IN SEARCH OF CLINICAL EXCELLENCE WITHIN S.O.T
Dr Robert Coté's Lifetime Clinical Research

- Who was Dr Robert Coté DC, DICS and what was his contribution to SOT during his 50 plus years of clinical work?

- Dr Coté's protocol that is intended to be applied when patient indicators or symptoms persist after performing the entire SOT procedure as covered by the SOT manual

A. Who was Dr Robert Coté DC, DICS, FICS and what was his contribution to SOT during his 50 plus years of clinical work?

WHO WAS DR COTÉ DC, DICS, FICS

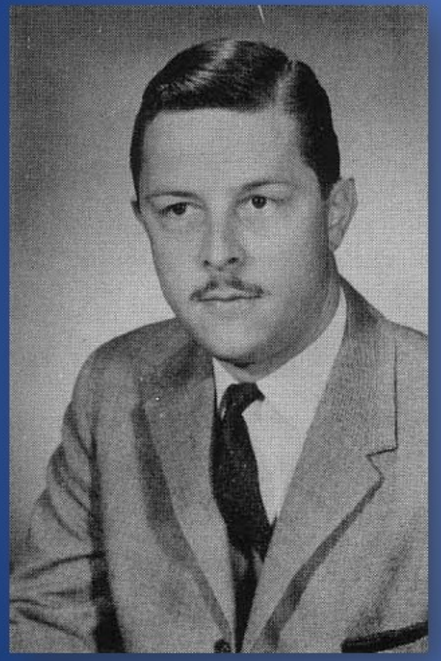
- The late Dr Coté was first introduced to SOT in 1943 when his father returned from a seminar given by Dr. DeJarnette; He said that he remembered himself standing in front of the distortion analyzer to demonstrate the new technique, SOT

- He graduated in 1959 from the Los Angeles College of Chiropractic and began studying and attending SOT seminars since 1961, every year for 25 years

Dr. R. St. Denis, Dr. R. Côté, Dr. G. Côté, Dr. René Labrosse.

Under the wonderful direction of Dr. R. St. Denis, President of the Quebec-Ontario study group, Drs. G. and R. Côté, respectively Treasurer and Educational Director, and with my humble contribution, the Canadians will have a

WHO WAS DR COTÉ DC, DICS, FICS



- He was active with the Sacro Occipital Research Society supporting Dr DeJarnette's work and from 1964 on, he was a member of the board of directors for 25 consecutive years.
  This includes a presidency in 1973-74 and a chairman position in 1975-76
- Dr Coté was certified in craniopathy and had his Fellow and Diplomate with the International Craniopathic Society throughout his life
- He held practice in Canada for over 50 years
- He was a primary SOT instructor in the US under Dr DeJarnette for over 20 years

WHO WAS DR COTÉ DC, DICS

- Has presented his innovative techniques and methods of care at the 2000, 2001, and 2003 SOTO-USA clinical symposiums
- Robert A. Coté, DC, DICS, FICS was awarded the 2003 SOTO-USA Lifetime Achievement Award

WHO WAS DR COTÉ DC, DICS

- Dr Coté was all about doing as little as possible to get the most results in order to avoid disrupting the natural process of the body
- He always said: ''Work WITH the body, its telling you what you need to know.
  YOU just have to figure out what it is saying !'' A true master of his art
- He taught us that nature has left a map on the body in the form of indicators for you to follow.
  He showed us that they are everywhere: on the arms, forearms, calves, gluts., T/S ring, traps., occipital bone and many others

B. Dr Coté's protocol that is intended to be applied when patient indicators or symptoms persist after performing the entire SOT procedure as covered by the SOT manual

