Dr. Raymond BRANLY

Reasoned Osteopathy

Method Niromathé

Osteopathy has been an empirical way of treatment for a long time, from the competency of the bonesetters, then for paramedics and other doctors.

But, during the last 20 years only, scientific medicine, admitting its efficiency, has started to take it into account.

Today, osteopathy remains obscur to people.

Osteopathy will find its place in therapeutic, physical, chemical and surgical arsenal.

This work is unpretentious. It has to be a document of intellectual fraternity, an additional contribution to the fight against the disease.

RB.

First, I would like to introduce myself. My name is Raymond Branly. I have a Cartesian mind: I studied mathematics before studying medicine. I was a brilliant student and a relentless worker since I was almost always the major of my class. That's why I obtained the tittle of winner of Medicine Faculty in Lille.

I started to work as a general practitioner in 1975 and quickly, I became discouraged. I realized that medicine is mostly a contemplative science and that from the therapeutical viewpoint, even if incredible progress have been made, it didn't represent much compared to the overall field of medicine. Therefore, I say jokingly: medicine is good, unfortunately there are patients!

One day, a very sympathic neighbor came to my office. He had a lumbago. Like all doctors would have done, I prescribed him an anti-inflammatory, a muscular relaxing, an antalgesic. Three days later, he called me back: he felt worst and was confined to bed. I pretended to know what to do and prescribed him the same thing but to give an injection.
The same problem resulted because nothing else existed nor exists today (even if names have changed). Two days later I meet him in the street, he was walking as if nothing happened.

Proud of my prescription, I questioned him:
"well, he said, let me tell you: I have been rushed to see a bonesetter and he cured me in fifteen minutes."

Still in shock, I was a doctor covered with diploma but not able to cure a lumbago like the bonesetter without a diploma did in fifteen minutes.

Because of my Cartesian mind, I needed to know if the techniques were reproducible.
I learned a lot of things at school but what a brain-washing it was!

Rather than despise the chiropractor like my haughty colleagues did (I don't know why!), I went to see the bonesetter and asked him to teach me his technique. His terms were mine. But he refused: he was haughty too!

So I looked after a school and I went to Rennes, at the Faculty of Medicine, with Yvon Lesage, a really nice person. I stayed for 3 years even if I lived in the Pas-de-Calais and I get the diploma of osteo-articular handlings. Then I went to the GETM of Lucien Grumholz and to the school of Raymond Richard in Lyon. I learnt chiropractic (Davenport technique), I attended the Sutherland school in Saint Ouen and I learnt the technique Moneyron with Guy Pointud, the successor of Jean Moneyron in Vichy. I visited a lot of osteopaths, chiropractors, and other doctors in France.

I think about Georges Fournier too, veterinarian-osteopath who accepted to explain me his technique. I thank them all; they helped me a lot.

Moreover, I have a diploma of accupunture and a diploma of homeopathy that I studied by curiosity. Of course I read a bunch of books about osteopathy.

Since 1978, I practice exclusively osteopathy. First, chiropractic for 8-9 years, then Jones technique with Wieselfish Giamattéo method for 8-9 years too: The technique Moneyron and method Niromathé next.

I want to share all my knowledge in this book.
Osteopathy is a revelation for me. It is not esoteric but Cartesian. I am going to try to present it and I hope, share my beliefs.

Journal entry: LA VOIX DU NORD – August 31st of 2003
Topic: « Orally » (reader's letters) :

Osteopathy, social security and me.

For over two years, I suffer from very strong pains for example while I'm working.
These pains prevented me from having any physical activity. In two years, I consulted two doctors and three specialists with no results. I consulted a professor of a faculty too who told me 10 minutes later that I had arthritis.
What I knew for 5 years! Following this, I paid 91.47 euros and this arthrisis had nothing to do with my pains.

I despaired and consulted an osteopath who asked me just one thing and manipulated me for two minutes. I left him cured of a disease that I had for two years!

From that, I can conclude this: what a shame that osteopathy is not reimbursed by social security. Moreover, is it normal that an osteopath found in 2 minutes the cause of my pains and cured me when I consulted a lot of doctors before?

It has cost a lot to the social security (consultations, physiotherapy and drugs) and the only consultation not reimbursed was the one that cured me!

GR Lille

I want to make 4 comments about this article:

1. An example has no scientific value. But it is absolutely not an example or an isolated case. I have this type of situation dozens of times during the consultations.

2. The author doesn't clarify what type of technique has been used by the osteopath

- There are techniques, not very efficient with 20% of recovery. This patient can be included in that 20%
- There are techniques, very efficient with 80% of recovery.
- This patient could have been one of the 5% of recovery from a worthless technique (placebo)

3. This patient suffered from arthrisis and he has never been cured

4. There is a phenomenal and surrealistic gap between osteopaths and the scientific medical community. This gap has to be filled. That is a part of the goal of this book.

To be good, a therapeutic method has to be:

- efficient
- harmless (primum non nocerer)
- repetitive

Osteopathy, in particular the method Niromathé, meets the requirements.

GENERAL CONSIDERATIONS

Osteopathy has existed for thousands of years. Egyptian frescos show manipulative gestures.

Eclipsed, sometimes scorned by official medicine, osteopathy has been used by bonesetters for a long time.

Its resumption, at the beginning of the last century by American doctors (Still, Sutherland, Fryman, Magoun, Mitchell, Jones) didn't convince.
Usually, everything from United States is good, though! Osteopathy is included in Medicine School recently.

Because of:

1st reason: the therapeutic side has been neglected.

The extraordinary progresses in medicine are mostly done on constations. The development of biology, genetics, medical imaging is fantastic.

Thanks to MRI, we can see the anomalies that we couldn't see without it. It has become a problem: is it really anomalies? Will they grow or remain in a quiescent state? Are they related to functional disorders of the patient? Should they be retired? The functional problems, as we know, have still not been resolved. Add to this the fact that each individual is functionally different from his neighbourg.

Moreover, progress in therapeutic field has not followed the progress in the fields of knowledge and technology.

Most of the diagnostics, labels put on problems, don't lead to adapted specific therapy.

We walk on the moon but we are unable to cure a cold. Most of the time, the terapy is just palliative: artificial smiles with antidepressents don't cure the patient.

But a good doctor is not the one who note, not even the one who treat but the one who cure.

It reminds me a movie "Manon des Sources" in which a stunned peasant reply to the scientist: "give our water back, you will explain us later why and how you did it"

2nd reason: Just like society, medicine has become too materialistic.

Medicine has become extremely technical.

Wittingly, most of the time. How to detect diabetes without biology? How to detect glaucoma without equipment?...

But this materialistic aspect leads often to aberrations:
A patient has dizziness... his blood pressure is checked and seems to be too high.
We put that down to HBP. Indeed, dizziness is one of the signals.
Blood pressure is measured with a pressure gauge and is seen as the cause.

But we could think that dizziness causes anxiety, anxiety causes higher blood pressure. Moreover, a third cause may improve the two symptoms. It is possible that the two symptoms have nothing in common too.

Increasingly, we think that biological morphological, radiological anomalies are the cause of the functional disorder. A patient consults a doctor because of persistent lumbosacral pains. The radiological check-up objectivize a patellar malalignment. Is it really pathological? Is it really the cause of the functional problem? Nobody knows, but we treat it surgically. We balance? It wasn't the reason of the consultation and the patient didn't come for that.

Other thing: the osteotomodensity. A patient has pains. Systematically, she has a osteotomodensity. A decalcification (natural at her age) is discovered. The decalcification is treated. It has nothing to do with the pains, though. Lot of osteoparotic persons have no pains.

Anyway, this hyper technology is omnipresent.

In these conditions, it is difficult to imagine that a simple cutaneous pressure can erase the symptoms.

3rd reason: medicine has progressively been monopolized by chemistry

Since the big fantastic chemical discoveries of the last century (vaccins, penicillin, aspirin, antiarrhytmic,...), all the medical activity is concentrated on chemistry.

The Nobel prices of medicine are not won by doctors but by chemists for 20 years.

Molecular biology is omnipresent.

The medical solution to problems is drugs.

The medical sectorization emphasizes this.

The ministry of Health and the Academy of medicine worry about this over-cunsumption.

This thought, directed on chemitry, has slowed down the development of adjecant therapies.

4th reason: Normalization

Today, cardiologists, dermatologists, gynecologists... are “clones” (it is not pejorative): they do the same thing. This normalization is officialized by the opposable medical references; It is the result of exchanges.

The confrontations and the synchronization are unquestionably beneficial. It is from confrontation that comes the light! But this standardization, this automation becomes inquisitive at the same time. Today, the patient can die if it respects the rules. It has slow down the development of different thoughts. Now, to discover something, we have to be atypical!

It is essentially thanks to the pressure of the patients and the mediatization that osteopathy has become more recognized.
The wishing of Social Security to save up, the increase in number of medico-legal recourses, the realization of the excessive medicinal presciptions should contribute to its development.

THE GOOD DOCTOR IS NOT THE ONE WHO NOTES,

NOT EVEN THE ONE WHO TREATS,

BUT THE ONE WHO CURES.

THE INDICATIONS OF OSTEOPATHY

A first question before starting:

WHAT IS OSTEOPATHY FOR?

Osteopathy is only for:

- Osteo-articular engorgement with a mecanical origin and for their consequencies: pains, functional impotency: acute or chronic.
- Visceral engorgement with a mecanical origin and for their consequences: pains, functional trouble: acute or chronic.

There is a long list of indications:

- acute asteoarticular engorgements:
    - cervicodymia (torticollis), dorsalgia, lumbago, sacralgia, coccydynia
    - Headache, migraine
    - Sinusitis, facial pains (See the chapter about this subject)
    - Tendonitis (the localization doesn't matter)
    - Facial, cranial, cervicobrachial, thoracic, abdominal, sacrum, crural, sciatic neuralgia
    - Periarthritis, capsulitis, bursitis
    - Inflammatory calcification (ex: calcified tendinitis of the supraspinatus or of the big plantar ligament.

- Chronic osteoarticular engorgements:
    - This list can be used in its wholeness. The word arthtitis makes an entrance (See the chapter about this subject)

- Chronic and acute visceral engorgement with mecanical origin.
    - Quantity of pharyngitis, aesophagites, gastritis, colitis cystitis, hemorrhoidal engorgement, gynecological disorders are cured thanks to osteopathy (see the chapter about th esubject)

- many functional troubles benefit of it also:
    - insomnia
    - dizziness (hardly always linked to a blocking of the 1st cervical vertebra)
    - new-born's crys who can suffer too, even if he can't express it with words

Or the whole, 60 to 70% of the pains and functional troubles:

- Have a mecanical origin
- Need an osteopathic treatment
- Will be cured with this one

Second question:

HOW CAN A VISCERAL OR OSTEOARTICULAR ENGORGEMENT THAT LAST FOR 20 YEARS BE CURED WITH AN OSTEOPATHIC TREATMENT?

