAL (RED LINE) ← NORMAL (GREEN LINE) → INCREASED (RED LINE)



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Patent Pending - Thoracic Denneroll: Canadian Application No. 137759, US Application No. 29/377,954

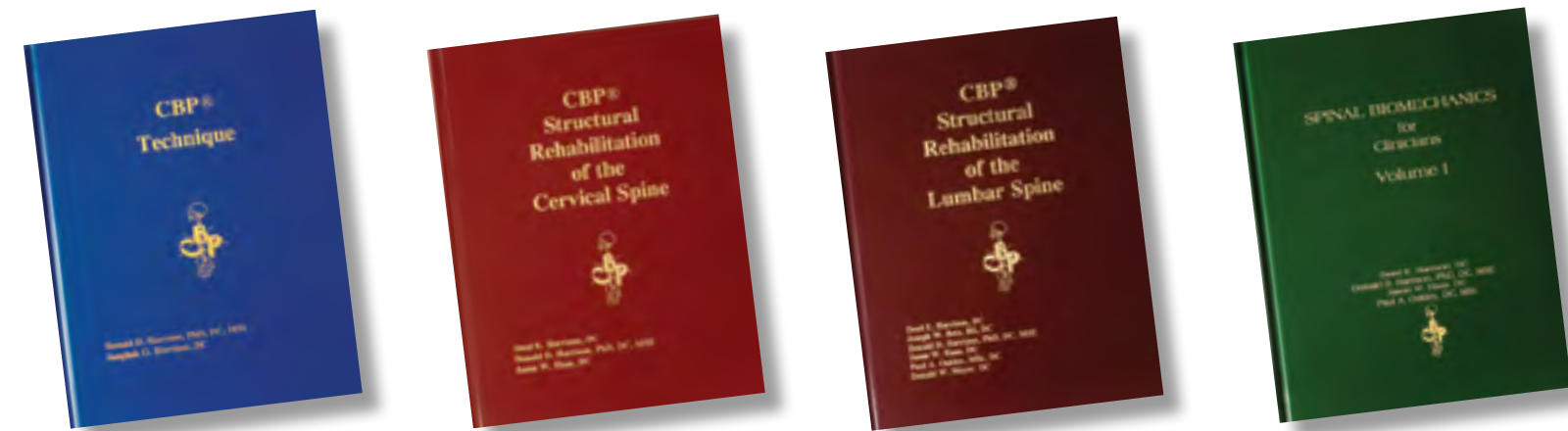