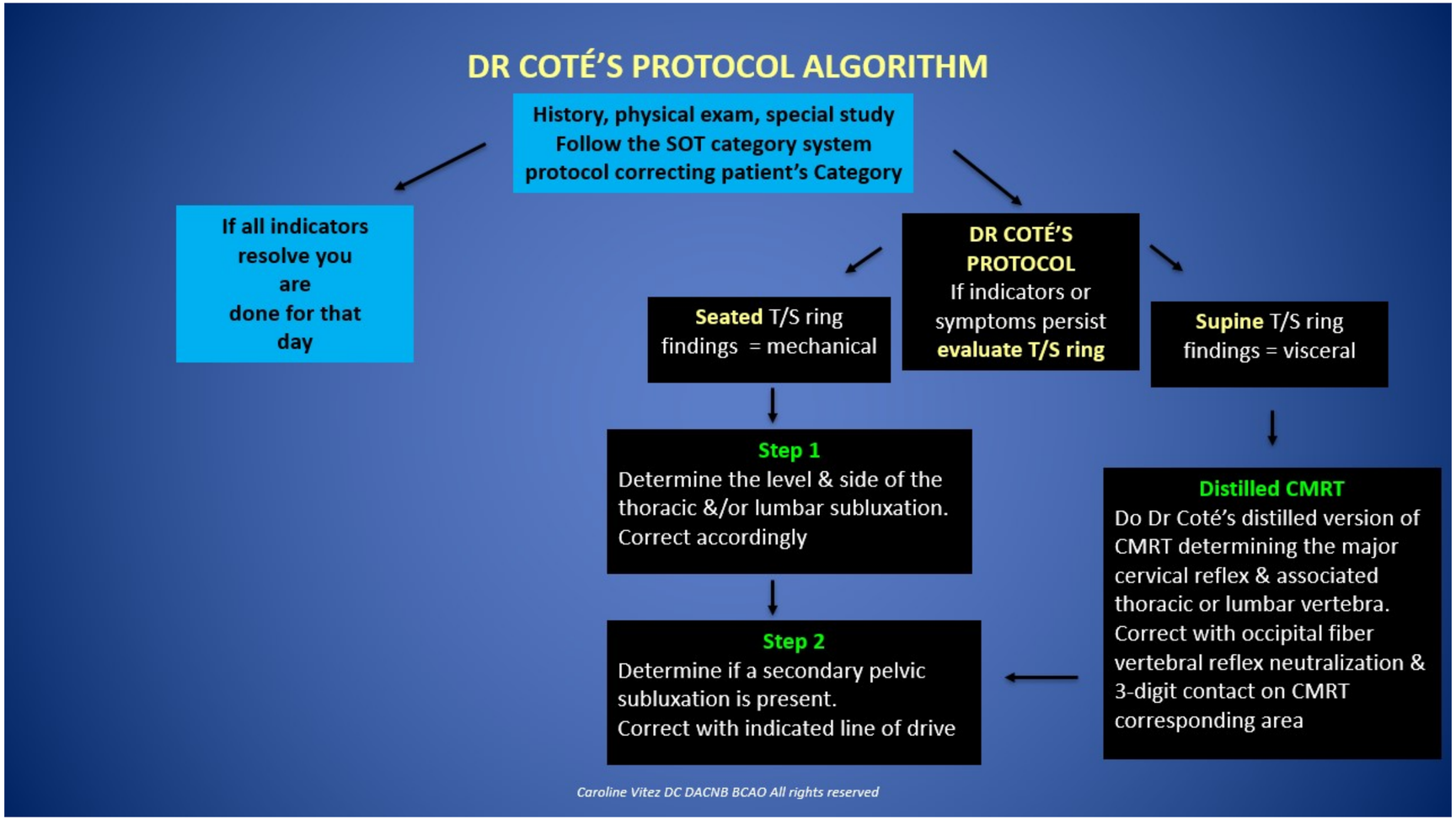
DR COTÉ'S PROTOCOL

FIRST AND FOREMOST

- Always begin by following the entire procedure as covered by the SOT manual which is complete and should be followed as given, establishing and correcting the Category that the patient presents along with all rotatory pelvic subluxation

- If all of the patients indicators resolve, you are **done** treating the patient for that visit

- If there are indicators that still persist or some of the patient's symptoms do not resolve after a few treatments with the SOT procedure, start Dr Coté's protocol


DR COTÉ'S PROTOCOL ALGORITHM
History, physical exam, special study
Follow the SOT category system
protocol correcting patient's Category
If all indicators resolve you are done for that day
DR COTÉ'S PROTOCOL
If indicators or symptoms persist evaluate T/S ring
Seated T/S ring findings = mechanical
Supine T/S ring findings = visceral
Step 1
Determine the level & side of the thoracic &/or lumbar subluxation.
Correct accordingly
Step 2
Determine if a secondary pelvic subluxation is present.
Correct with indicated line of drive
Distilled CMRT
Do Dr Coté's distilled version of CMRT determining the major cervical reflex & associated thoracic or lumbar vertebra.
Correct with occipital fiber vertebral reflex neutralization & 3-digit contact on CMRT corresponding area
Caroline Vitez DC DACNB BCAO All rights reserved

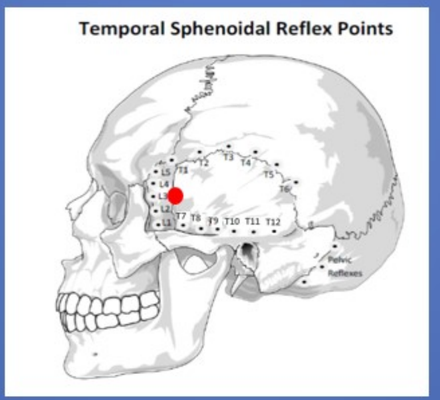
DR COTÉ'S PROTOCOL

- Evaluate the patient's temporo-sphenoidal (T/S) ring in two positions:

Seated: musculoskeletal

Supine: visceral malfunction

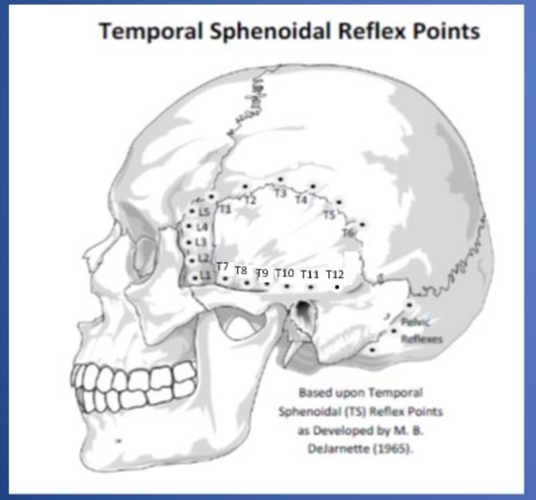
Note: **NEUTRAL POSITION BLOCKING** on ''non acute'' patients is used when multiple T/S ring indicators are present to sort out the major indicator reflexes.
Monitor with a reflex located on the greater wing of sphenoid (red circle)
Leave the blocks in until the reflex becomes tension-free/pain-free bilaterally.
Reassess the T/S ring indicators, only the major reflex should remain.

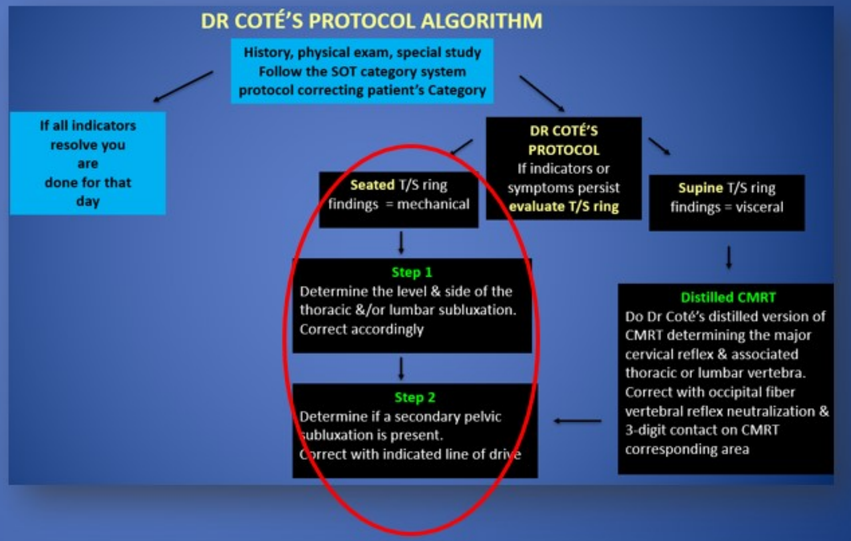


Occipital fiber chart							
Occipital fibers	1	2	3	4	5	6	7
Trapezius fibers	1	2	3	4	5	6	7
Cervicals	1	2	3	4	5	6	7
Thoracic	1,2, 10	3,11,12	4,5	6	7	8	9
Lumbars			1	2	3	4	5

T/S RING INDICATOR FINDINGS SEATED – Musculoskeletal

- If the T/S ring findings are predominantly found in the sitting position, these are **musculoskeletal** in nature
- Perform step 1





