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New methods of reducing recurrent spinal fixation

James DW Hogg

Narrative: Spinal fixations are a common cause in many areas of muscular neuron-inhibition often resulting in severe pain and functional issues. Classic corrective approaches are effective in clearing these problems but for some patients' fixations tend to recur. This paper will explore effective methods of reducing recurrence using treatment of coccygeal locking and injury reflexes.

Indexing terms: Chiropractic; Applied Kinesiology; Spinal Fixations; Coccygeal Locking; Injury Reflex; Disc Degeneration; Low Back Pain.

Introduction

As we all have learned, spinal fixations can cause a number of neuromuscular inhibitions causing severe pain and dysfunction for our patients. (1) This is a problem I check on pretty much all of my patients on a regular basis. It's an extremely effective technique and often the only way to clear some structural problems and pain. Unfortunately for some patients these structural problems become recurrent. I've had some patients who needed fixation work on every visit despite checking them for the need of vitamin E and giving instructions to avoid certain positions and activities that may cause fixations to recur.

> *... treating spinal fixations is extremely important; it's even more important to find and treat the underlying cause ...'*

Over the years I've developed the use of some techniques that have been very helpful in decreasing fixation recurrence which I'll share below along with a review of fixations and the problems they produce for our patients.

Background

Here's a short review of common fixations and their effects. Pain across the low back, especially with bending or lifting as a result of bilateral gluteus maximus inhibition caused by upper cervical fixations. Sometimes low back and hip problems from poas inhibition can be caused by occipital fixations. Posterior knee pain with a tendency for hyperextension because of bilateral popliteal inhibition caused by mid cervical fixations. Severe shoulder pain and dysfunction along with numbness on the arms and hands because of bilateral deltoid inhibition caused by cervico-thoracic subluxations. Mid-back/scapular pain along with posture problems because of bilateral lower trapezius inhibition caused by thoraco-lumbar fixations. Neck pain and

restricted range of motion because of inhibition of the posterior muscular group caused by lumbar and sacroiliac fixations. Of course, there are more fixation results that have been presented in papers over the years but these are the classics.

While all of these fixation relationships are important, those that I see most common with patient complaints are upper cervical fixations resulting in anywhere from mild to incapacitating low back pain and dysfunction as well as cervico-thoracic fixations resulting in mild to incapacitating shoulder problems as well as arm and hand numbness, numbness being less common. The other fixations seem all in the middle frequency range except for mild cervical fixations which I tend to see the least frequently.

Although the above results of spinal fixations are serious enough, we all know that there's another important effect for long-term fixations. Spinal discs, as we know, don't have much blood supply. They require movement of the spinal segments that they live between to help pump out toxins and pump in nutrients. With the reduction in movement between spinal segments caused by fixations that remain for prolonged periods, discs can start to degenerate.

The meninges run from cranial and upper cervical areas down to the dorsum of the first segment of the coccyx. (2) They line the intervertebral canal and have been known to alter flexion and extension of the spine when under tension from coccygeal locking. (3) Because of the cranial attachments meningeal tension from coccygeal locking can contribute to cranial subluxations in the temporal and saccital areas.

While the above are classic AK findings with meningeal tension, a variation I've been finding the last few years is that meningeal tension can be a contributor to recurring spinal fixations. When I've adjusted the same fixation several times and educating the patient about activity and life habits doesn't provide a reason for recurrence, I check for meningeal tension related to coccygeal locking. If the coccygeal challenge shows positive, I perform the classic simultaneous adjustment of the coccyx and upper cervical area. (3) In this situation, once the coccyx is clear, the spinal fixation also becomes clear and the associated muscles become facilitated.

Often when patients have this problem, there is not just one recurring fixation. There are often four or five fixations. What I loved was discovering that, in this situation, clearing the coccyx will often clear ALL the fixations and facilitate all the associated muscles! Sometimes there will be one fixation left that needs to be adjusted.

Methods

To release meningeal tension related to coccygeal locking:

1. Testing
    a. Walther suggests that the test needs to be the patient touching and pushing inferior on their coccyx. (3)
    b. Since this is more a challenge than a therapy localisation, I've found that it also works for the doctor to push inferiority on the patient's coccyx.
        i. iThe challenge needs to be maintained during the muscle test.
        ii. iIf the patient performing the challenge, they need to lay their finger along the surface of the coccyx and push inferiorly without much anterior pressure
        iii. If the doctor is performing the challenge, they should use three finger tips along the surface of the coccyx and push inferiorly without much anterior pressure.
    c. A key to both of the above is to cover most of the coccyx to effectively push inferiorly without having to push much anteriorly.

2. Treatment
    a. Lay your middle finger of one hand along the surface of the patient coccyx
    b. With your other hand, contact the occiput and upper cervical area
    c. Gently pull both hands together until you feel a subtle increase in motion in both areas
        i. Usually, I find the upper cervical area will loosen a few seconds before the coccyx but sometimes there will be a different sequence
        ii. If you don't notice the subtle loosening/movement, just hold the points for 30-40s
3. When done, simply retest as above to ensure correction
4. Once meningeal tension has been released you will find that most if not all fixations have released themselves. You may also find that some cranial subluxations like sagittal suture and temporal bulge have been released.

If patients have recurrent meningeal tension via coccygeal locking, it is often because the way they tend to sit puts pressure on the coccyx. In that case I instruct them to make sure to sit up rather than slouching so '*your sitting weight is on your buttocks rather than your tailbone*'.

While I find that meningeal tension from coccygeal locking is the most common cause of recurring fixations, I sometimes find that Injury Recall Technique (IRT), as introduced to ICAK by Dr. Walter Schmitt (4) is needed instead. As you probably remember, injury recall can be a common cause of many recurring problems as the body maintains an injury reflex resulting from a trauma that may be days or years old. Fortunately, it's easy to reset the reflex that was useful at the instant of trauma but has 'forgotten' to get turned off.

In the case of the fixation related extended injury reflex:

1. Pinch lightly over the segments that are locking together
    a. pull superior on the talus bone in the foot and test a previously facilitated muscle.
        i. If this results in inhibition of the test muscle, it tells you that there is a fixation in the pinched area.
        ii. Of course, there is a small chance that the talus is subluxated and that's why the the facilitated muscle became inhibited. If you suspect this, just pull superior on the talus without touching the fixation area and see if it causes muscular inhibition. 99.9% of the time you will probably find that a simple superior talus challenge has no effect.
2. Once you've established that there is an injury reflex in the area of the fixated segments
    a. simply repeat the pinch challenge in the fixation area and pull inferior on the talus.
3. Another classic way to challenge for fixations is to have the patient TL over the fixated segments instead of pinching and repeat the above testing.
    a. In this case, treatment will be with TL instead of pinching.
4. One more method I presented in 2004 is to stimulate the suspected injury reflex area with a low level laser therapy (LLLT) (5).
    a. Swipe the light back and forth over the suspect area 2-3 times, challenge the talus superior
        i. if positive, repeat the laser swipe and pull inferior on the talus to clear the injury reflex.
        ii. Basically, swiping with the laser light is the same as pinching the suspect area.

b. The LLLT approach is especially useful when treating IRT for surgeries or other deep seated injury areas.

Conclusion

Clearing fixations and keeping them clear is important to enhance function and pain relief for our patients. My patients and I have been extremely pleased by the impressive reduction in spinal fixation recreance using coccygeal release and injury recall techniques.

While treating spinal fixations is extremely important, it's even more important to find and treat the underlying cause.

James DW Hogg
DC DIBAK
Private practice of Chiropractic
Davenport, IA
drhogg@drhogg.com

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