

Adverse Effects

Dvorak, J. and Orelli, F. V. ***How dangerous is manipulation to the cervical spine?*** Manual Medicine 1985; 2 (1): 1-4 **Located in third floor stacks**

SUMMARY: We report on a 35 year old woman who became paraplegic after manipulation to her neck probably the result of ischemia of the brainstem due to mechanical compression of the vertebral artery or to a reflex spasm following forced rotation and reclination of the head. A survey among the members of the Swiss Society for Manual Medicine (SAMM) provided some data on morbidity resulting from manipulation to the neck within the past few years. In one out of 40,000 cases, slight neurological complications were observed, and one important complication was found in one out of 400,000 manipulative procedures.

Abstract from publication

Adverse Effects

Grayson, M. F. ***Horner's syndrome after manipulation of the neck.*** British Medical Journal 1987 Nov 28; 295 (6610): 1381-1382 **Located in third floor stacks**

Manipulation is a safe and effective means of relieving painful mechanical problems of the spine including the neck. As with all treatment, however, things may go wrong, and neurological damage from manipulation of the cervical spine has been reported before. I describe a case of Horner's syndrome after chiropractic manipulation of the cervical spine in a fit man with no known contraindications.

Abstract from publication.

Adverse Effects

Grieve, G. ***Contra-indications to spinal manipulation and allied treatments.*** Physiotherapy 1989 Aug; 75 (8): 445-453 **Located in third floor stacks**

Four categories of contra-indications to spinal manipulation are covered. 1) Contra-indications specific to the techniques of passive movement, oscillatory technique, mobilisation, stretching, traction, proprioceptive neuromuscular facilitation, and active movement are discussed in detail. 2) Certain conditions and syndromes that offer a misleading diagnosis are reviewed, including several visceral diseases with somatic manifestations. Specifically, spinal involvement of neoplasms and associated pain patterns and radiographic appearances are addressed. 3) The rationale of using manipulation to treat malalignment is discussed, with emphasis on the theory of spinal symmetry and normal asymmetry. 4) The incidence of accidents involving spinal manipulation and general guidelines to avoid such accidents are presented. Manipulation is contra-indicated if the clinician does not fully understand the presenting condition, is working from an unscientific or indefensible hypothesis, or is not competent to use the techniques of spinal manipulation safely. The clinician is advised to provide safe manipulation when it is indicated, and to avoid manipulation in patients in which it is not specifically indicated.

Abstract (unknown)

Angina Pectoris

Davis, D. ***Spinal nerve root pain (radiculitis) simulating coronary occlusion: a common syndrome.*** American Heart Journal 1948; 35 (1): 70-80 **Located in third floor stacks**

The purpose of this report is to call attention to the syndrome of dorsal spine radiculitis with acute attacks of anterior chest pain, simulating and often mistaken for coronary artery disease.

Angina Pectoris

Stiles, E. G. ***Osteopathic approach to the patient with chest pain.*** Osteopathic Medicine 1977 May; 2 (5): 93-95 **Located in third floor stacks**

Correction of somatic dysfunction using OMT can be a component for the total management of patients with chest pain. Several topics need to be considered: 1) Evaluation of the Patient 2) Importance of Sympathetic Nervous System 3) Importance of Rib Cage Excursion 4) Evaluation of the Lower Extremities, Low Back, and Pelvis. OMT has the ability to improve ventilation of cardiac tissues, to improve vasomotor tone to the cardiac plexus, to assist venous and lymphatic drainage from myocardium, and to decrease energy demands of the cardiovascular system. Osteopathic Manipulative Treatment can be an adjunct in the the management of a patient's chest pain.

Abstract by Sudipta Chaudhuri (March 3, 2004)

Arthritis

Steinbaum, D. S. ***Prevention and treatment of arthritis by osteopathic manipulation.*** Osteopathic Medicine 1978 Feb; 3 (2): 41-42, 47-48, 50-51, 53 **Located in third floor stacks**

Degenerative joint disease is a major health concern today as the number of elderly in the population of the U.S. grows. Arthritis pain has traditionally been treated symptomatically with anti-inflammatory medications. Osteopathic medicine offers an additional arsenal to the treatment for arthritis. This article reviews the methods for the management and treatment of arthritis including the use of osteopathic manipulation. Treatment and management for adhesive capsulitis (frozen shoulder) and for the arthritic knee in both juvenile rheumatoid arthritis and adult osteoarthritis are included.