T/S RING INDICATOR FINDINGS SEATED – Musculoskeletal

STEP 1

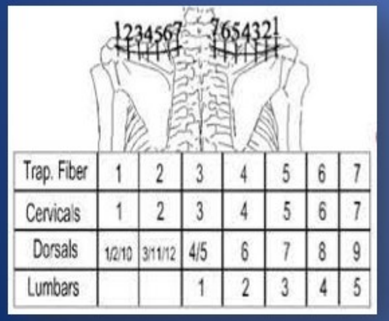
- Confirm T/S ring thoracic and/or lumbar indicator findings with the palpatory findings of the following reflexes:

I. TRAPEZIUS FIBERS: to confirm the cervical level involved and associated thoracic or lumbar vertebra (ex:right trap fiber 4: C4-T6- L2)

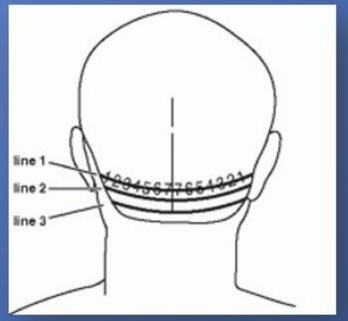
II. CALF OR POSTERIOR ARM REFLEXES: to confirm the cervical level involved (ex: right C4 calf reflex: C4-T6-L2)

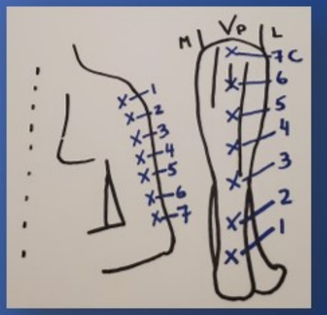
III. OCCIPITAL FIBERS: to confirm the cervical level involved and associated thoracic or lumbar vertebra (ex:right occ fiber 4: C4-T6-L2)

IV. SUPERIOR ILIAC CREST REFLEXES: to confirm if there is T11-L5 vertebra involvement directly (ex: right L2 reflex)



Trap. Fiber	1	2	3	4	5	6	7
Cervicals	1	2	3	4	5	6	7
Dorsals	1/2/10	3/11/12	4/5	6	7	8	9
Lumbars			1	2	3	4	5



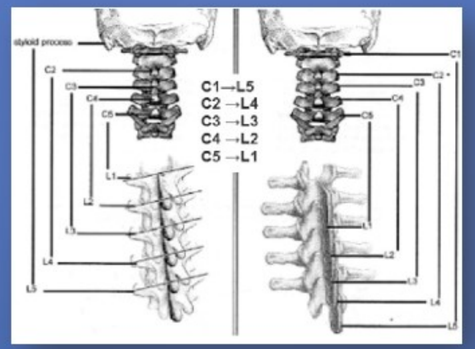


T/S RING INDICATOR FINDINGS SEATED – Musculoskeletal

STEP 1

- If a **lumbar** vertebra is involved, determine the specific subluxation pattern based on cervical Indicators thought the R + C palpation and correct it:

  - Cervical **spinous** process tender indicates lumbar **inferior** ipsilateral (ex: right C4-L2)
  - Cervical **transverse** process tender indicates lumbar **anterior** rotation ipsilateral (ex: right C4-L2)



- **The correction can be made with any method you would like**

T/S RING INDICATOR FINDINGS SEATED – Musculoskeletal

STEP 1

- If a **thoracic** vertebra is involved, adjust at the corresponding thoracic level:

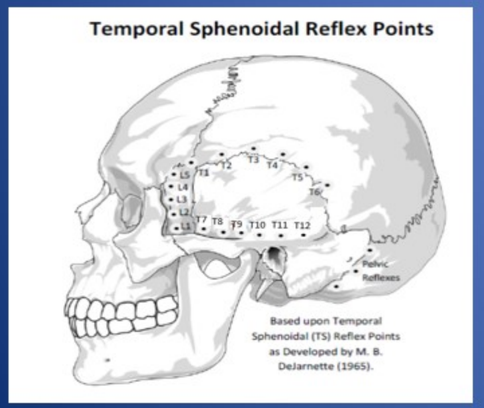
  - The correction (ex: C4-T6) can be made with any method you would like to use

  - Once the indicated lumbar and/or thoracic adjustment has been done, recheck your T/S ring seated and other previously positive indicator reflexes, they should be clear

T/S RING INDICATOR FINDINGS SEATED – Musculoskeletal

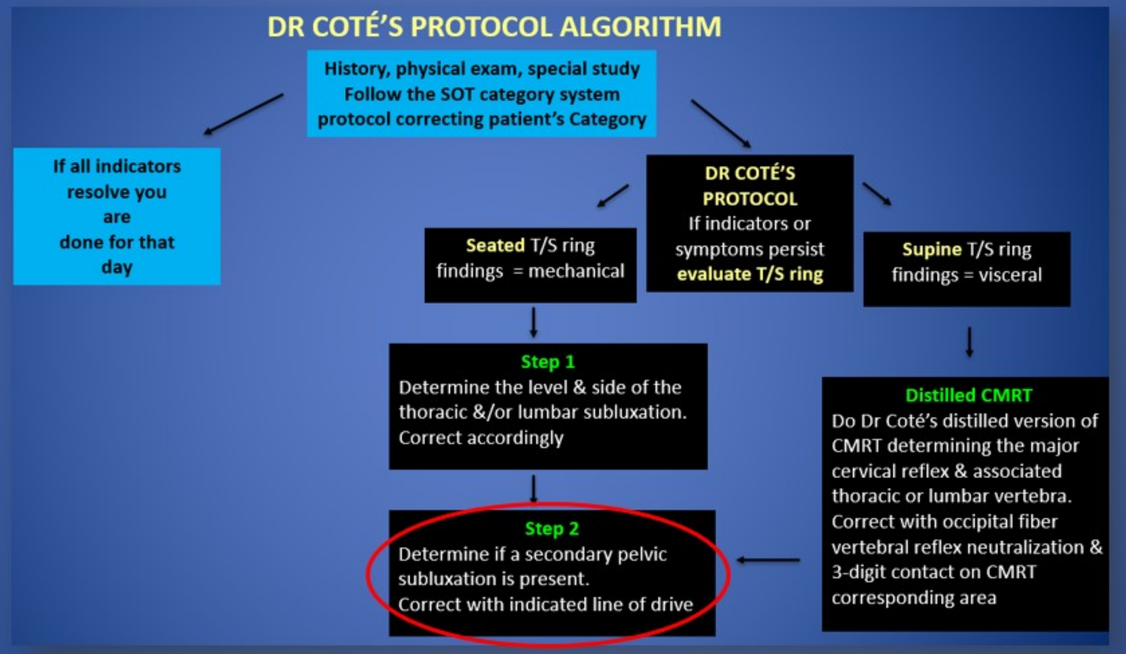
STEP 1

Putting it all together-step 1:
- T/S ring
- Superior iliac crest reflexes
- Calf/arm reflexes
- Occipital fibers
- Trap fibers
- Lumbar vertebra adjusting according to R + C palpation
- Thoracic vertebra adjusting



