



INTERNATIONAL COLLEGE
OF APPLIED KINESIOLOGY UK

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Introduction

Upcoming Seminars

Muscle of the Month: Hamstrings
by Jeffrey S. Kurtz, DC, CCSP, DIBAK

Fundamentals Review: Category 1
by Jeffrey S. Kurtz, DC, CCSP, DIBAK

Introduction

Dear Colleague,

Summer is here, but I wouldn't know it from the weather. With floods and non-stop rain, it doesn't leave very many opportunities for going to the beach.

I hope everyone's practice is going well. Summer can be a slower time of year with all the vacations and such during the holiday for students. It can also be a good time for doctors to recharge, review, and get ready for the Autumn season of seminars and treating patients.

In this edition, there is a review of the intricacies of Category 1 and with it a focus on the hamstrings. Category I is used frequently for the resolution of many problems and is worth reviewing. It is easy to fall into a rut sometimes with the things doctors do often, so reviewing this technique will remind us why we do it and why it is so effective.

If you have any questions, comments, or if you have a request about review topics, please feel free to contact the ICAK UK at icak-uk@hotmail.co.uk.

Sincerely,

Jeffrey S. Kurtz, DC, CCSP, DIBAK

Upcoming Seminars

2012

If you would like to be added to our email list or you would like more information regarding seminars, please email the ICAK-UK at: icak-uk@hotmail.co.uk.

27-28 October, 2012 Using Applied Kinesiology to Assess the Developmental Profile

This course is an advanced course covering special needs and primitive reflexes. See the flyer here. If interested, please contact the ICAK UK as soon as possible.

More seminars are possible and we will be sure to notify you when they are scheduled.

Muscle of the Month:

Hamstrings

Written By:

Jeffrey Kurtz, DC, CCSP, DIBAK



Semimembranosus



Semitendinosus



Biceps Femoris

The Hamstrings comprise of 3 muscles: Semimembranosus, Semitendinosus, and Biceps Femoris. They work together to stabilise the hip and knee joints especially during gait. The biceps femoris specifically works with the medial head of the gastrocnemius to diminish the horizontal oscillations that occur in the first 100 ms after heel strike (Wakeling et al.). Vleeming et al. found that in late swing phase it decelerates the forward motion of the leg and pretenses in preparation of heel strike in order to protect the SI joint. The tension created by the long head of the biceps femoris increases tension in the sacrotuberous ligament which in turn decelerates nutation of the sacral base. These tension forces are then transferred to the ipsilateral multifidi, crossing the sacrum into the contralateral erector spinae, and into the latissimus dorsi. The biceps femoris tension will change depending on the ground reactive forces and increase when forces are higher, as in running or jumping.



Sacrotuberous Ligament

This is great information, but what does it mean clinically? In treating knees, hips, SI joints, lumbar spines, and even necks, weak hamstrings can be a contributing factor. For example, if a patient/athlete has an unstable SI joint that is chronically worse when walking, there are many possibilities to why. But in checking upper and lower gait muscles, an astute doctor may find that the hamstrings may be involved with the contralateral sacrospinalis and latissimus dorsi. In applied kinesiology, there are invaluable ways to demonstrate where problems are coming from using therapy localisation and challenge. More details will be in the Fundamentals Review of Category 1.

Muscle testing of medial and lateral hamstrings involves changing the amount of internal and external rotation of the hip. In the prone position, the medial HS are tested by bringing the leg into internal rotation and into external rotation for the later HS. In testing these muscles, cramping often occurs. If it does, decrease the angle of flexion at the knee and repeat the test. If further cramping occurs, check for betaine HCl and calcium deficiencies. If the patient is stressed out and has low HCl in the stomach, he won't be absorbing minerals very well leading to many problems, one of which is increased muscle cramping.