Simply because the osteopathic lesion, responsable of this engorgement, is a living phenomenon (even if it lasts for 20 years!)

The osteopathic lesion (O.L) is a spasm:

MUSCULAR SPASM + TENDON + LIGAMENT + FASCIAL

It can last 8 days: acute cases: lumbago, torticollis
2 months: sub-acute cases
10 years: chronic cases (called arthrisis when it is about the joints)

This spasm can disappear spontaneously, thanks god, or everybody would have arthrisis at all levels.

This spasm can disappear very easily thanks to osteopathy.

Third question:

WHAT OSTEOPATHY IS NOT FOR?

Osteopathy is not for osteoarticular engorgements with visceral origin:

- traumatic fracture, tear
- infective: bacterial infections, viral, mycotic and parasitic
- metabolic:gout, arteriosclerose, thrombosis process
- tumor: benign and malignant tumors
- immuno-allergic: progressive chronic polyarthritis, ankylosing spondylitis, system sickness, allergies,...

I want to alert, not about the lack of knowledge of the non-doctors or doctors practising osteopathy (they just have to be trained), but about the mediatization and the circulation of wrong information about osteopathy. Osteopath non-doctors who obtained extraordinar results in a lot of fields, have done and written anything. The mediatic system, greedy for sensational stories, quickly relayed them.

Anyway, everyday, people come for an alopecia, asthma, diabetes, eczema, temperamental child, obesity, arteriosclerosis!

For a method to be efficient, it has to be repetitive. This is fundamental.

I am not against the fact that a dentist or a physiotherapist practice osteopathy. And i support initiative and curiosity. But it has to be regulated.

4th question:

WHAT ARE THE GUIDELINES?

The osteopath always has to make a diagnosis

He must be sure that the etiology is mecanical and be sure it is not: an osteoporotic, trauma, infectious or tumoral slowing, a vascular cause (bony infarct), an infectious, metabolitic, immunoallergic, tumoral cause, an intercurrentcause (phlebite, arthritis, hepatic or maphritic colic, infarct...)

If he thinks that the origin is mecanic and if the symptomatology lasts for more than 3 sessions, he must do a new diagnostic.

Conversely, a patient with bonny metastasis can have mecanical lesions and have an osteopathic treatment. His state would be sometimes much better (his treatment would not be manipulative). A classical treatment for the metastatic lesions will be associated.

That’s the role of the doctor to see the differences.

Few examples:

A/ ARTHRITIS

Arthritis is commonly related to use, degenerative modifications envisioned by radiography:

- articular pinch
- micro geodes
- osteophytes

This use is a natural phenomenon related to aging.

This use, not even osteoporosis, has nothing to do with functional signs that the patient can have: engorgement, pains, and stiffness.

Classical examples:

1/ Mister X, 60 years, complains about pains and stiffness in knees.
Radiographic results objectivize important signs of usury. It is said that symptoms are related to usury. He goes on holidays to Provence (Soutth of France). His pains disapears totally during his vacations: he can run, walk with no symptoms. But usury didn't disapear. An X-ray there would be the same that the last one.

What happened?

Because of the change of climate, environment, spasms stopped!

This is this work that an osteopath does (with some techniques like Niromathe method). It is clear that we can't cure usury. But we can make stiffness and pains disapear.
Patient doesn't ask for more.

2/ Mister Y, 75 years, have disastrous radiographies: he is "full of arthritis". But he has no pain and run well.

3/ Mister Z, has obvious by arthrosic pains. But his radiographies are absolutely normal.

There is no relation between radiographic signs of osteoporose or arthritis and the pains or stiffness of the patient.

The pain is "alive". It is not a morphological entity.

The mecanical pain is a spasm.

A muscular, tendon, ligament and facial spasm. A persistent spasm.

Use, on the other hand, is a natural, asymptomatic phenomenon.

B/ SINUSITIS, EARACHES (acute, subacute and chronic)

8 times/10, they are secondary to a blocking of the bones of the skull and of the face.
As we will see later, the bones are mobilizing with breathing, not only the ratings, all bones, particularly bones of the skull.

The blocking leads to immobilization of the skull bones. This immobilization in turn generates a congestion zone: evacuation ducts (eustachian tube, sinus channels) is congested. The cavities are not drained. We can label this situation:

- Headache, if it is about the sphenoïd or the bones of cranial vault.
- Sinusitis if it is about the nasal bones, the maxilla and ethmoïd.
- Otitis if it is about the vomer, the rock and the sphenoïd.

This engorgement can promote secondary a bacterial, viral or fungal development, but it is the origin of the blocking.

The origin is the blocking.

I systematically treat ear infections, sinusitis, headache ... with my fingers ... with spectacular results.

The same pattern may apply to the pelvis. Often, after having treated a back pain, patients reported disappearance of their hemorrhoïds or their recurrent cystitis.

Of course there are genuine sinusitis, cystitis, otitis related to a vira1 or bacterial infection, to an immuno-allergical disease, to a thumoral disease! It is the role of the doctor to diagnose.

But the fact remains that the mechanical origin is the main cause especially when these disorders are chronic or recurrent.

C/ visceral pain

Pharyngitis, esophagitis, gastritis, enteritis, colitis, cystitis ... may have infectious, immuno-allergic, psychological, metabolic, tumoral origin.

Often, however, especially if they are chronic or recurrent, they are just the reflection of a compression of trophic spine or cranium nerves.

Spinal or cranial blocking is responsible for neuralgia that generates a visceral engorgement.

It is once again the role of the physician to diagnose and to separate things, between what is mechanical and what is not.

The fact remains that the osteopathic treatment should be routinely undertaken in the case of chronic or recurrent lesions.

D - DISCAL HERNIA

The appearance of discal hernia is a natural phenomenon linked to aging.

As we get older, we lose a few millimeters. With age, the vertebral trays approximate. The intervertebral disc naturally extends and overflows on both sides.

3/4 of patients over 60 years have it without functional spinal symptoms.

Conversely, many patients have spinal symptoms without discal hernia.

Again, the radiographic appearance has no correlation with the functional symptoms.

The spasm, when it occurs, is the origin of:

- The blocking that generates pains and helplessness.
- And the discal hernia that appears or majorises.

The elimination of the spasm spasm makes the discal hernia to go back to its previous state and caused the disappearance of the symptomatology.

PATHOPHYSIOLOGY OF THE OSTEOPATHIC LESION

4 ESSENTIAL NOTIONS:

- **Articular breathing**
- **Notion globality**
- **Origin of the spasm**
- **Origin of persistence**

ARTICULAR BREATHING

Articular breathing

Clinicoanatomical correlations

The body can be divided into three main areas. These three areas are similar, symmetrical and superimposable:

- lumbo-sacral area
- cervicothoracic area
- the cranial area.

a) The lumbar-sacral area includes:

- Seven free vertebrae: the 2 last dorsals and the 5 lumbar vertebrae
- 10 welded vertebrae: 5 sacred + 5 coccygeal extended laterally by sacred and coccygeal fins.
- Each side: ilia and ischia.
- That are extended forward by the pubic.
- In their union, the acetabulum and the lower limb.
- In front: the pubic symphysis.
- Stretched across: the pelvic diaphragm (floor of pelvis).

b) The area cervicothoracic includes:

- Seven free vertebrae: cervical vertebrae.
-10 welded vertebrae: the first 10 dorsal vertebrae, extended laterally by the ribs.
- On each side: the thorny pits above and below the scapula.
- Which extend forward of the clavicles.
- To their union the glenoid and upper limb.
- Forward: the sternum
- Stretched across: the thoracic diaphragm.

c) the cranial area includes:

- The occipital bone, which can be likened to the sacrum.
- In the middle, articulated on the occipital, a free axis: sphenoïd, ethmoïd, vomer, nasal bone, frontal, upper jaw.
- On each side the temporal and parietal.
- Which extend forward of the mandibles.
- In their union, the extemal ear canal and ears.
- Forwards: mentionniere symphysis.
- Stretched across: diaphragm cranial (tentorium).

Articular breathing:

There are three superimposable areas that will behave similarly and synchronously during breathing.

A/ INSPIRATIüN:

- The pelvic, thoracic and cranial diaphragm stoop
- The pelvis, chest and skull expand
- The spinal curvatures diminish, the person grows.
- The upper and lower limbs are positioned in abduction – external rotation

B/ EXPIRATION:

- The pelvic, thoracic and cranial diaphragms rise.
- The pelvis, chest and skull shrink
- The spinal curvature increased, the size decreases.
- The upper and lower limbs are positioned in adduction - internalt rotation.

Consequences:

1) This respiratory movement activates the movement of the cerebrospinal fluid and the lymph: the primary respiratory motion (PRM) of Sutherland (?). That beats at the same rythm than breathing (12-16 cycles per minute) but with an offset manner.

2) A prospective osteopathic lesion blocks the movement of bones during breathing. This generates a local engorgement.

3) The breathing of these three areas is done synchronously. Big disorders often result from a global rhythmic shift (generalized fibromyalgia).

Comments:

1) The musculotendinous, fascial and ligamentous spasm causes articular clocking.

- The bones can not move:

• When the person moves.
• And especially when he is breathing.

It is that this immobility or this hypomobility that is responsible for local engorgement and pains.

Ex: there is no active mobility of the skull bones. But an OL of the cranium compromises the breathing mobilization. It causes the headaches.

2) At the same time, "a deprogramming» of reflex points more superficial happens: periosteum, muscular, tendon, ligament, fascial, sub-cutaneous.

These points become "sticky", realizing a true capture of lymph, precluding a free mobilization of the tissues.

They have raised the fascial theory of Sutherland.

These points can be materialized by a very simple test: the Lasegue's:

- When a patient presents sciatica, the elevation of the tensed lower limb is limited and painful.

This sign has been assigned to a stretching of the the sciatic nerve for a long time. Today we attributes it classically rather a stretching of musculo-tendinous chains. In fact, identical pain, may be reproduced by a simple stretching of the skin, the member remaining put on the table.

The release of these specific points, superficial (Moneyron technique), at the level of the sacroiliac, ischium, the tibio-perionieres joints and cuboid forexample, make the pain immediately assign and make the sign of Lasegue disappear.

For Sutherland, classical articular breathing punctuated by the lungs and a interrelated subcutaneous "lymphatic" breathing coexisted.

GLOBALITY OF HUMAN BODY

The globality of HUMAN BODY

All joints are interrelated.

there is a permanent balance of blood pressure. It is constantly called into question following the positioning of the center of gravity.

We measure here, the impact of scars, including surgical scars.

The body can be compared to a sailboat with ropes. These are tense and adjusted at the millimeter, in 3 planes of space:

- Flexion, extension.
- lateral tilt.
- Rotation.