T/S RING INDICATOR FINDINGS SEATED – Musculoskeletal

STEP 2



T/S RING INDICATOR FINDINGS SEATED – Musculoskeletal

STEP 2

- Determine if **secondary** Pelvic adjusting is required utilizing indicators:

  - The entire pelvic adjusting procedure as covered by the SOT manual is complete and should be followed as given. But it only covers the ilium subluxated in rotation: UMS (posterior) and LLL (anterior)

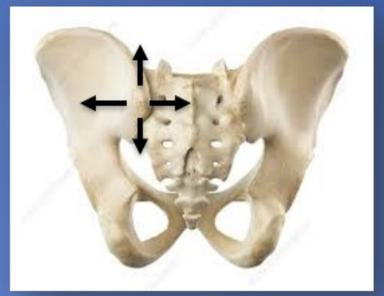
  - Once this is corrected following the S.O.T procedure and your indicators are negative, your indicator system is void and no longer informative

  - Does this mean that the pelvis is clear? Not always

T/S RING INDICATOR FINDINGS SEATED – Musculoskeletal

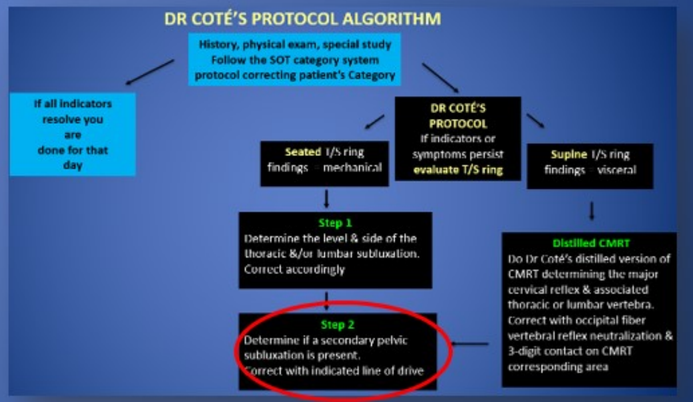
STEP 2

- Once you have made your indicated corrections according to the SOT protocol, and all indicators are negative, make a careful examination of the occipito-mastoid sutures bilaterally



- If you palpate pain or swelling, the ipsilateral SI joint is still under stress and further corrections are needed to correct the **secondary pelvic subluxation for:**

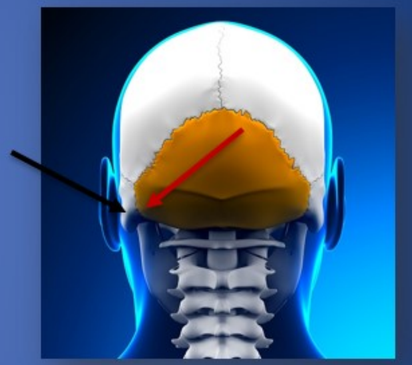
  - Ilium subluxation ''in block'' (C1)
  - Sacrum subluxation (C2)



T/S RING INDICATOR FINDINGS SEATED – Musculoskeletal

STEP 2

- **ILIUM** indicators ipsilaterally swollen or painful upon palpation:
  - lateral occipito-mastoid suture (temporal bone)
  - 3rd rib



- **SACRUM** indicators ipsilaterally swollen or painful upon palpation:
  - medial occipito-mastoid suture (occipital bone)
  - 4th rib
  - C2 spinous rotated ipsilaterally

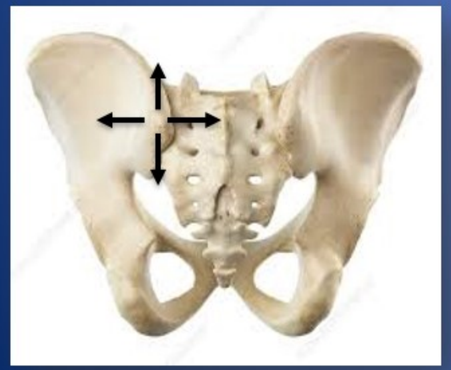
T/S RING INDICATOR FINDINGS SEATED – Musculoskeletal

STEP 2

- Determine the line of drive required to correct the secondary subluxation of the ilium ''in block'' or of the sacrum:

- The patient is prone and the practitioner stands on the side of involvement
- Contact the painful occipito-mastoid suture or rib with one hand and the corresponding ipsilateral ilium PSIS or Sacral 2-3 with the other

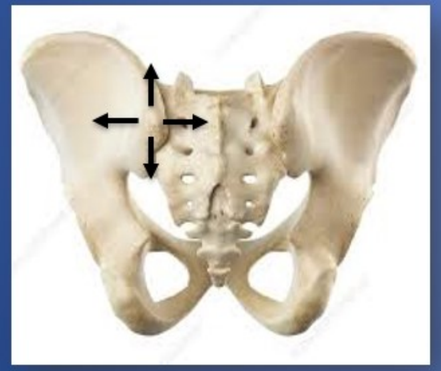
  - **Ilium**: lateral occipito-mastoid suture or 3rd rib → Ilium PSIS
  - **Sacrum**: medial occipito-mastoid suture or 4rd rib → Sacral 2-3