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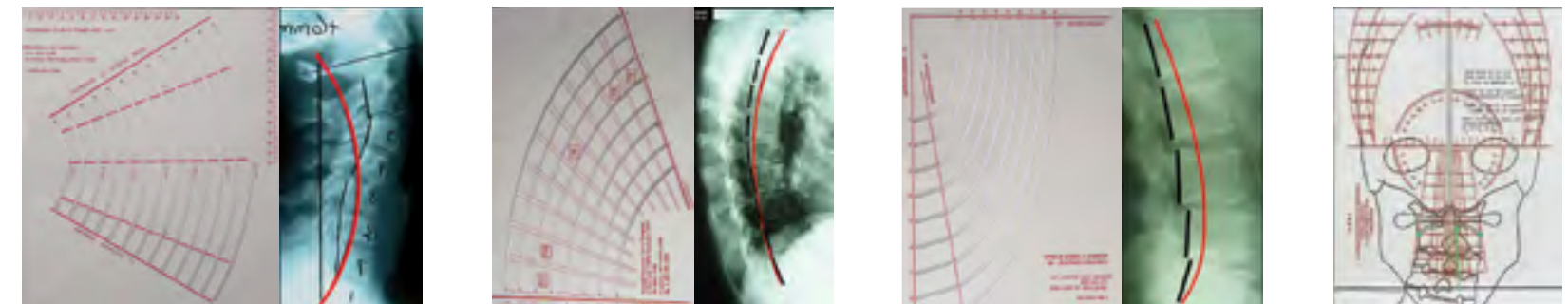
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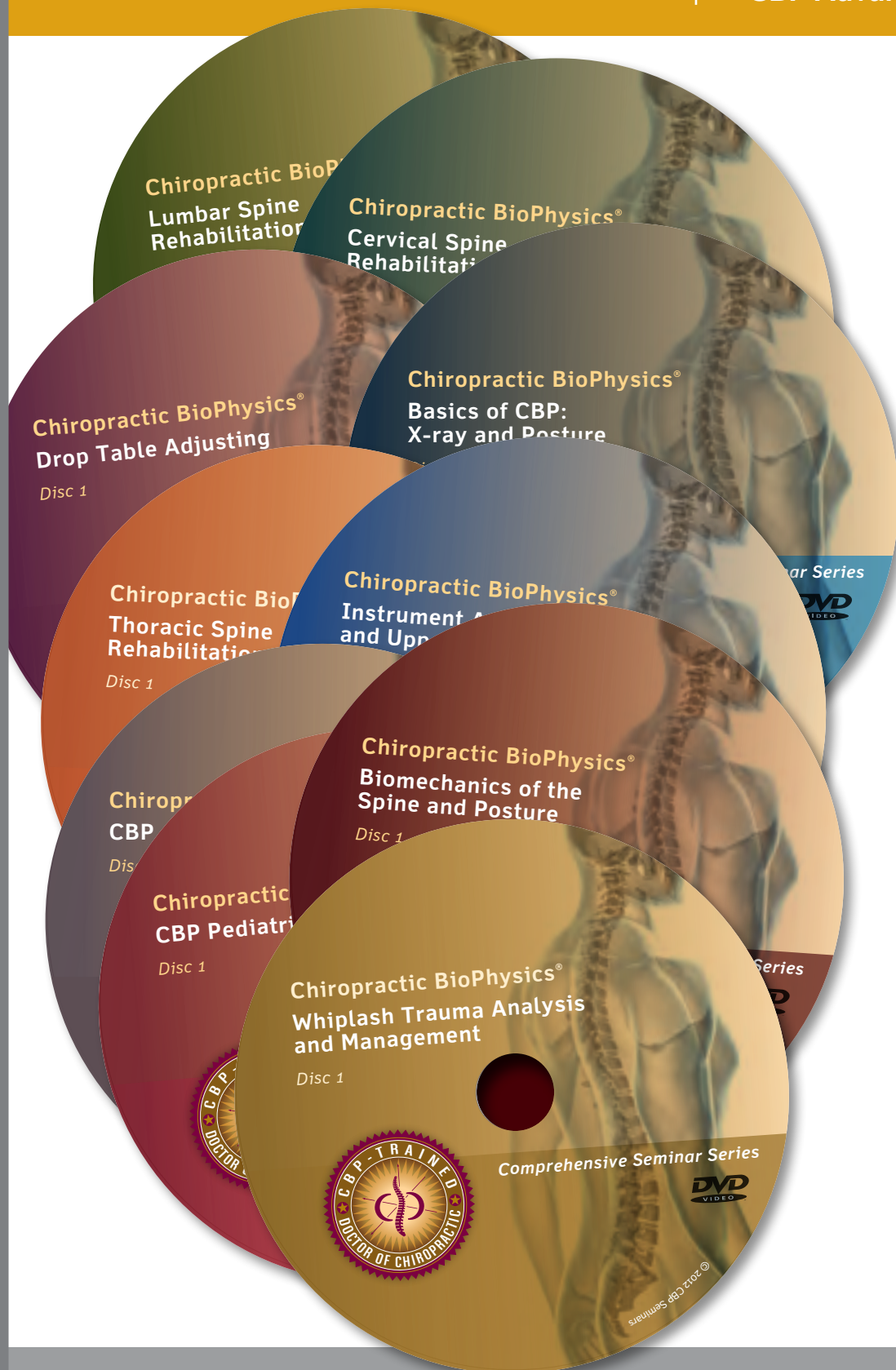
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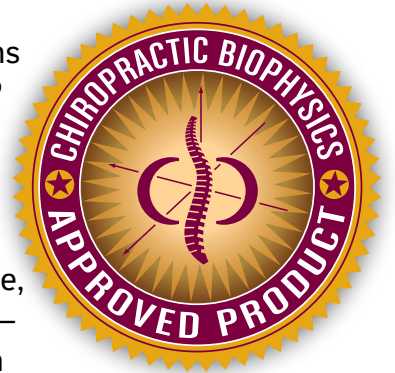
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