EVERYTHING IS LINKED.

Examples daily substantiate that:

- An operation on a wisdom tooth or on a double vision can make a sciatica disappear.
- The correction of a blocking of the bones of the foot may cause the removal of mlgraines.
- A surgical correction (redundant or necessary) can make the osteopathi disorders appear or disappear from a distance.
- Sometimes it is a complete side of the body that is blocked. The patient presents of tiered neuralgia: cranial, facial, cervicobrachial, thoracic, abdominal and sciatica well lateralized.

A blocked joint leads a work in an awkward position.of tendons, muscles, ligaments and fascia. This unsuitable work has repercussions on neighboring or remote joints.

Some authors have also tried to identify the "lines of the human body", chains of musclulo-tendineous and facial reach.

As we have seen previously, the three diaphragms are simultaneously fighting in this spider web, perfectly woven.

1st conseguences.

An osteopathic problem should never be handled locally (whether with a scalpel, with infiltration and even with the hands).

2nd conseguences.

Any disturbance of this balance perfectly measured may have particularly pejorative implications, local, regional or from a distance.

A scar, a fortiori an osteoarticualr scar will leave irreparable traces.. It will disrupt the tentional balance.

I have just seen out a patient, 40 years old. This man has a cervical plate for 2 years. He complains of pains particularly acute in the calves and feet. He does not sleep more than an hour per night. These pains have settled for six months. They gave him 2 times morphine. And in addition, neck pains are still present. These plates are probably the cause of pain in the lower body, of their trigger and the fact they are durable.

They will also hinder a lot my work of rebalancing.

Not only the surgeon did not cure locally, but it has also caused other lesions (that he disn't realize unfortunately).

This is serious because these aftermaths are definitive.

This is serious because a single osteopathic work would have removed neck pains (initial reason for consultation).

This example is unfortunately multi-daily.

3rd conseguences

Our treatment is uniform (Moneyron method, Niromathé method and Sutherland method).

We treat the same way a knee pain and sciatica.

If you look properly your patient complaining of knee pain, you will see that 9/10 times, he has also some pains more superficial of course, but authentic, in the back, buttock or foot, if not in the cervical or head.

A knee pain, with our line of reasoning, is just a truncated sciatic.

Similarly, periarthritis of shoulder is often with pains in the forearm and wrist.

Carpal tunnel is exceptionally isolated in 8/10 times, the other member and the cervico-dorsal region are affected.

We do not differentiate cervical-brachial neuralgia, thoracic outlet syndrome, carpal tunnel, scapulohumeral periarthritis, epicondylitis ... All this is a matter of spasm, spasms more or less staged, more or less generalized.

Of all manièces, even if it's a pain in the little toe, EVERYTHING will be processed.
This simplifies our task. Our thinking is global.

Example:

A patient consults me for sciatica hyperalgesia. He can move in a prone position. At the first meeting, difficult in any case, I treat the thoracolumbar region and lower limb.

I saw him eight days later. The improvement is insignificant. I look after more points and I start treating him at the skull. During my intervention on his head, the patient tells me he feels her sciatica disappearing. I interrupt the session voluntarily. I ask him to get up and walk what he did with no problem. Miraculously*, the sciatica has disappeared. Even if I did not hit the back or the spine or the leg of my patient.

This is a caricatural example.

This type of constatation is common.

The concept of globality is really fundamental.

* For me, a miracle would be to see the arm of an amputee growing again

ORIGIN OF THE SPASM

ORIGIN OF SPASM

When an individual is afraid, especially in a brutal way, he crouched, he contains, he spasms.

When, unconsciously, the body is afraid, he did the same thing.

The spasm happens when the body is surprised and not ready to make a movement:

- Either in the space: the subject thinks carrying 5 kg, but it is 50 kg to raise. Conversely, he thinks he has to carry 50 kg but it is just 5 kg.

- Either in the time: the person is dozing, lying in his couch.The ringing of the telephone rang suddenly and he raised too quickly. Or still, he worked in his garden in a tuck position during a long time. Someone call him. He gets up suddenly, too fast. Or again, he has no time to adapt.

The body that is not ready to move in time or space reacts by spasms. This is what we commonly call the clumsy movement.

It happens during a period of physical or intellectual fatigue: the person has a long road, it has dig his garden, ... activities that he doesn't use to have. During the following week he is tired, stiff. It is during this period of fragility that will happen the clumsy movement.

This clumsy movement can occur on the occasion of a violent effort, but it can also occur during an minimal "effort": coughing, sneezing, ...
Sometimes it happens by night, and for course, the person doesn't realize it. He is blocked at the morning.

In a smaller number of cases, the spasm occurs as a result of some cold. Riding with the window of his car opened is a frequent cause of torticollis.

Whether experienced or not, the clumsy movement leads a muscular, tendon, ligament and fascial spasm.

This spasm can be localized anywhere in the body (skull, trunk, member).

It can last for 8 days, 1 year, 10 or 50 years.

It may remain localized at the level of initial damage or extend to other joints (globality).

ORIGINS OF PERSISTENCE

ORIGINS OF THE PERSISTENCE

It is remarkable to notice that when a patient presents persistent lesions, these eh lesions are in the same areas.

Some patients spontaneously get very quickly unblocked. Others have their lesions become permanent and chronic.

There are of course factors predisposing the onset, the persistence of osteopathic lesion.

The 1st factor is undoubtedly the AGE:

Patients are more often 60 years are than 10 years.

Yet children are blocked too, often, but they unblock themselves spontaneously and very quickly in the vast majority of cases.

But children can have authentic lumbago, authentic tortieolis, authentic sciatiques. The classical pains when they grow up are in fact osteopathic lesions. We treat it well with an osteopathic treatment.

There are a lot of other contributing factors:

There are about fifty factors.

They are represented by anything that will create an imbalance, an asymmetry in the sailboat with the countless sensible cordages that represents the human body.

Include:

- scoliosis.
- short leg.
- uneven level of implementation of cotyles.
- a defect of horizontality of vertebral plates.
- a hemi-sacralization.
- knee varum or asymmetrical knee valgum.
- shallow foot or a flat foot.
- a disorder of artical dental, a prosthesis dental apparatus.
- ocular disorders (diplopia, trouble of accommodation).
- hearing disorders (unilateral hearing loss).
- muscular hypertrophy localized, congenital or acquired.

- Consequences of a surgery (removal of an organ, osteosynthesis equipment , malalignment of bones, osteoarticular, musculotendineous or even cutanee scars).
- using the right or left hand
- extemal factors: professional or sportive constrains
- The general factors like obesity, leanness, a hypolaxite, a muscular hypertrophy, stress, weither ...

The problem is complex for several reasons:

1) There are several predisposing factors willingly.

Of course, sometimes (rarely) it happens that there is just one. Removal of wisdom tooth for example, causing disappearance of the periarthritis of the shoulder. But I most often, there are 4, 5 or 6 predisposing factors in one person.

How to find them?

6 of 50 possible factors, we call it a lotto.

2) The predisposing factors don't express automatically. How identify their expression?

- This is not because a patient presents a scoliose that it is a factor leading to an osteopathic lesion. Lot of persons with a scoliose have no osteopathic damage.
- The removal of a wisdom tooth does not lead systematically the disappearance of periarthritis.
- We can live without pain with a short leg or a genu varum.

All of these factors may or may not express itself!

How many times have I seen and heard the following things:

- Lose weight, your knees won't hurt you anymore. The patient loses 20 kg but still have pains. There are also thin people who have painful knees.

- Develop your muscles, everything will be fine! I have treated 15 days ago a champion of Swimming; a real Rambo. He complained of a sciatique.
Very strong athletes are very common in my consultations.

- Do yoga. But, I regularly treat yoga teachers.

How to know that there is a factor that is existing and is the cause?
I still haven't found the solution.

3/ The correction of these factors does not exist

Even if we successfully identify these risk factors; unfortunately, for 90% of them, there is no true solution to make them disappear and allow an ad integrum restitution of the body.

How to remove a scar? How to correct scoliosis, a short leg, muscular hypertrophy? ...

Any intervention at this level seem fanciful.

I've never met methodologies or rules worthy of the name. Some have sometime results, but these are never repeated. They lead very often to opposite and disastrous situations, especially when it is about untimely surgical corrections (Review these patients one or two years later!).

All intellectual constructions sold (Proprioceptive insoles or not, orthodontic methods, posture tests, magnets, anatomical pillows, ...) seem simply fanciful. Of course, research must exist. But before presenting them or send them, they must first prove their effectiveness. I met many researchers, but not yet "finder."

Our contemporaries, are looking for the "all risk insurance". To their questions: "What can I do to not be blocked anymore? "I gladly answer: "back in 500 years!" .

4) What is true for one is not necessarily true for an other.

Our thinking too materialist would have us equate to equipment. Nothing is further wrong on the functionally base. Some people feel better after a nap, others feel worse. A hard bed will be good for a patient but not necessarily for his neighbor ... How to establish rules in these conditions?

The only advices that I give, are nous measures.

I've seen (that is unfortunately the only preventive finding that I have done after 25 years of practising), that excessive physical activity is prejudicial. Athletes (especially older athletes) and manualworkers, are undeniably the persons that consult the most. I recommand to moderate physical activity. Sport, like wine, is excellent for health, but only for the well being, without abusing it.

Comfort is also undoubtedly an element of prophylaxis. Just a spacious bed for example, whether hard or soft! Everyone sleeps as he wants, as he feels good. This is the best prophylaxis. There are no rules to impose.

I am happy to release my patient. I make his pains disappear. This is already not so bad.

Recidivism? Maybe? On the occasion of a clumsy movement. In one month, in 1 year, in 10 years or never?

The release itself has nevertheless preventive action, since harmonizes the structures.

I'm not going upstream. Simply because I do not know
When we do something, it must be effective, do no harm and know what we done. You have to be Cartesian of course, but Cartesian till the end.

SUMMARY

The osteopathic lesion (O.L) occurs after a clumsy movenet.
It usually occurs during a period of fatigue.

The O.L usually stops spontaneously in a period of ten days.
The body possesses the potentials that enable to make the O.L disapear.

It is remarkable that the change of climate and
environment considerably increases the possibilities of reaction.

However, sometimes, the O.L persiss and perpetuates. It can remain
localized, extend it to other areas, sometimes to a complete hemibody,
sometimes it's to the whole body (fribromyalgie, it is now a fashionable term).

The occurrence of O.L, its recurrence, its sustainability, are favored by the
aging and the multiple factors, generators of asymmetry in which ii is
illusory to work today.

The O.L is a DYNAMIC phenomenon, since it is a PERSISTENT SPASM
.

The stop of the O.L cured the patient.

HOW TO STOP THE SPASM?