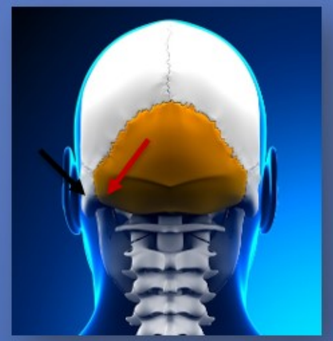


T/S RING INDICATOR FINDINGS SEATED – Musculoskeletal

STEP 2

- For a left side **ilium** or **sacrum** the practitioner stands on the left side
- The practitioner's left hand makes a finger contact on the painful occipito-mastoid suture (ex: lateral Left for ilium) or rib (ex: 3rd rib Left) while his right hand contacts the ilium PSIS or sacrum (ex: Left Ilium)
- The doctor then applies mild pressure with his right hand cephalad, caudal, lateral and medial
- The direction that removes the corresponding occipito-mastoid or rib pain is the line of drive to be used to correct the ilium or sacrum subluxation





- If the vectored pressure at the PSIS or sacrum does not completely control the indicator pain, vector your contact at a slightly different angle (anywhere between these 4 directions) until the suture or rib indicator is pain-free (L3, sacrum))

T/S RING INDICATOR FINDINGS SEATED – Musculoskeletal

STEP 2

- Correction of secondary ilium or sacrum subluxation:

  - It can be made with a side posture, drop, logan basics, sustained contact, or any other method you would like to use as long as it allows the correction to be in the determined line of drive and clears the indicators

- **Recheck your occipito-mastoid suture or rib indicator: If it is not pain-free, go back and recheck your line of drive**
- **If the indicator is negative, you are done treating this patient for that visit**

T/S RING INDICATOR FINDINGS SEATED – Musculoskeletal

STEP 2

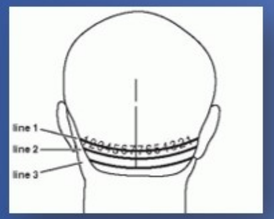
Putting it all together-step 2:

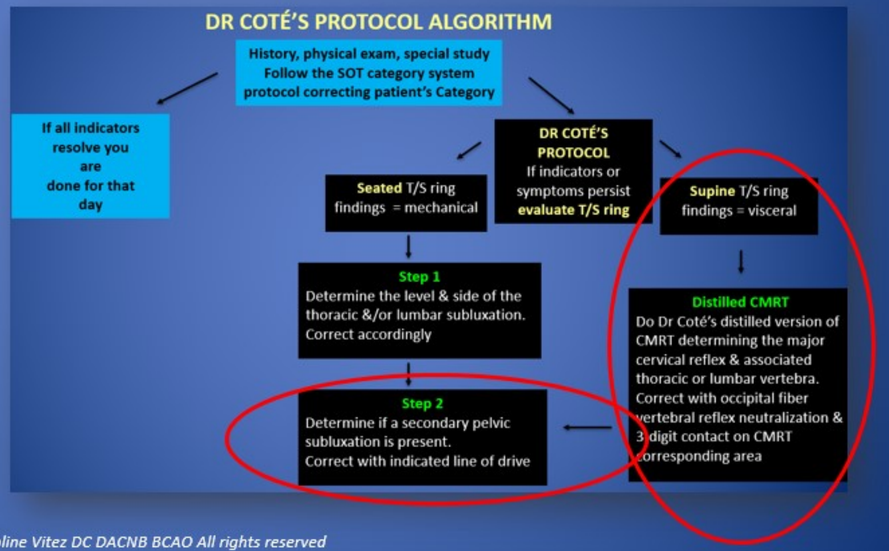
- Sacrum, ilium indicators at occipito-mastoid suture/4th & 3rd rib
- Finding the proper line of drive for correction contacting sacrum/ilium and corresponding indicators

T/S RING INDICATOR FINDINGS SUPINE – Visceral malfunction

- If the T/S ring findings are predominantly found in the supine position, these indicate more of a visceral component:

  - Perform the Distilled CMRT shown in the algorithm before you do step 2 described in the previous slides





T/S RING INDICATOR FINDINGS SUPINE – Visceral malfunction

DISTILLED CMRT

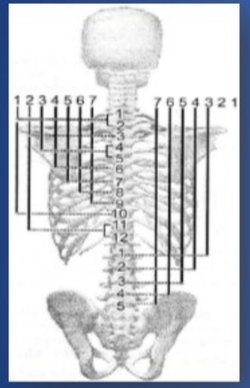
- This version of **CMRT** utilized to correct visceral malfunction consists of the following procedure :

1. Confirm T/S ring findings with the palpatory findings of cervical overload reflexes: Reflex arc
2. Correct with occipital fiber-vertebral reflex neutralization
3. Adjust the thoracic &/or lumbar vertebra associated
4. Perform the 3-digit contact on CMRT corresponding area
5. Correct the anterior misalignment of the associated cervical vertebra: effortless/painless adjusting

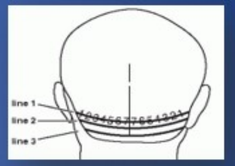
T/S RING INDICATOR FINDINGS SUPINE – Visceral malfunction

DISTILLED CMRT

1. Confirm T/S ring thoracic or lumbar indicator findings with the palpatory findings of the following reflexes: Reflex arc



This is done by correlating T/S ring indicator findings with the following major cervical overload reflex palpatory findings and symptomatology



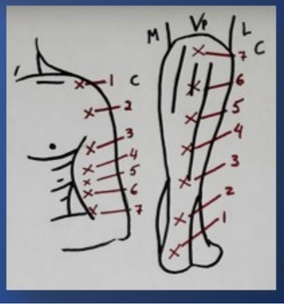
I. TRAPEZIUS FIBERS: to confirm the cervical level involved and associated thoracic or lumbar vertebra (ex: right trap fiber 3: C3-T4-S1)

Occipital fiber chart							
Occipital fibers	1	2	3	4	5	6	7
Trapezius fibers	1	2	3	4	5	6	7
Cervicals	1	2	3	4	5	6	7
Thoracic	1,2, 10	3,11,12	4,5	6	7	8	9
Lumbars			1	2	3	4	5
Sacrals		1	1	2	3	4	5

II. OCCIPITAL FIBERS **LINE 2**: to confirm the cervical level involved and associated thoracic or lumbar vertebra (ex: right occ fiber 3: C3-T4-S1)

III. CALF OR ANTERIOR ARM REFLEXES: to confirm the cervical level involved and associated thoracic or lumbar vertebra (ex: right C3 calf reflex: C3-T4-S1)