Reasons for weakness in the hamstrings:

- 5 factors of the IVF (L5,S1,S2, Organ: rectum, LI meridian, Vit E)
- Increased sacrotuberous ligament tension
- Bilateral weakness: Category I or III. Victor Frank associated bilateral weakness with a posterior sacral base, which I have found to be true in some cases.(since sacral nutation is controlled partly by the sacrotuberous ligament, increased tension would bring it posterior)
- In cases of hemorrhoids, the hamstrings can be weakened

Postural signs of weakness of the hamstrings:

As a group: Increase lumbar lordosis, anterior pelvic tilt

Medial HS: External rotation of leg bringing foot into ER

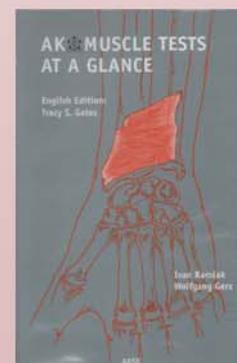
Lateral HS: Internal rotation of leg bringing foot into IR

For more information on the hamstrings and other muscles, I recommend the following references as they were referenced in the writing of this article:

Applied Kinesiology Synopsis, 2nd edition
by David Walther



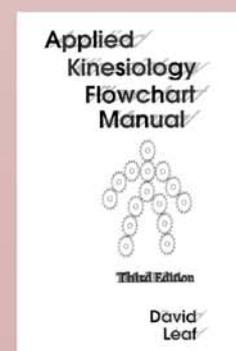
AK Muscle Tests at a Glance
by Ivan Ramsak and Wolfgang Gerz
-Translated to English by Tracy S. Gates



AK Flow Chart Manual
by David Leaf

This must be ordered from the USA and can be found on the ICAK-USA website:

www.icakusa.com



Category I Review

By Jeffrey S. Kurtz, DC, CCSP, DIBAK

By definition, the Category I pelvic fault is torsion of the pelvis without a subluxation of the SI joint. This affects the flow of cerebrospinal fluid. Is it possible to have multiple category problems at the same time? Yes. However for the purposes of this review, the focus will be on category I (Cat I).

The relationships of this category to the spine are many. It can increase tension in the cervical spine, change the tension and orientation in the shoulder, and have a large effect on spine movement during gait. It also involves cranial faults.

Diagnosis:

Gait: The person with this pelvic fault will walk with a very stiff spine with little or no shoulder rotation. There may be arm swing, but there will be very little shoulder movement and maybe a complaint at the TL junction area.

A two handed therapy localisation is used to determine if this fault is present. With the patient prone, one hand is placed over each SI joint and a normoreactive muscle is tested. This differs from the category II TL where the patient is supine and uses a one hand TL on the SI joint. If the patient cannot lie prone, this can be tested in standing using the neck flexors as the indicator muscle(s). If the test is positive, then both hands are placed over one SI joint and tested. Both SI joints are tested individually with both hands to determine the side of involvement.

Note: If the two hand TL is not positive, the TL with both palms up, then one palm up, one down both ways. Sometimes the Cat I will show this way.



Muscles that can be hyporeactive due to a Cat I include piriformis (in weight bearing), Quadratus Lumborum, and Sacrospinalis. The piriformis is tested in a hands and knees position. Since the piriformis becomes an internal rotator above 90 degrees of hip flexion, bring the knee slightly short of 90 degrees and test the muscle. It should be weak on the same side of the positive TL (if not, check for switching). Generally, there will also be weakness in the QL and Sacrospinalis as well. Test these muscles and correct the reflexes found to make them weak (usually Chapman reflexes).

Question: How does one find side of involvement when the patient cannot reach behind to TL because of shoulder problems?

One of the other signs of Cat I is 1st rib tenderness on the side of involvement. Both sides may be tender, but one will be more tender. That will be the involved side (check for switching or neurological disorganisation to confirm).

Treatment of Cat I:

After finding the side of involvement and treating the weak muscles, the doctor must challenge the pelvis. Challenge the pelvis by pressing firmly on the ilium by the iliac crest and the other on the contralateral ischial tuberosity followed by the testing of a normoreactive indicator muscle.