IT IS SO EXTRAORDINARY TO BE ABLE TO CURE SOMEONE JUST USING THE HANDS AND NOTHING ELSE

The osteopath or osteopaths?

There are about twenty osteopathic methods and techniques.

- (Apparently) very different from each other.

- Some are dangerous, others harmless.

- Some are very effective, others have a mediocre performance.

- Some need ten minutes, others an hour for their realization.

- Some are painful, others painless.

- Some are sharp, some are very soft, some even seem "Sulphurous": lwe touch the patient just a little.

- Some has immediate effect, others have delaying effect.

There is an extreme polymorphism in this discipline.

Practiced by doctors, dentists, veterinarians, chiropractors, physiotherapists, midwives, chiropractors ...

Add this that it has just been deremboursed by Social Security when it is practiced by doctors (October 1998) and that it strangely has just been recognized by the Academy of Medicine, and began to be studied in Faculty of Medicine.

Yet, despite all sueh disparities, all are called Osteopaths.

As if it was the same monolithic "science" like dermatology, pulmonology, cardiology!

What Happens Next? There was enough to get lost. I understand the disarray of public opinion, of the medical world and of the joumalists.

A common thread relys all these actors: work with hands.

A common goal unites them: stopping the SPASM.

A recent ministerial decree provides that the discipline is practiced by non-doctors:

- without specifying who can practice it, physiotherapists? dentists? Chiropractor? nurses?

- without specifying the details of such training: who will teach osteopathy? To who? What will they teach?

- There is also the problem of European harmonization.

Doctors, who have neglected this discipline for a long time, began to appropriate it. But medical schools only provides courses of osteoarticular manipulation (in a particular aspect), Mitchell technique (myotensive), and sporadically, Jones technique. But this represents just a small portion of osteopathy.

What will you do with the other facets of this discipline? I think about Sutherland, Reiki, Randolph Stone, Lyson methods... sometimes close to dowsing, in total contradiction with the analytica way ofl thinking in Western Medicine.

Who will make a diagnosis to eliminate shingles, phlebitis, a osteonecrosis of the femoral head, a tumor-induced bone loss ... ?

Admittedly, most osteopathic practices are safe and don’t worsen the patient, but a delayed diagnosis may nevertheless be detrimental: phlebitis may develop a blood clot and cause the death of patient if not treated in time!

It is a gigantic undertaking and particularly complex that awaits legislature.

We will review a score of techniques and osteopathic methods
.We will present, analyze, criticize them. We will see they do not have the same performance, same indications, same disadvantages.

At the end of book (Niromathé method), we will summarize this techniques. We see that they actually perform the same work: acting on subcutaneous sensors, reflex points, the "glue points", modulators pieces of blood pressure system, with very different approaches.

INDEX OF THE DIFFERENT OSTEOPATHIC TECHNIQUES AND METHODS

REPERTOIRE OF DIFFERENT OSTEOPATHIC METHODS AND TECHNIQUES

The ciassification we offer is totally artificial, butpractice because symbolic.

The truth is simple, often colorful.

We successively analyze the techniques and methods:

- bone
- muscular
- Ligament
- fascial
- cutaneous
- tendon

BONY TECHNIQUES

For everybody, including most of the doctors, they represent osteopathy, in a simple equation:

Osteopathy = Handling = Cracking = Replacing.

Always the result of our materialistic way of thinking.

.....

A. T. STILL (1828-1917) founded the first college of chiropracty has at Kirksvill in Missouri, classically represented as the precursor of osteopathy.

In fact, the famous names and famous schools, while being more scientic, will always depend on the heritage that comes from the begining. Unfortunately, Man who should have 3000 years of experience, is a childr again at each generation.

AI THE PRINCIPLE OF BONY TECHNIQUE:

Adjust the facet joints misaligned textures by inhibiting periarticular antagonists that cause and maintain a joint portion even in very small wrong position.

The principle is purely biomechanical.

The return to normality must go through a stance phase in reverse order of the construction of the lesion.

A vertebra, for example, is moved and blocked in flexion, left rotation and right Inclinaison. The exaggeration of Flexion, Left Rotation and right inc1inaison of this vertebra exacerbates the symptoms.

At the contrary, the setting expansion, right rotation and left Inc1inaison of this vertebra bring the comfort of the patient.

A thrust, I mean an intense and short pressure majorises this comfort and allows the repositioning of the joint. It is the inversed parameters.

The point of contact, the impact, action levels are bony, so it is why we have used the term bony techniques.

Lot of problems arise:

1) Is this vertebra not well positioned?

• Compared to the upper block?
• Compared to the lower block?
• Or both relative to the upper and lower blocks?

Where is the level of injury?

2) The problems is more complicated if there are several vertebrae displaced and blocked, especially if they are displaced in a different way. For example, we may considerate a C4 (fourth cervical) blocked in extension, right rotation, right Inclinaison, and a C6 blocked in flexion, left rotation, right Inclinaison. How to find then a comfortable position? But this situation is frequent!

The classical traffic accidents ("whiplash") willingly give this cornplex type of case.
How in these conditions can we make a diagnosis and a correct biornecanical correction?

Many schools and many theories have succeeded in an attempt to solve these biomechanical problems
- In terms of diagnosis
- In terms of the correction.

Include:

• The para-vertebral palpation: But para spinal contracture does not mean posteriority of the transverse process!
• The pinch roll and the dermalgic sensitivity to specify the significant area. But how to know when there are several juxtaposed levels. Pain may also be another origin (rnuscular pain for exernple). Finally, a test is subjective since it relies on the interpretation of the patient only.
• The pressure of epineurial the pressure of the annoyed epineurial: always subjective.
• The scheme in a star shape, which will handle in the sense of the not pain.
How to understand when reconnect when multiple reversed lesions are juxtaposed?

• The morphological marks: an epineurial is moved in subsequent and precedence, superiority, inferiority, rotation, twisting, rocking ... This serves of diagnotic landmarks. But, of course, a epineurial can naturally be hypertrophic, hypotrophic or displaced, although this is not the testimony of a osteopathic lesion. Similarly a high iliac crest and high PSIS (postero-superior iliac spine) does not mean: Ilium blocks in anticipation. Perhaps the PSIS was naturally highest (scoliosis) and it has MOVED by subsequent and even while remaining higher than the contralateral PSIS!

Finally, I have a long nose, others have large ears and the patient has an anterior ilium without this disease is pathologic!

• The sign of the attraction of the PSIS would indicate the level of injury. But it would mean that the patient can bend over!
• The sign of Piédalue is very controversial.
• The Downing handling must help to determine where the situation of the ilium in Anticipation or after the fact. The result depends on the motivation of the operator. I can put it on in anticipation or in posteriorities following my degree of application. Even positive, it doesn't testify the pathological nature of the anomaly.
• We should also mention the law of Fryette: used by many vertebrotherapeutes; it serves as a test for diagnosis:

The law says:
- When the column is in Flexion: the Laterale slope (Left) of the spine accompanied by an opposite rotation (right) of the vertebral bodies (= lesion F.S.R.).
- When the column is in a position of extension: the Laterale inclination (Left) is accompanied by a counterpart rotation (Left) of vertebral body (= lesion E.R.S.).

In other words, when a vertebra is blocked in a position of flexion, its transverse process protrudes into the convexity. When a vertebra is blocked in a position of extension, the transverse process protrudes into the concavity.

The practitioner uses these data to apply the positioning and corrective action.
But for 50% of manipulators using this law: Lumbar Flexion = dorsal flexion = Cervical flexion = Getting kyphosis of the spine.
And for 50% of other operators, flexion = Reconciliation of curvatures and Extension = Distance of curves. In this Design:
Dorsal flexion = kyphosis of the dosal spine
Lumbar flexion = implementation of the lumbar spine
cervical flexion = lordosis of he cervical spine.

Conclusion
One and the other group using the same theory on definitions, ie on work's bases diametrically opposite (at the level of lumbar and cervical column)!
And best of all, both lead to the same level of results!

This theory is also false since there are authentical O.L (eg dorsal) in Flexion with rotation and counterpart inclinaison and Extension with rotation and opposite inclinaison.

All this to say (and we'll see with the Davenport technique and with the Niromathe method) there is no biomechanical solution ... because problem is not biomechanical.

B) THE DIFFERENT TECHNIQUES BONE

Bony techniques (osteoarticular manipulation) concem essentially arthrodies.

They concem mainly the vertebrae, so the term of spinal manipulation very employed.

Optionally, the peripheral joints of this type: carp, tarsus, acromioc1aviculaires, Radio ulnar, tibioperionieres can benefit.

There are two major groups of manipulators:

The chiropractors and the "osteopaths".

1) Chiropractors:

- From the American Schools (Kansas City, Kirksvi11e, Dallas, Davenport ...).
- Requires an articulated table, very sophisticated. The patient arrives standing, facing the table. He comes close to the table. This one bends and goes horizontal (formerly mechanically today electrically). The patient is in prone position and not moving. Everything happens in this position.
- The diagnosis is based mainly on morphological criteria: positioning of the epineurial, iliacs, iliac crests, ischial tuberosity, transverses, mastoïds ...
- The positioning of comfort, including flexion-extension of significant areas has done is done thanks to mobile pads (small cranks were previously present at all levels of the table). The epineurial provides by this way a sub-normal position.
- The docotr proceeds to the vertebral readjustment directly by a recoil based on bony frames in significant areas

2) Osteopaths:

From the European Schools (many private schools, Maidstone, Bobigny, medical faculties ...).

- Dynamic tests identify the lesionnal levels and the sense of the blocking.
- Positionning is close to a position hand-to-hand
- Handling willingly uses long lever arm from the skull, the shoulder, hip ...

C) THE TECHNICAL DAVENPORT

- It is a chiropractic technique. it needs a table of chiropractic, on which the patient is placed in a prone position.
- We first look after significant areas: infiltrated, contracted areas, in which one or more epineurials are staggered.
- Index and middle fingers are put on both sides of this area, on para vertebral mass.
- We put the body in positions that will increase the discomfort of the patient (and at the same time, the para vertebral tension) or at the contrary will to decrease it. We research obviously the situation of maximal hypotension For this:

• We realize a positionning in left or right rotation of the head. It has repercussions on all vertebrates (up to L5).
• We realize a right or left inclination positioning an arm above the head, the other remaining extended along the body. There are repercussions on all the vertebrae.
• We realize finally a flexion or an extension by an adjustment of pads.

Simultaneously, the fingers evaluate the blood pressure level. Minimal level conesponds to the position of comfort of the patient. Then we triggered a Thrust on the significant area. No matter the exact seat of the bony impact. The blocking almost spontaneously freezes.

I used this technique for several years. I conclude that we proceeded in reality by a proprioceptive vibration on a situation of comfort of the significant area.