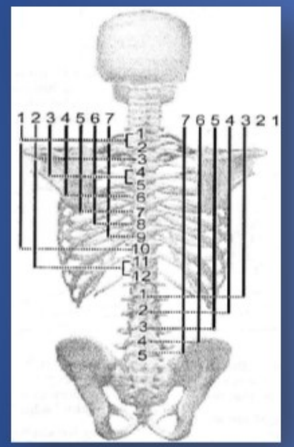
IV. HISTORY/SYMPTOMATOLOGY/POSTURE OBSERVATION: to confirm the reflex arc and associated organ involved (ex: right C3-T4-S1-gallbladder)



T/S RING INDICATOR FINDINGS SUPINE – Visceral malfunction

DISTILLED CMRT

2. Correct with occipital fiber-vertebral reflex neutralization



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Lumbars			1	2	3	4	5
Sacrals		1	1	2	3	4	5

- Dr Coté's clinical theory of an organ malfunction

- Bilateral occipital-thoracic or lumbar contact

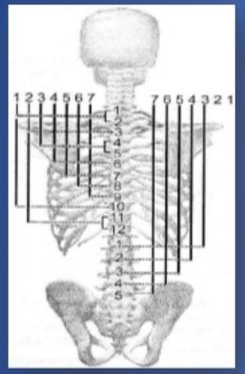
Practitioner at the **left** of the prone patient, a bilat contact is held by his left hand at the occipital fibers involved (ex: occ fiber #3 line 2) and by his right hand on the corresponding paraspinous thoracic or lumbar area bilaterally (ex: T4) lightly putting a headward pressure until occipital pulsation is felt

- Cervical paraspinous-thoracic or lumbar, 2 inches lateral contact

Doctor then moves his left hand to contact the corresponding paraspinous cervical area (ex: C3 right) while his right hand contacts 2 inches lateral to the corresponding thoracic or lumbar paraspinal area (ex: T4 right).
Both contact makes a soft tissue relaxing motion to release tissue stress until pain is absent in the thoracic or lumbar contact

T/S RING INDICATOR FINDINGS SUPINE – Visceral malfunction

DISTILLED CMRT



2. Correct with occipital fiber-vertebral reflex neutralization (cont.)

- **Cervical paraspinous-sacral contact**

Once the thoracic or lumbar area is pain-free, move your right hand to the corresponding sacral segment (right sacral 1). Palpate from medial to lateral at that level (S1), ¼ inch at a time, making 4 pressure contacts, identifying the most painful one. Hold that contact until the cervical paraspinal area (C3) is pain-free.

- **Sacral-occipital fiber contact**

If pain persists at the sacral area, maintain that contact with your right hand and contact the corresponding occipital fiber (#3) with your left hand until the sacral contact is pain-free

Occipital fiber chart							
Occipital fibers	1	2	3	4	5	6	7
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Lumbars			1	2	3	4	5
Sacrals		1	1	2	3	4	5

T/S RING INDICATOR FINDINGS SUPINE – Visceral malfunction

DISTILLED CMRT

1. Confirm T/S ring findings with the palpatory findings of cervical overload reflexes: Reflex arc
2. Occipital fiber-vertebral reflex neutralization :
   - Bilateral occ/thoracic or lumbar contact
   - Cervical paraspinous/thoracic or lumbar 2 inches lateral contact
   - Cervical paraspinous/sacral contact
   - Sacral/occipital fiber contact

T/S RING INDICATOR FINDINGS SUPINE – Visceral malfunction

DISTILLED CMRT

3. Adjust the thoracic or lumbar vertebra involved

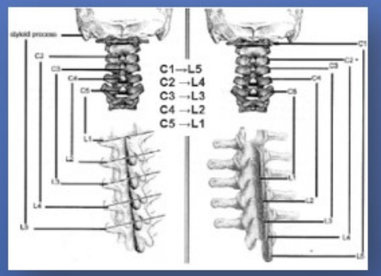
Thoracic

If the indicator initially revealed a thoracic involvement (ex: T4), make a bilateral thenar contact at the corresponding thoracic area making a very light headward adjustment

If that does not release the indicated thoracic segment (ex: T4), do an anterior thoracic correction at that level (ex: T4)

Lumbar

If the indicators had initially revealed a lumbar involvement, determine the specific subluxation pattern based on cervical indicators through the R + C palpation and correct it with any method you would like



T/S RING INDICATOR FINDINGS SUPINE – Visceral malfunction

DISTILLED CMRT

4. Perform the 3-digit contact on CMRT corresponding area

- The patient then goes supine, standing on the **right** side of the patient, you will make a 3-digit contact at the C.M.R.T. area for the organ corresponding to the previously determined indicators (ex: gallbladder, right C3-T4-S1):

  - clockwise if done on the right side (energizes the organ)
  - counterclockwise on the left (destresses the stressed organ)

- When an organ begins to malfunction it looses its energy, this occurs on the right side

- Recheck the patient's T/S ring supine and other previously positive indicator reflexes, if clear, you are done with CMRT (go do step 2)

T/S RING INDICATOR FINDINGS SUPINE – Visceral malfunction

DISTILLED CMRT

5. Correct the associated cervical anterior subluxation: Painless & effortless ajusting

- The patient supine, palpate the tissue on the anterior body of the cervical vertebra at the indicated level and side looking for pain (ex: C3 right): the abnormal reflex coming from an organ malfunction is located on the anterior portion of the cervical vertebra
- Holding the painful contact on the anterior cervical vertebral body (C3 right) with your thumb, slowly **passively** rotate and laterally flex the patient's head away to a position where the contact is pain-free
- Hold that head position, pumping the painless anterior cervical vertebra tissue cephalad, for about 1 minute, releasing all tensions at that level: anterior cervical vertebra adjusting
- Then **passively** bring the head back to neutral and recheck your cervical reflex indicator that should be pain-free
- Recheck the T/S ring supine and other previously positive indicator reflexes, if clear, you are done with CMRT (go do step 2)

"painless and effortless adjusting"

T/S RING INDICATOR FINDINGS SUPINE – Visceral malfunction

DISTILLED CMRT

3. Adjusting the thoracic or lumbar vertebra involved
4. 3-digit CMRT
5. Adjust the associated cervical anterior misalignment: Painless & effortless adjusting