Challenge:



Block Placement:



When positive, the pelvic blocks are placed OPPOSITE the challenge. This is the rebound phenomenon in use, so the correction is in the direction that makes the normoreactive muscle weak. One could use a static challenge, but unless you have 4 arms or an assistant, it would be difficult. With the blocks in place, the doctor always follows one simple rule for correction: Push repeatedly with about 4-6 pounds 20 times on the UNINVOLVED side and NEVER INTO A BLOCK. With that in mind, it leaves only one place to apply your pressure. As you are treating, the anterior 1st rib tenderness can be checked and compared with previous sensitivity. It will decrease. Ask the patient if the first palpation was a 10/10, what is it now? When the tenderness gets down to around a 2, you have treated enough and the blocks can be removed. This is a great titration point to verify your treatment is effective and also demonstrates this to the patient.

Patients may notice changes in muscle strength, but they WILL notice changes in pain. Sometimes however, the patient says it is painful and a grimace is made and following the correction the patient may say the pain is about the same, but the difference is they don't grimace or squirm as they did before.

Other things that correlate to a Cat I and should be checked and treated if found are the following:

1. Temporal Bulge
2. Parietal Descent
3. Atlas and TMJ
4. Sacral Wobble

David Leaf wrote a paper about a consistent finding he had when correcting a Cat I. After Cat I correction, all but 4 of 207 cases had it return after walking and jumping. The 4 cases had a Cat II problem that needed correction. Of the 203 cases, all but 5 demonstrated a reactive muscle pattern between piriformis and glut max muscles. The most common finding was a hypereactive piriformis inhibiting the glut max muscle. After resolving the reactive muscle pattern, 4 of the 203 cases had the Cat I return after walking and jumping. This is very important and I have often found this pattern as well.

Category I is very prevalent and is a "bread and butter" treatment. I find it on just about every patient. With the general public having increased stress which can cause dural torque which then can cause a Category I, it is not surprising.

I hope this is a helpful review and I refer you to the same resources found in the Muscle of the Month page for further information. The Synopsis by David Walther and The Flow Chart Manual by David Leaf was used in the writing of this article.

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by Tracy S Gates D.O., DIBAK

27/28 October 2012



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Worthing Road, Southwater, West Sussex. RH13 9JB

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Please note that the seminar fee is non-refundable once payment has been made

Programme

Seminar Times:

Saturday 10.00am to 6.00pm – Sunday 9.00am to 4.00pm

**A two-day course based on the work of
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- ◆ Assessment and treatment using AK methods
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... and so much more!

Due to the complexity of the course, it is essential that all candidates have completed a basic education in AK.

****THIS COURSE IS ACCREDITED FOR
OFFICIAL ICAK CREDIT HOURS****

Tracy S Gates, D.O., DIBAK



Tracy S. Gates is a registered osteopath of 25 years standing.

Having practised for several years using osteopathy and cranial osteopathy, she studied Applied Kinesiology, successfully achieving her diplomate status in 1994.

As part of her diplomate she made a research study into the use of AK in treating Special Needs children. The research was further backed up by a period of time spent at the Peto Institute in Budapest; as well as study at the Institute for Research into Human Potential in Philadelphia.

Today, Tracy lectures in the UK and throughout Europe. She makes regular presentations of her ongoing research at various conferences in Europe and the USA. She is currently involved in working with and treating athletes competing at an international level.

Tracy is Vice-Chair of the International Committee (I.C.) of ICAK, Secretary and Treasurer of the International Educational Council (IEC) and the International Representative for ICAK-UK.

What previous delegates have said about this seminar.

“For those wanting to understand and treat the underlying cause of patients' symptom patterns this course covers everything. Tracy's obvious deep wealth of knowledge and clear presentation style really animates the subject matter - with plenty of demonstrations and supervised practical to appreciate the intricacies of this work.” *Matt Bourne D.O.*

“What I loved most about this seminar was that I learnt material that was profound in its impact and yet so easy to understand and apply – something to take away and start using in clinic the very next day. Tracy's teaching style is clear and structured, and I was struck by the fact that these techniques can – and should – be applied to anyone and everyone, not just those with special needs” *Anne French D.C.*