My future experience will confirm besides this version: the stop of spasm is obtained by an action of brief and strong stimulation of cutaneous receptors (cf. Methode Niromathe)

The biomechanical rationale is absolutely unnecessary.

SUMMARY: TECHNIQUES BONE

Advantages

- Results are immediate (when manreuvre succeeds).

Disadvantages:

- Requires a perfect use of the technique.
- Fracture risk: bony techniques are therefore contraindicated for the eldest and for fragile people (osteoporosis metabolic, metastatic ...). A radiographic examination is essential before any handling.
- Not esay to put into practice on children, pregnant women, people with disabilities ... almost impossible for new-borns.
- Painful when they are realized following bad criteria, or just when the opposite lesions are juxtaposed, preventing from obtaining a position of comfort.
- The indications are limited to O.L, sitting on arthrodies (Essentially Vertebral).
- The indications are limited to simple, consistent, harmonious problems.

Useless with this type of technique to hope to cure complex lesion, an inflamed lesion (eg, acute torticollis), an advanced lesions (major disc hernia), an established sciatic, a peripheral arthritis (eg osteoarthritis), periarthritis to shoulder, etc..

All these factors lead to a worse image of bony techniques. They made the bad reputation of Osteopathy.

They have nevertheless helped:
I think at this girl, blocked for 2 years following an accident, unable to walk, in a wheelchair, who was "resurrected" immediately after an unlock of the the sacroiliac joint.
I think at those thousands of lumbago, back pain, neck pain which could instantly be cure and have permitted a normal life..

MUSCULAR TECHNIQUES

The O.L summarizes for these authors, a MUSCULAR SPASM.
- The stretching of the muscle spasmed makes the pain become worse.
- The shortening of the muscle attenuates the pain and make it disappear.

The aim of these techniques is to stop this muscular spasm.

THE MITCHELL TECHNIQUE:

= Myotensive = muscular contro resistant stretching

Principle:

Consider an example: a cervical vertebra is blocked in extension right rotation and right inclinaison.. The level of injury is the underlying to the vertebra that is
therefore secured to the upper block and head (I actually use voluntarily a biomechanical reasoning for teaching reasons).

The extension, right rotation and right inc1inaison is painful.

The flexion, left rotation and left inc1inaison is free.

The doctor will treat the 3 parameters. For the rotative parameter, he places the head in right rotation up to the painful gate. He asks the patient to be in an inspiratory apnea and do voluntary a left contra rotation. The doctor opposes this movement. At the end of inspiration and during the expiratory phase he puts the head back passively in a right rotation to the new painful barrier. He has more amplitude like that.
This movement is repeated 3 or 4 times.

The parameters Flexion-Extension and Inc1inaison are then treated in the same way.

Sometimes the doctor individualizes a musc1e clearly involved. He stretches this musc1e passively and asks the patient to contract following the same principles.
He works case by case, correcting musles and identifying restrictions of amplitude. For some muscles, sitting is required, for others the supine is essential.

Advantages:

- In theory, all O.L can be treated.
- Harmless handling that have no contraindication.
- Painless painless.
- The improvement of symptoms is immediate, but true (when manreuvre is positive) will only take a few days later.

Disadvantages:

- The positivity rate (for healing) is relatively low. That technique takes no account of the fascia and ligaments that are yet largely involved.
- The cure (when it occurs) is not immediate and the practitioner is in doubt as to its effectiveness.
- This technique is tiring for the practitioner.
- It is a technique long. Imagine that the patient presents several lesions osteopathy (neck + shoulder + Left right lower limb): the dozens of interventions are necessary.
- It is a technique poorly adapted to the complex. Imagine that the patient this 2L W juxtaposed, opposite nature! It is ifficult in these conditions to determine a sense of pain and not posture correctly.
- It is a subjective technique that involves the patient. It is a major drawback. Sometimes we have to deal with a great athlete or a dancer at the Lido, physically and intellectually brilliant. Their Participation will be no problem. But more often, it refers to physically handicapped persons, if not intellectually. This technique similar to the sidelines whiles the feat. So it is almost impossible to use it.
- This technique is tiring for the patient even aggressive. These cautions posture and these efforts unwanted disturbances worsen happy adjacent.

Definitely, this is a technical performance mediocre. It can be usefulness in the context of muscle reeducation eg post-traumatic.
It requires an O.L ideal in an ideal subject

Created by L. H. JONES (Oregon) at the beginning of last century.

It is "the opposite" of MITCHELL technique.

The practitioner shortens the spasmed muscle. It goes in the sense of поп-pain. He maintains this posture 90 seconds. Positionning is slow and passive. Return to a neutral position is slow and passive.

Immediately, the patient feels no benetice. Recovery happens 48 hours later.

The identification of the posture is based on two concepts:
1. The direction of the pain: basic.
2. The trigger points, relaxation points

The trigger points are receptive areas very small located in the thickness of muscle, fascia, ligaments and subcutaneous connective tissue.

They are active, painful with pressure, when the muscle is spasmed.

Therefore, to a trigger point (active) соnеsроnds a muscle and соnеsроnds a posture (shortening).

In the first time, the practitioner takes stock of the trigger points (and muscles) involved in the osteopathic lesion. It is subjective technique of identification since it is the patient who reported the existence of a not of a sensitivity of the trigger point.

In a second time, he corrects case by case each injured muscle.

Advantages:

- All L. O. can be so treated (ex: ип lumbago, ипе knee osteoarthritis ипе Epicondylitis ...).
- Manreuvre inoffensive пе this cons-no indication.
- Manreuvre painless.
- Manreuvre рош the patient comfortable.

The cure rate is higher a la technical Mitchel1. Еп this effect technique is indirectly, any реи еп account, fascia and ligaments. It is about 40 a 50%. Several sessions are frequently necessary.

Disadvantages:

- The recovery will only take 48 hours. The doctor is in doubt about its efficiency. In principle, the sensitivity of the trigger point disappears if the handling is positive (??).
- It is less startling in reality for the practitioner, but nevertheless tiring.
- It is a long technique. Imagine that the patient presents several levels of lesion. There are 200 pairs of muscles in an organism; any of them may be involved.
- It is a technique poorly adapted to the complex cases, when several reversed O.L are juxtaposed. It is difficult to find a painless posture in these cases.
- It is a subjective technique that involves the patient for the diagnosis.

Definitely, this is a technical with a medium performance, which may suffice for proper exercise. It is an intermediate technique which nevertheless allowed considerable advanced in the knowledge of osteopathy.

THE WIESELFISH - GIAMMATTEO METHOD

The Jones technique, as its name suggests, is a technique: a posture corresponds to a trigger point.

However, when practicing this technique, we notice, with a little of experience, that it is often the same postural cases that are manifested.

In the case of suracute pain, the sens of the non-pain and of the positionning is obvious.

So, for example, lot of right cervical-brachial neuralgia responds to this postural schema:

- Flexion (anterior) and left rotation of the head.
- Elevation (= flexion)+ external rotation+Abduction of right arm.
- Flexion of elbow + external rotation + Abduction of the right arm.
- Flexion of the wrist + external rotation + abduction of the right hand.

It is a position adopted by the patient to feel better. He sleeps with a big pillow under his head, he tums head to the left. And he puts his right upper member into the air, above.

It is from such observations that the osteopaths Wieselfish-Giammatteo have been able to develop this method.

Principles:

Flexion = Fexion of peripheral joints.
Ilium, scapula and Temporal in anticipation.

Extension = Extension of peripheral joints.
Ilium, scapular and Temporal in posteriority.

Opening = peripheral joints in extemal rotation and abduction.
Pubis, clavicle and mandible in ipsilateral deviation.

Closing = peripheral joints in intemal rotation and adduction.
Pubis, clavicle and mandible in contralateral deviation.

In total, the patient may present the following combinations:

- Flexion + left or right opening
- Flexion + closing right or left
- Extension + left or right opening
- Extension + right or left closing.

➔ The problem is more difficult when we know that the three lombopelviennes, cervico-thoracic and skull areas can be blocked differently.

Example:

- Flexion Left opening for skull
- Extension Left Closing for cervical rib.
- Extension Left Opening for thoraco-pelvic.

All combinations are available.

➔ The problem is more complicated when we know that there is no (or at least, personally I do not know) reliable diagnostic method helping to identify the mix.

The sense of non-pain is the most developed way. In acute cases, it is very reliable. But in chronic cases it is much more random.

Finally 20-30% of cases of injury do not fit to this schema; including post traumatic O.L (such as "whiplash") where in a same segment co-exist more reversed lesions.

However, this method is very convenient: it helps to save precious time. The three levels can be treated with a maximum of 8 positions.

The example of the cervico-brachial neuralgia described above represents something like that:

- Flexion left opening for the area of skull.
- Flexion right opening for cervicothoracic area.
The situation of the lumbo-pelvic area has to be clarified

It would be good to posture exaggerating the situation.

In total, it is relatively efficient. I practiced for years. It brought me a lot of satisfactions. But I found better with technique Moneyron and method Niromathé, more efficient, faster, much less tiring and especially with immediate effect.

LIGAMENTAR TECHNIQUE:
W. G SUTHERLAND (1872-1954)

During the first part of his life, SUTHERLAND acted a little bit like Jones. He positionnes the injured joint in the easiest sense, of the non pain, of more flexibility. But he does it very sweetly, very superficial, without trying to shorten it completely. He lets the joint slightly free during this posture. He modifies the amplitude when he notices the appearance of tensions, he changes it very slightly, a few tens of degrees. He varies his action in the sens of greatest facility. He does not have to feel a resistance of the tissue. Ten minutes later, the joint "collapses", becomes soft.
Any tension disapears. The patient can stand and is cured.

This can be any joint: the skull (headache), a knee, a wrist...

Vertebrates such as:

- He positiones his fingers in small Para Vertebral depressions, corresponding to transverse in anticipation. A slight pressure on the area majorises rotation effect. He also applies a pressure in the cranio coudal sense to bring the vertebrae to meet each other (sens of the greatest facility, ie inclination).
- Finally he is helped by an apnea of inspiration or expiration to increase the situation of flexion (expiration) or expansion (inspiration).

Then, he considers working on ligaments shortening them. He establishes a ligamentar theory. Extended ligamentar shortening allows a stop of the spasm spasm. This one is immediate. I haven't practice this technique, I can not judge it. It has also been abandoned, and I hardly know osteopathe using today this technique.

I think it is very interesting to mention in order to show that Sutherland's thought lead to fascial osteopathy.

Indeed, Sutherland noticed later that it was not so much a ligamentar shortening it generated, but a fascial tension by the intermediate of the cutaneous tissue.

FACIAL TECHNIQUES

TECHNIQUE A. SUTHERLAND

= Techniquelisten = cranio-sacral technique = P.R.M (Primary Respiratory Movement).