T/S RING INDICATOR FINDINGS SUPINE – Visceral malfunction

DISTILLED CMRT

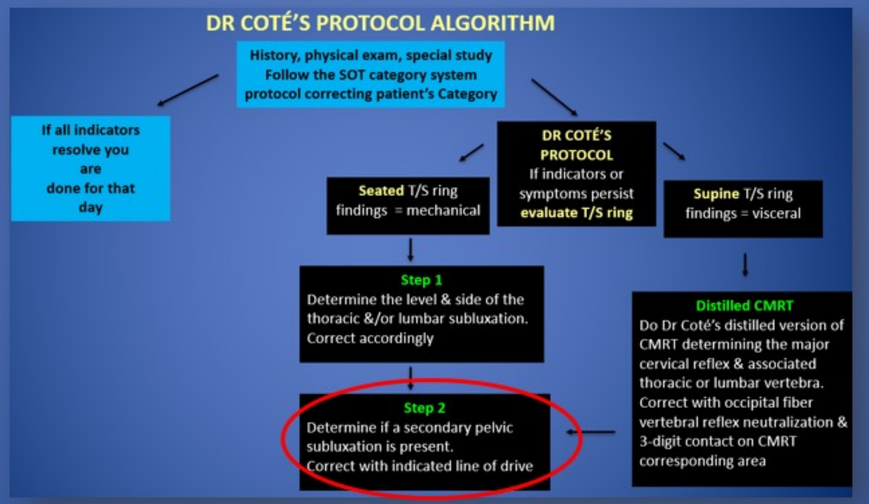
Putting it all together-distilled CMRT:

1. Confirm T/S ring findings with the palpatory findings of cervical overload reflexes: Reflex arc
2. Occipital fiber-vertebral reflex neutralization
   - Bilateral occ/thoracic or lumbar contact
   - Cervical paraspinous/thoracic or lumbar 2 inches lateral contact
   - Cervical paraspinous/sacral contact
   - Sacral/occipital fiber contact
3. Adjusting associated thoracic or lumbar vertebra
4. 3-digit CMRT
5. Adjust the associated cervical anterior misalignment:
   Painless & effortless adjusting

T/S RING INDICATOR FINDINGS SUPINE – Visceral malfunction

STEP 2

- Determine if **secondary** Pelvic adjusting is required utilizing indicators:



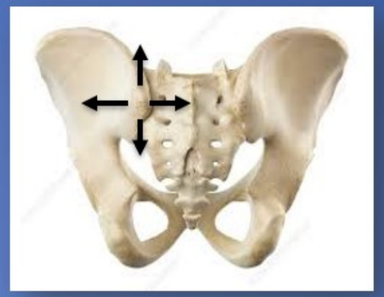
T/S RING INDICATOR FINDINGS SEATED – Musculoskeletal

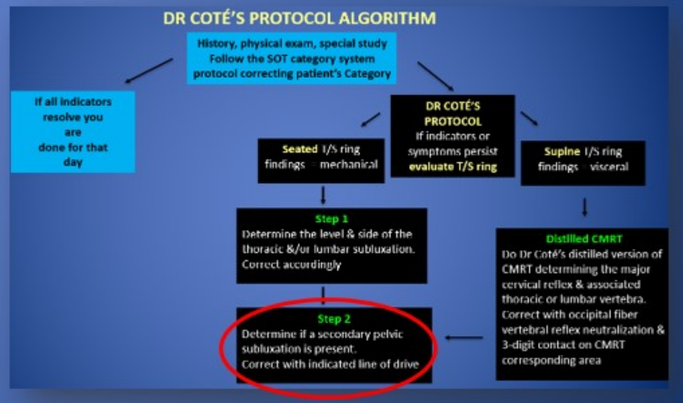
STEP 2

- Make a careful examination of the occipito-mastoid sutures bilaterally

- If you palpate pain or swelling, the ipsilateral SI joint is still under stress and further corrections are needed to correct the **secondary pelvic subluxation for:**

  - Ilium subluxation ''in block'' (C1)
  - Sacrum subluxation (C2)





T/S RING INDICATOR FINDINGS SEATED – Musculoskeletal

STEP 2

- **ILIUM** indicators ipsilaterally swollen or painful upon palpation:
  - lateral occipito-mastoid suture (temporal bone)
  - 3rd rib

- **SACRUM** indicators ipsilaterally swollen or painful upon palpation:
  - medial occipito-mastoid suture (occipital bone)
  - 4th rib
  - C2 spinous rotated ipsilaterally

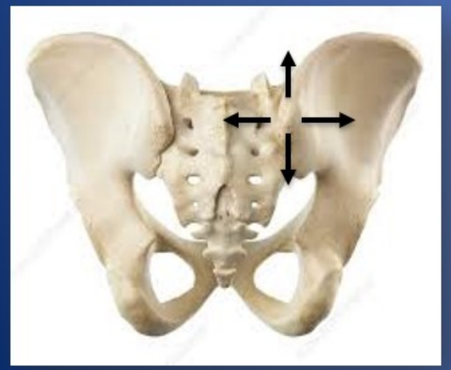
T/S RING INDICATOR FINDINGS SEATED – Musculoskeletal

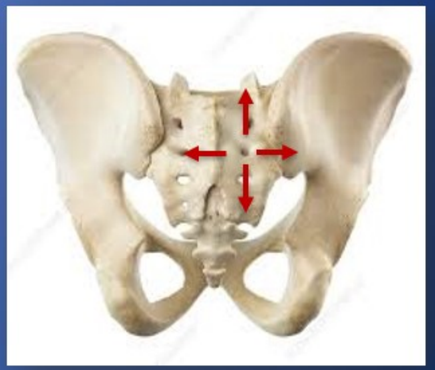
STEP 2

- Determine the line of drive required to correct the secondary subluxation of the ilium ''in block'' or of the sacrum:

- The patient is prone and the practitioner stands on the side of involvement
- Contact the painful occipito-mastoid suture or rib with one hand and the corresponding ipsilateral ilium PSIS or Sacral 2-3 with the other

  - **Ilium**: lateral occipito-mastoid suture or 3rd rib → Ilium PSIS
  - **Sacrum**: medial occipito-mastoid suture or 4rd rib → Sacral 2-3