Inventor: W. G SUTHERLAND.

Many authors have followed him (H. Magoun, V. Fryman, 1. Up1edger, B. Arbuck1e T. Zink, B. Gabare1, L. Busquet ...).

Today, more than the half of the osteopaths uses Sutherland technique.

After years of practice, Sutherland noticed that the mechanism of correction does not resume a shortening only of the the ligamentar beams. He was interested in that, too, the sub cutaneous tissue and deeper tissue: the envelloppes of musc1es and viscera (fascia), and even muscles and bones.

The O.L results of excessive tension in these tissues, or more or less localized, with an alteration of the superficial lymphatic circulation.

W. Sutherland discovers the Primary Respiratory Movement, movement of tissue, which manifests itself in successive waves, at a rate of 12 to 16 cycles per minute. This movement is felt in the form of rhythmed paresthesia, which have nothing to do with the first heartbeat and breathing rythm of the patient and practitioner (?) It may be linked to L. C. R movements, of the lymphe and extra-cellular liquid. We can feel it ourselves. We just need to be in a dorsal supine position, with silence and comfort, put the hands superficially on the thorax at the level of the pectoral muscle. 5 to 10 minutes later, paresthetic waves appear which raise the fingers frequency of 15 cycles per minute, waves normally harmonious and symmetrical.

A unilateral or bilaterale discrepancy reflects the existence of Osteopathic lesions.
Their re-alignment leads to the disappearance of osteopathic lesions. The result is instantaneous.

Various therapeutic approaches are possible:

1) Local approach:

- Some osteopaths work locally the injured joint. At the knee for example: it is gradually placed, always very softly, thanks to a very superficial handling, in a posture that gives the maximum of amplitude and harmony to the P.R. M. Once the search P.R.M established, the attitude is maintained as long as needed: 10, 20, 30 minutes until the recovery of a harmonious P.R.M

2/ General approach

- Some osteopaths work globally all the body: skull, the cervico-dorsal junction, thoracic diaphragm, chest, pelvis, feet, and hands.
The principle is the same.

3/ Regional approach:

- Some osteopaths work only the skull.
- Others work only the skull and the sacrum (the first authors in particular, which led the expression of cranio-sacral). They consider these two poles as fundamental in the synergy of the P.R.M

4/ Approach "truncated"

- Some totally disregard these morphological aspects, they choose any part of the body. They resolve the problem, whatever it is, from this single observation.

Let have a look on Georges Fournier's work, Veterinary osteopath:

Pauline's house limp for 6 months. He can not be riden. When we want him to accelerate, the limp is obvious and the horse must stop. Various treatment (?) were tested without success. George puts his hands on the horse's neck. Patiently, he waited for the P.R.M. It occurs 10 minutes later. It's relatively disharmonious of the left side. George asks mentally joints (I agree to say that this aspect is closed of the dowsing). He asks members; P R.M. preserves practically the same moderately dysharmonic structure at the left. Disharmony becomes clearer when questioning the left sacroiliac joint and the lumbar area. He concludes that the problems (O.L) are at these levels. He remains mentally positioned on these two levels and he modulates the peristalsis of the wave of P.R.M at the neckline. He corrects, very gradually, the left wave to make it start again. in the three areas, in a same form than the right side. This work is long. It takes more than 30 minutes. It requires an extreme concentration and patience. When they believe that the wave has regained its volume and the symmetry is perfect, George gently removes his hands. He asks Pauline to make her horse walk and trotted, and finally to ride the horse.
Immediately the horse takes a normal pace. He doesn't limp anymore. He is cured.
It was 8 months ago and the horse is still doing well.

I understand that for a neophyte, this is close to magic. But these results are reproducible. Certainly they were not systematic; the rate of positivity is 50 to 60%. However, it is much more than a placebo would do.

FACIAL TECHNIQUE

Advantages

- These techniques are for all O.L
- Painless, harmless, no contraindication.
- Comfortable for the patient who may be sitting or lying.
- Immediate results 1 time/2

Disadvantages:

- long technique (at least 30 minutes)
- Techniques that require a lot of patience, concentration, detail, so a great availability of mind (that I have not).

B - TECHNIQUES OF POLARITY =
Randolph Stone, Reiki. Technique

Practitioners using these techniques do almost the same thing that with the technique Sutherland. They work on the patient in the same way, but they just put their hands for a longer period (willingly one hour).

They consider:

1) That their hands are equipped with electrical properties: a positive hand, a negative hand;
2) That the patient is the place of electro magnetic currents too:
- A circular current around the trunk, skull and each member.
- A longitudinal craniocaudal current.

3) That the O.L. (And even all the pathologies???) result from poor movement of the electro-magnetic current.
4) That the laying of hands will restore the electro-magnetic circulation and remedying the problems.

Some of them think that they have some magnetic or divine powers!

I have tried this technique and cured severe coxarthoses, acute and subacute periarthritis, what was unexpected andspectacular. I must say that the results were not very repetitive, but I must say I rarely have the patience to wait an hour. Nevertheless, these cures were indisputable.

I think the "small materials" responsible for the tensio-activity of tissues, situated between the dermis and fascia, disrupted with the O.L, can also be reprogrammed in this way (electric effect 7).

We will detail this explanation and my understanding of the actionl with the Niromathe method.

CUTANEOUS TECHNOLOGIES

Will also be studied the periosteal and trigger points, although they are respectively bony and muscular,.

A) THE TECHNIQUE DICKE = Bindegewebs massage (E. DICKE 1884-1952).

This method of massage of the connective sub cutaneous tissue has a segmental reflex action.

The practitioner proceeds like that: He moves the skin on his bony or muscular seat by performing a relatively slow and deep line.

It causes stimulation by tension of the skin. This handling is done with one or two fingers pulling the skin. The fingers are more or less bending over the body surface. The lines cover the entire surface of the body according to predetermined directions. These patterns were called constructions.
The practitioner performs this handling two or three times, realizing tens or hundreds. Some are very short: others are very long.

Many variants are possible:

I) Small construction on the hips and lombs.

2) Big construction.

3) Lines proceeded of muscular massage, kneading tendon, of stretching, breathing exercise.

4) Work localized on particular areas:

• Area of Head (areas where the connective tissue is altered, infiltrated, retracted). These areas of Head correspond to possible areas of visceral projections.
There is a nice, systematized projection, with a somatic and visceral contingents (origin is from C7 to L2)
Similarly, there is a parasympathetic projection with a visceral aim . Maybe there is also a somatic projection? (Origin is at the nine cranial III, VII, IX and X and sacred thread from S2 to S4).
A manual work on these cutaneous areas could affect visceral therapy. Some authors are convinced.

• Hyperalgesia areas.

• Longitudinal areas of Fizerald: the body is divided into ten bands in cranio-caudal direction.

5) Work exclusively localized on peri articular areas

The features are centripetal, converging towards the articular interlign

The technique of R. PERRONEAUD represents a variant: the finger is fixed near a joint. The mobilization of the joint leads to the realization of a line and the same result.

All these techniques will have some results. However, they are inconsistent. Several sessions are usually necessary. Is a technique a little painful. It is for all the O.L and have no contra-indication. It is quite tiring for the practitioner. Ten sessions are usually required. Indeed, it stimulates a phenomenal quantity of sub-cutaneous points.

The results are very average, very random, sometimes immediate, sometimes retarded, sometimes absent.

Some practitioners combine these lines to other techniques of massage (Point of Knap, for example) or tendon vibration (Moneyron), this in order to essentially improve their performance or to avoid the phenomena of rebound.

B) POINTS OF KNAP. G KNAP (1866-1953)

G Knap establishes a summury of cutaneous and sub cutaneous points, exquisitely painful, related to a specified disease. Each of these points is well related to a segment, n area, a function, a disease (without taking care of its origin).

He differences the major points and minor points and establishes a specified mapping of these points. But this mapping strangely looks like the other maps: periosteum points, points of Chapman, shu / mu points, Ah Chi points in Acupuncture.

Knap relieved and cured a lot of patients.

The technique involves to "massage" these points (with the endpoint of a fingertip or Ia second phalanx), first superficially, then stronger and more and more deeply, without ever releasing them with a rotator movement.

The results are apparently both immediate and delayed.

I have no experience in this technique.

It is obviously a painful technique.

My principle is to never hurt my patient.

C) Periosteum points (D. Vogler):

The massage of periosteum points causes actions on rorgans and joints.

The practitioner makes contact with the extremity of a finger or the second phalanx, on a very localized periosteal area. He carries on this point, a strong and rhythmic pressure (altemation pressure and relaxation), without ever losing contact with periosteal area. A rotary completes the handling.

There is a precise mapping of periosteum points with points of local action and regional action points too.
Ex: by acting on the 7^{th} and 8th dorsal vertebrae we obtain a relief of stomach pain.

This technique is particularly painful, sometimes unbearable.

Even efficient, It has no interest in the treatment of benign disease that represents the majority of O.L (There are indeed other painless methods).

Vogler claims it can have an effect on visceral disease, like areas of Head.

D) POINTS OF F. CHAPMAN:

F. CHAPMAN based his entire osteopathic career on the research of lymphatic congestion areas. These areas or points are put in relationship with an organ or a disease. CHAPMAN conducted a topographic survey of these pointsHe established a neuro-lymphatic theory to explain its results.

It is remarkable to see that his mapping looks like a lot of other authors the mapping.

The diagnosis involves a search of these points. These are perceived: at the anterior side of the trunk like small sub-cutaneous pellets and posterior side like edematous areas, realizing sometimes beneficial closets.

The treatment involves a massage of these points using a finger or second phalanx. It is a rotary massage that lasts 2 to 3 minutes.

E) ITEMS NEURO-MUSCULAIRES:

JONES individualized the neuromuscular points or trigger points, or tender points, or myo-fascial points.

Their sensitivity corresponded to a state of activation of these points. It meant spasm of the corresponding muscle and required the positioning of shortening of the muscle.

Other authors, in particular J. TRAVEL also individualizes the trigger points.

Are they the same points?

It seems so. In any case, their situation and their mapping are superimposed or very close. But these authors, this time, use the trigger point as a therapeutic leverage.

1) The technique of S. Lieff:

It consists of the image of the Bindegewebsmassage of DICKE, to make lines on the body. But these lines are much deeper here. They invest the muscle. Any the hand is used to perform this handling: the four fingers, the thenar eminence or the hypothenar eminence. The movement is slow, perpendicular to tendons, but parallel to the muscular bodies. For reasons of comfort, the patient is supine.

As in the technique of DICKE, there are schemas, constructions. As in the technique of DICKE, it stimulates dozens of points and God must find his own. As in the technique of DICKE, the results are very medium and several sessions are required. It is nevertheless a technique used by some osteopaths.

Variations are possible.

Include:

- The segmentotherapie (QUILITZSCH): the displacement of hand in a twisted way

The vibration is slow, effected with the thumb or the entire hand. Genral direction of the handlings is done from cranial to caudal and from the periphery to the spine.

- Rolfing (1. Rolff: 1896-1979):

We using the fingertips, and often the knuckles and the flat of the elbow. 1. Rolff was called "elbow". Work here is much deeper. He was interested mainly by para-spinal muscles. It is painful for the practitioner (Sessions of 60 'to 90') and certainly painful for the patient (Pains)

2) The points of J. TRA VELL:

- A little like Knap and Chapman for the under cutaneous tissue, J. TRAVEL individualies neuro-muscular points or trigger points.

For the record, note that John F. Kennedy presented chronic chest pain. J. Travell cured him thanks to his technique. He got the post of White House physician under the presidencies of John Kennedy and Lyndon Johnson.

A muscle contains one or more trigger points. This trigger point may be in an inactive or active state:

• If he is inactive, its stimulation (eg the pressure) doesn't trigger anything.

• If it is active, its stimulation triggers pain in precise territory, always the same for a trigger point. This pain is called refered pain. It has nothing to do with metamerism. It has no relation to the neighboring nerve.

Example 1: The refered pain of trigger points of the scalene muscle triggers pain in the radial territory of the ipsilateral upper limb. The compression stimulates nets inferior nerve of the cervical-brachial plexus and triggers a reported pain in the cubital area of the ipsilateral upper limb.

Our traditional medical knowledge does not explain the projection of the refered pain.

Example 2: Note for the anecdot, that the compression of the trigger points of the solear muscle leads to a pain in the leg but also a pain in the ipsilateral hemifacial! The reality exceeds the fiction.

The fact is that when a patient arrives with pain in an area X, J. TraveII identifies the muscles that can create such a pain.
The pressure of the trigger point at the muscle leads again to, if it is implicated, the same pain or makes it get worse.

Treatment of trigger point leads to the disappearance of this refered pain.

This treatment consists for exemple in a prolonged ischemic compression accomplished with the finger, with a rotary component. It may also be a puncture with a needle or the application of local warmness (moxa).

J. TraveII stretched the muscle and then made an injection of xylocaïne at the trigger point.
This technique is long, tedious, with medium results. It needs the participation of the patient because he is the one who can objectivize the pain. It is nevertheless used by some osteopaths, either directly or by other techniques.

3) MA CKENZIE areas:

Like areas of HEAD corresponding to cutaneous areas of visceral projection, there are areas of MACKENZIE, hyperalgesia and infiltrated muscular areas, with visceral projection.

4) Deep and localized muscular massages massages – like Cyriax-type

F) POINTS OF KINESIOLOGY (Goodheart):

Kinesiology: "The health through touch" is a method of relaxation which tends to develop.

The author attaches a muscle or a group of muscles to a meridian of accupuncture.

Stress influences the muscular strengh and allows testing the vitality of the muscle, and consequently (?) the vitality of the meridian of acupuncture and anything linked. The principle is obviously very questionable. I don't judge this intellectual construction (one more) that seeks to explain (posterior) therapeutic results obtained with an empirical way. This is not the purpose of this work, there would have a lot a say in this field. There is worse, since we enter sometimes in intellectual construction without being sure that there is a therapeutical result.

Anyway, Godheart corrects pathological effects that the patient has by an action on cutaneous areas he listed. To a muscle corresponds a cutaneous area located on the body, called neuro- lymphatique point. A precise mapping of these points has been established. Again, it looks a lot like those that we studied. To a muscle, corresponds also a cutaneous point located on skull, called neuro-vascular point. A mapping of these points has also been established.

Stimulation of these points: a simple touch while dozens seconds, or a rotary massage leads to the disappearance of symptoms.

G) ORIENTAL TECHNIQUES:

They are probably very numerous.

I do not know them.

There is an obvious parallelism between the previous maps and Shu / mu points and Ah chi points in acupuncture.

…….

I've probably forgotten cutaneous techniques.

The aim of this work is not, anyway, to make a comprehensive list of all that exists in this area. It would not interest.

However, I wanted to describe you a few to show that under very distant designations sometimes, all have the same common denominator:
Stimulating points to bring sub-cutaneous disappearance of deeper spasms (ligament, muscular, fascial, visceral ...) and to make the related symptomalogy desapear.

TENDON TECHNIQUE

A) TECHNIQUE MONEYRON.

A name is very important at this level: J. MONEYRON (1923-1994). "His" technique, he learned this technique bya religious: Sister G. CHABRIT who had received herself a "Gift" during a travel in India. J. MONEYRON, a pharmacian in Vichy was initiated by her. He obtained exceptionnal results very quickly which gave him a big notoriety. His reputation became Intemational. In the list of his patients you can see the french presidents У. Giscard d'Estaing and F. Mitterand, and foreign presidents. Rich American came to Vichy to seek his treatment. At the end of his carreer, you had to wait for 9 months to get an appointments! Bothered by the Council of Order, he refused systematically to give his technique to doctors. (I wrote him in 1985). F. Mitterrand did get him a diploma of PHYSIOTHERAPY to regularize his situation. He gave his technique just to six persons including Mister G. POINTUD. It is G. POINTUD who taught me this method. It was a revelation. I really want to thank him.

THE PRINCIPLE:

The technique is based on a vibration of the tendon, often close to its bony insertion. The captors located there are meant to create a retlexe mecanism, freeing the lesionnal phenomena (O. L.).

• Avantages:

- The stimulation is short. A very partieular movement is necessary to obtain the herapeutic vibrator effect. This stimulation will be repeated once or twice. It requests 3 " for its implementation.

- The stimulation is painless. Note that ischemic compressions of retlexe points of conjonctif tissue or muscular tissue (KNAP, CHAPMAN, Travel ...) require three minutes and are painful for the patient and for the practitioner.

- Stimulating leads to an immediate result on the lesionnal phenomenon.

• Disadvantages:

The therapeutic application requires to be learnt and to be detailed with the fingers on the intensity, speed of execution, depth, rhythm.

The location of the points to be treated is subjective. It is based on recognition by palpation, active points. They are characterized by local edema, loss of elasticity of the tissue. The skin seems to adhere to the underlying tissue by a suction effect, by a viscoelastic mechanism of piston.

Overall, technique MONEYRON is a technique very interesting:

- It is quick, painless, with immediate effect.

- It is not very tiring for the practitioner (personally I work sitting).

- The patient doesn't participate

- It is for all the O.L

- There is no contraindication or disadvantages

- The level of performance is very high (positivity rate: 60 to 70%).

It nevertheless suffers from the need for the practitioner to know recognize the changes in tissues at the reflexogene points.

B) THE TECHNIQUE R. FOX. G. TECHNIQUE LAMORIL

Sister Chabris and J. MONEYRON were not the only ones to introduce this technique in Europe.

I met many other practitioners (mostly old bonsetters) using this technique.

R. FOX for example had learned it in 1919 in the Dardanelles (Balkans) while doing his military service.

G. LAMORIL worked in Bonneville. He also had an Intemational reputation since he treated the Queen of England.

They associated readily to their practice some lines like DICKE, the muscular stretchings and cutaneous tractions with the other hand.

It is their practice that inspired me the method NIROMATHE.

THE METHOD NIROMATHE

25 years of practice, observation, research, experimentation, allowed me to discover concepts and develop the method NIROMATHE.

This method is based on four concepts.

A) First Notion: The "detachment" of the skin.

Osteopathic techniques are in fact no bony, no muscular, no ligament, no tendon, no fascial or no cutaneous. They are in fact for Tenso- Modulator Elements = T.M.E. located between the skin and deeper structures.

These T.M.E are disconnected by "stickying" the skin

Their detachment led, at the same time, to their reprogramming and instantaneous disappearance of O.L

Example: A young patient has a hyperalgesia stiff neck. The very detailed analysis of the skin helps to identify the “sticky”, the deprogrammed T.M.E.. The skin is retracted, lumpy, fixed, sticked to the underlying M.T.E.
A very thin stimulation of the skin, for example with the technique of Moneyron, allows an immediate detachment. At the same time, the spine becomes painless and regains its flexibility.

Everything happens as if the blocking, the "seizure" of the joint didn’t stand at the joint itself, or even in the muscles, but resulted from a "cutaneous hanging" at the T.M.E : articulation can not tum right because the skin can’t be stretched to the right.

This finding concems in fact all the joints, all O.L. no matter their localization, their intensity, their seniority.
Osteopathic treatment consits in a detachment of the skin at the level of the T.M.E

This separation can be done:

- Directly, by a direct action on the skin itself. *

- Semi-directly, by an action on deeper structures : bony, muscular.

- Indirectly, by polarity.

I) DIRECT STIMULATION.

It can be done by a needling (acupuncture), by injection xylocaïne (Method J. Travell), by local heat (moxa).

Looking at it from that angle, it is clear that we must be on the point and not next to it, and if 30 points are involved, a lot of time would be necessary.

But it is important to be able to locate exactly! This explains poor results with these techniques.

It can also be made with the fingers by ischemic compression (Painful) but also by a very thin skin vibration, a cutaneous propriocetive disturbance. Cutaneous, that means very superficial (kinesiology, technique Moneyron Niromathé Method). The greater flexibility allows working on these 30 points.

2) SEMI DIRECT STIMULATION.

- A bony proprioceptive disturbance (handling) will stimulate .E. and induce their detachment.
- A repeated muscular stretching, (Mitchell) or prolonged muscular shortening (Jones) have the same résult.
The detachment of T.M.E is done here by the depth.

3) STIMULATION POLARITY.

- Technique Randolph Stone, Reiki.
- Fascial Techniques (Sutherland).

About the Reiki, the situation is clear, since his followers consider that it is the polarity of their hands that carries the therapeutic effect.

About the fascial techniques, the mechanism of action is controversial:

- Is it a direct stimulation: by a stretching or cutaneous stretchings (superficial, extended)? Maybe ...

- But then, how to understand that the laying of hands in one place of the body can make a pain in the left knee and in the little right toedisapear?

Personally, I do not believe in the existence of an P.R.M. I consider that the rhythmed paresthesia that you can feel is just the resultant of the respiratory and cardiac movements of the patient and practitioner. The notion of P.R.M. has no justification.

The laying of hands on the patient in any place, in a very superficial way (important) generates a magnetic mpulses, which in 45 to 60 minutes (if hands are really passive: Reiki) induces a detachment of the skin at the level of all active T.M.E

The laying of hands, when one of them is animated by a light movement of reptation or oscillation (technique Sutherland) shortens a lot this period. 20 to 30 minutes are usually sufficient to get a result.

The advantage of this technique by polarity is the simultaneous raise of all the T.M.E of the body.The hands can be put anywhere.

The drawback is the time it takes.