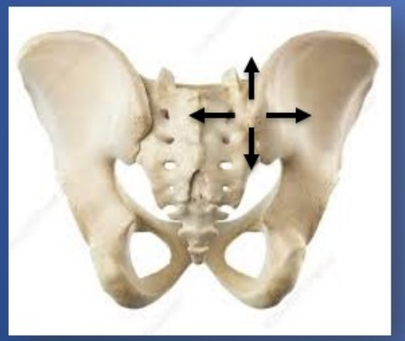


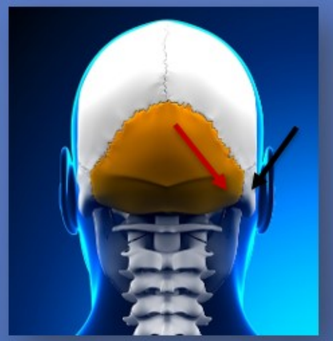


T/S RING INDICATOR FINDINGS SEATED – Musculoskeletal

STEP 2

- For a right side **ilium** or **sacrum** the practitioner stands on the right side
- The practitioner's right hand makes a finger contact on the painful occipito-mastoid suture (ex: medial for right sacrum) or rib (ex: 4th rib right) while his left hand contacts the ilium PSIS or sacrum (ex: right sacrum)
- The doctor then applies mild pressure cephalad, caudal, lateral and medial
- The direction that removes the corresponding occipito-mastoid or rib pain is the line of drive to be used to correct the ilium or sacrum subluxation





- If the vectored pressure at the PSIS or sacrum does not completely control the indicator pain, vector your contact at a slightly different angle (anywhere between these 4 directions) until the suture or rib indicator is pain-free (L3)

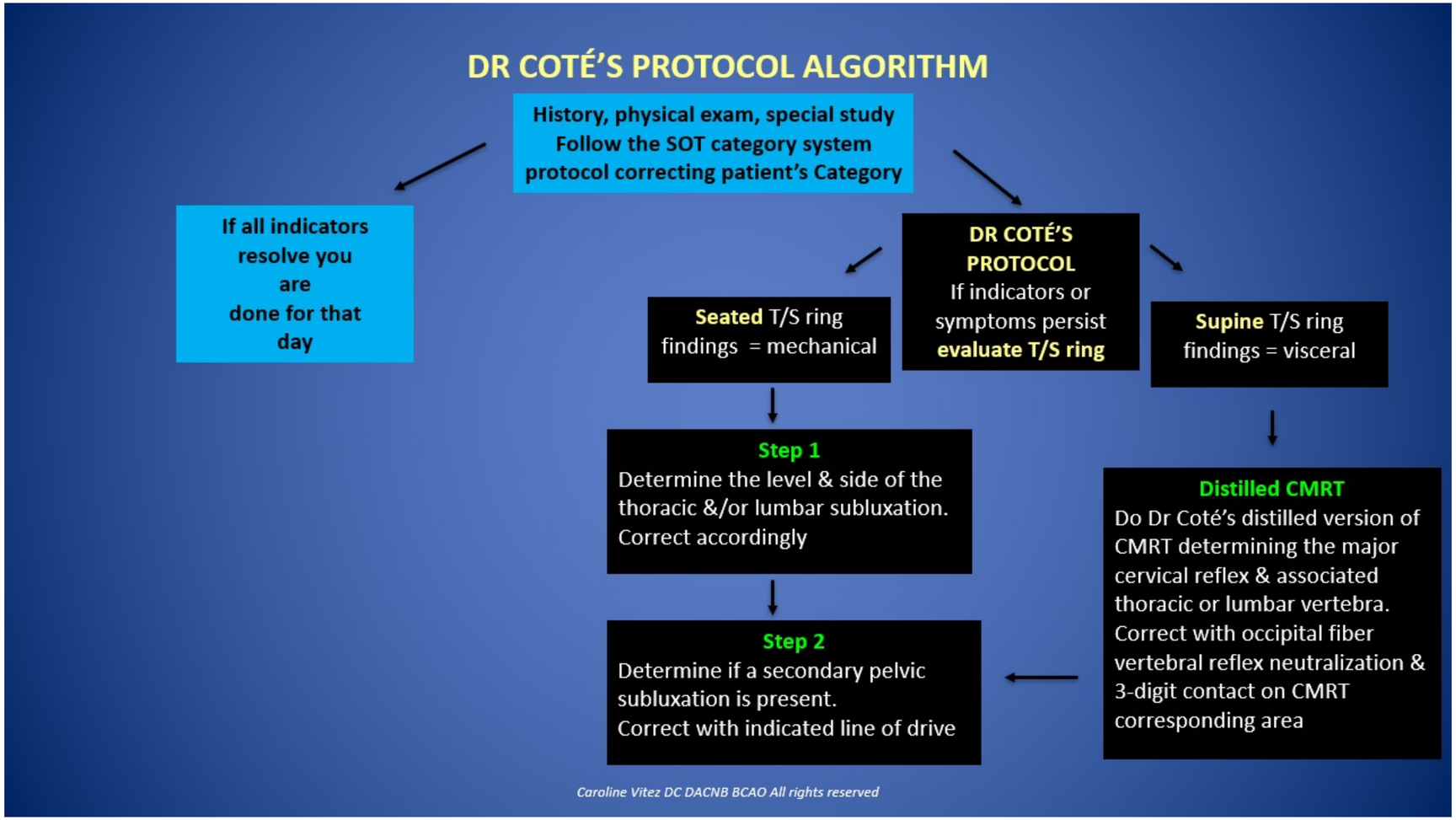
T/S RING INDICATOR FINDINGS SEATED – Musculoskeletal

STEP 2

- Correction of ilium or sacrum secondary subluxation:

  - It can be made with a side posture, drop, logan basics, sustained contact, or any other method you would like to use as long as it allows the correction to be in the determined line of drive and clears the indicators

- **Recheck your occipito-mastoid suture or rib indicator: If it is not pain-free, go back and recheck your line of drive**
- **If the indicator is negative, you are done treating this patient for that visit**


DR COTÉ'S PROTOCOL ALGORITHM
History, physical exam, special study
Follow the SOT category system
protocol correcting patient's Category
If all indicators resolve you are done for that day
DR COTÉ'S PROTOCOL
If indicators or symptoms persist evaluate T/S ring
Seated T/S ring findings = mechanical
Supine T/S ring findings = visceral
Step 1
Determine the level & side of the thoracic &/or lumbar subluxation.
Correct accordingly
Step 2
Determine if a secondary pelvic subluxation is present.
Correct with indicated line of drive
Distilled CMRT
Do Dr Coté's distilled version of CMRT determining the major cervical reflex & associated thoracic or lumbar vertebra.
Correct with occipital fiber vertebral reflex neutralization & 3-digit contact on CMRT corresponding area
Caroline Vitez DC DACNB BCAO All rights reserved

IN SEARCH OF CLINICAL EXCELLENCE WITHIN S.O.T
Dr Robert Coté's Lifetime Clinical Research

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