First notion, thus: the cutaneous detachment at the level of the T.M.E

The proof of this mechanism of action:

My results with the Niromathe technique are excellent, whatever the corpulence of the patient. Would say they are even better in the obese patients. I treated a Sumo a few months ago. He weighed 160 Kg He has a lumbo-sciatica. Useless, with this type of patient, to try to identify anything. But the results are excellent. A simple superficial cutaneous work, has waived the spasms.

B) SECOND NOTION: The polarity.

This notion of polarity, widely reported in the fascial techniques (Reiki, Sutherland) is nevertheless present in regard to other techniques.

- Osteo-articular manipulation necessarily requires the presence of both hands for their realization.

- Similarly, the technique Mitchell (myotensive).

- Jones always left his second hand on the patient's body, at the level of a Trigger point.

Note: I personally tried to realise Jones technique with just one hand, particularly at the spine cervical. The results are not as good.

- It is the same about cutaneous and tendon technique.

Note: After months of exercising technique Moneyron I noticed that results were better at the level of cranio-cervical segment. I research for a long time to understand this difference. I realized one day that unconsciently, on cranio-cervical, I used my two hands, just to avoid sloshing head. Indeed, I often work, patient and myself, sitting and my second hand, because not necessary, at the Dorso-lombar.

So there is an effector hand and a receptor hand. Each of them has a difference of polarity between his hands. Some less than others. This is why; the work in pure Reyk is random. For conscequence, the animation of one of hands increases this effect (Sutherland).

The effect by polarité takes time to manifest. But it exists too, in a short work. One of the hand must have a rotatory movement (Niromathé).

C) THIRD NOTION: The mapping of points.

Practicing very intensively the technique of Moneyron, I obtained often very disconcerting results:

Two humeral scapulo periarthritis or for exemple two lombosciatics, seen successively (treated in the same 30 minutes), are treated the same way, with the same state of mind, has resulted to opposite results: for the first we reached recovery, for the second it was unchanged. What have I done? Or have not?

After a lonng research work, after hundreds of experiments, I noticed that contacted points (apart the concept of polarity) and the work of my fingers were not quite the same.

Indeed, the pains are different following the modality.

Take for example the diurnal or nocturnal character of the pain.

There are two groups of patients (+ 2, or 4 groups):

<u>Group 1:</u> Patients presenting diurnal pains.

These patients wake up feeling good, without pain. Pains appear and progressively worsen in few hours to reach their climax at the end of a day. At night, these patients can't wait to go to bed. The supine and the rest quickly bring total sedation. They have a comfortable night.

In fact, the involved tissues (musc1es, tendons, and fascia) are here posterior tissue: These are the tissues of standing position, erector tissues. These tissues when they are the headquarters of O.L are spasmed. Their stretching is done in the standing position. It is progressive to reach its peak at the end of the day. This stretching bounds for the painful symptoms. The resting, the shortening of these tissues (supine) brings the yield.

<u>2nd group:</u> Patients presenting nocturnal pain particularly during the second half of the night.

The day is calm, even if not totally serene. Patients have little or no pain. They have no limitation of physical activity. At night, they go to bed, and gradually the pain appears, waking up at 4or 5 am. They become unbearable. There is no antalgic position. In fact, there is just one and only antalgic position: setting upright. Patients get up, walk. The pain is attenuated and disappears in 5' or 15 ', to reappear immediately as soon as they are recovering at bed.

These are the anterior tissues that are involved. These tissues, spasmed because of the O.L, stretch in the lying position. This reaches its maximum stretching in the second part of the night, waking up the patient. The standing position shortens the tissue and brings immediately the yield.

I want to say that this has nothing do with an inflammatory pain (much rarer). It is diurnal and nocturnal. There is sometimes nocturnal resurgence. But it does not cease with the standing position.

The pains of this second group are of course worse than the pains of the first group.

3rd group: diurnal and nocturnal pains

They concern simultaneously previous and posterior tissue.

They are very difficult to bear because patients don't have an analgesic positional situation.

4th group: Pains more difficul to label:

For example we have a mix of the 2 groups sectorized. A lombar pain aggraved by day and a pain in the shoulder aggraved by night can coexist: non simultaneous blockings arrived at different periods.

Or when pain evolves in its modalities. A pain at first nocturnal can become diurnal few weeks later.

It corresponds to 2 kinds of blockings:

- **The ones that happen in Inspir = Opening**
  - **worsening with immobility, rest**
  - **Improvement with movement**

- **the one that happen in Expir = Closing**
  - **worsening with movement**
  - **Improvement with immobility, rest**

Exemple: headaches

Now consider the blockings in Flexion and Extention:

Some examples:

- In periarthritis of the shoulder, the patient can not raise his arm: he can not put in flexion. By concequence, the arms hanging along the body (= extension) is an analgesic position.

- Conversely, many of cervico-brachial be relieved when the arm is in a position of flexion, placed above the head. The pain exacerbated the contrary, when the arm is pending, extended along the body (Extension)

- Amount of sciatica are improved when the sacroiliac and hip flexion are (antalgic curled up) and instead aggravated by extension.

  - Other sciatica are aggravated by bending sacroiliac. This is the classic sign of Lasegue: traction on the ischiopublic ilium by hamstrings positioned in the bone where Flexion vis-a-vis the sacrum. Conversely setting Extension sacroiliac relieves the patient.

  - Some patients are aggravated sitting in their seats, so in lumbar flexion, but they have improved in Extension back injury that is to say, sitting on a chair or standing or lying down.

- Dizziness is almost always associated with a first cervical locked in Extension; Look up (= put in Extension) triggers the dizziness. The bending of the head instead makes them disappear.
  - Etc. ...

The link will be stunned and locked in position by flexion or extension of its location at the wrong move. Similarly it will be stunned and locked in position Opening (= Abduction-external rotation) or closing (adduction-internal rotation) based on the situation in state or Inspir Exhalation of the patient.

A very rapid recognition of the type of blocking will allow, with the Niromathe method, to adapt a specific gesture and mapping specific T.M.E

- The mapping corresponds to the situation in flexion or extension of the O.L
- The gesture is dependent on the nature Open (Inspir) or closed (Exhalation) O.L

C / FOURTH CONCEPT: The gesture

- A basic rule: the application of hands must be very superficial for a maximum action. This also explains that massage is a totally ineffective on the release of osteopathic lesions. They are far too long and too pusched.
- The effect is increased if one hand is animated by a particular wave motion (Sutherland)
- It is greatly magnified if the effective hand is driven by a wave motion but not rotation.
- It is further increased if the impact point of the efective hand is very localized (a finger, a distal interphalangeal joint) at the T.M.E
- The gesture must be very precise about its location, its degree of pressure, direction and rhythm.
- It must refer to the methodology

See the importance of of rotative character of the movement of stimulation. In the cutaneous techniques (segmentotherapy: spinning movements), periosteum, subcutaneous (Knap, Chapman, Goodheart, Moneyron ...) a rotary or spiral movement is always applied and considered essential.

In acupuncture too, rotary movement of the hands is significant: we tone up with the gold needle by turning it clockwise and we disperse with silver needle by turning it counter-clockwise. It is not impossible that the needles were driven simultaneously, one with his left hand, the other with his right hand, and that the metal allow to keep this polarity difference.

The Niromathe method uses a rotary movement. The result is very powerful because O.L stops immediately.

Niromathe method combines:

- An identification of T.M.E (precise mapping)
- An appropriate gesture
- The notion of polarity
- The principle of globality

In a clear goal: the undermining of the skin of T.M.E

Result:

It is a method:
- Efficient: the cure rate is 80%
- In a meeting in the acute and recent.
- In one to three sessions in chronic cases

Indeed, I usually say that when a joint has taken a bad habit for months or years, it has a tendency to start again.
Two or three sessions are usually necessary.
This means that there is 20% of failures (relative) that will need more than three sessions.
There are essentially two groups of people: the “Museums of medicine "and the " vegetables ". These words are not pejorative and do not reflect an effect of repression on my part about what I can not control.
But they simply reflect the unfortunately common cases that physicians recognize easily

- Museums of medicine: it is full of patients who had a lot of surgeries.
  Ok with the necessary surgery, of course, but those made by principle, certainly not.

- Vegetables:
  These are polymedicated patients including neuro-psychiatric drugs. Yesterday, a patient, 53 years old, without serious disease, arrived with a list of 17 types of drugs he swallows regularly for several years. How can we reach such extreme cases?

  These hyporeactive patients are really difficult for us.

- Objective: the patient has nothing to do
- Quick: 10 minutes by session
- Painless
- Not very tiring: the patient is sitting or standing
- Wide indication: for all the osteopathic lesions
- Harmless: no contraindication
- Immediate result

Epilogue

I mention in this book, a multitude of names.

Most are American!

Even in an area so devoid of technology, the truth refers once again to America!

Aberrant anyway!

Osteopathy comes from the mists of time. The East, the Middle East, Europe abound osteopaths.

Why this complex with our continent?

Ancient literature helps us to find very interesting recipes with medical plants. The spice trade was once flourishing. Magellan circumnavigated the world for God and spices. The spices made the rank of God! These spices were used to actually care. It was drugs.

The drugs were divided into 4, 5 or 6 groups, according civilizations. They were used to warm, to cool, to dry, to moisten, to invigorate, to take away spasms the body. Terms and subtle associations allowed to potentiate their effects. They were used in the form of essential oils or mellitus (honey mixed with powdered plants). This allowed them concerver.

These plants, recipes and theories are now totally abandoned.

Why this complex with our past?

Man should have 3000 years of experience but become a child at each generation.

Old texts, mainly greeks, help us to find the names of the doctors who used osteopathy. They are not called masseurs but “touchers”. It is a question of touching and it is linked to the notions of reflex spot and polarity.

I chose the name NIROMATHE.

Since this time, nothing has been invented in this field. They may work as we do, in the same way, as good as we are.

Through that name, I dedicate this book to them.

SUMMARY

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REASONED OSTEOPATHY

Osteopathy is for:

- Osteo-articular engorgements with mechanical origin and the consequencies: pains, functional impairment, acute (neuralgia, lumbago, stiffneck…) or chronic (arthritis)

- Visceral engorgements with mechanical origin and the consequencies: pains, functional disorders, acute or chronic

About fifteen techniques exist today. Some are very efficient, other are much less efficient. They look different about their application and their action.

But there are not Osteopathies but one Osteopathy!

Indeed, they have the same impact regarding their physio-pathologic mechanism of action.

It is what the author shows after 25 years of practice, research and observation.

It led to the method NIROMATHE: certainly the most elaborated form of Osteopathy because:

- quick: 10 minutes per session
- painless
- harmless
- large indication
- very efficient: recovery rate from 80% to 90% after one session for acute case, and one to three sessions for chronic cases
- immediate effect