Abstract (unknown)

Arthritis

Stiles, E. G. ***Osteopathic approach to rheumatoid arthritis.*** Osteopathic Medicine 1977 Aug; 2 (8): 75, 79, 81, 83 **Located in third floor stacks**

Rheumatoid arthritis is a systemic joint and tissue disease involving dysfunction of the immune system. Clinically, each patient will manifest unique signs & symptoms. For tissue to remain healthy, it must have normal arterial supply, good venous & lymphatic drainage, and proper innervation. Metabolic demands must be properly met for normal and physiological balance. The musculoskeletal system is the link between external environment and visceral functions. Somatic dysfunction adversely effects the vasomotor system and can produce altered neurotrophic axionic flow to tissues. In plasma and synovial fluids, complexes form composed of rheumatoid factors, IgG, and complement. Complexes become antigenic. Synovial cells phagocytize these complexes & perpetuate inflammation. Respiratory movements of rib cage play a maximal part in return of venous and lymphatic fluids. OMT programs assist in lymphatic return and removal of chemotactic and lysosomal factors. Local effects decrease microtraumas of somatic dysfunction, and improve patient's joint mobility. Patients frequently report improvement in stiffness and edema following OMT. Hopefully, OMT can decrease duration and frequency of medication, and further decrease side effects of these medications.

Abstract (unknown)

Asthma

Wagner, L. C. *Respiratory Allergies*. Journal of the American Osteopathic Association 1950 May; 3 (1): 481-483 **Located in third floor stacks**

In this paper Dr. Wagner discusses the management of the allergic child. In the acutely allergic child the importance of therapeutic measures is emphasized to include hypodermic injections of epinephrine (1:1000), Aminophylline IV at 6.5 mg/kg, humidified oxygen, increased water intake and inhalation, potassium iodide, and OMT aimed at relaxing and mobilizing the cervical and thoracic spine with a final lymphatic pump. However, Dr. Wagner reports that the management of the child between acute episodes is of the utmost importance. This chronic management must include a hypo-sensitization regime aimed to reduce exposure to the allergen by environmental control measures such as dust covers and removal of potential allergens such as pets. Weekly OMT is also recommended with special attention to vertebrae and rib lesions and lymphatic pump. The Paper concludes with a discussion of the advantages of radiation therapy in eliminating hypertrophied lymphoid tissue and its positive effects in decreasing rate and acuity of allergic/asthmatic attacks.

Student abstract by Jason Smith (March 31, 2004)

Back Pain

Arden, B. S. *Osteopathic management of chronic low-back pain*. DO 1962 Jan; 2 (5): 93-95 **Located in third floor stacks**

This is a case study discussing the benefits of OMT, lift therapy, muscle relaxants, and stretching exercises in a patient with chronic low back pain. A 52-year-old female presented with a chief complaint of sharp piercing pain in her lower back which radiated bilaterally. The patient had low back pain for 4 years with recent exacerbation. The patient also had incidental findings of hypertension and thyroid disease. After six months of treatment with the above-mentioned modalities, articular mobility was restored, muscular spasms were dissolved, and the physiologic and anatomic normality of the spine was restored

Abstract (unknown)

Back Pain

Atha, J., Yeadon, M. R. and Quinnell, R. *Low back configuration changes following osteopathic therapy: a pilot study*. Clinical Biomechanics 1988; 3 197-203 **Located in third floor stacks**

The effects of one session of manipulation by an osteopath on lumbo-sacral configuration were examined on ten out-patients with low back pain. Each patient was measured three times, twice before and once immediately after treatment. In each measurement session the patient executed six forward or six lateral flexions whilst continuous primary, and associated secondary, rotations were recorded using a Coda Scanner. The effects of the treatment were also assessed subjectively by the osteopath and by the patients. Significant treatment effects, not necessarily improvements, were observed in the secondary asymmetry angles of five patients. All four patients judged by the osteopath to have responded to his treatment were found included within these five. Patient evaluations of the effectiveness of treatment in improving movement were not closely related either to the judgments of the osteopath or to the measurements of change.

Abstract from publication

Back pain

Bogduk, N. and Jull, G. *Theoretical pathology of acute locked back: a basis for*

manipulative therapy. Manual Medicine 1985; 1 (3): 78-82 **Located in third floor stacks**

SUMMARY: As an explanation for the pathological basis for acute locked back, meniscus entrapment is a concept that is inconsistent with both the anatomy of zygapophysial menisci and the clinical features of acute locked back. Two alternative explanations that better fit the clinical features are postulated: meniscus entrapment and intradiscal nuclear displacement, both of which are amenable to manipulative therapy.

Abstract from publication

Back Pain

Chrisman, O. D., Mittnacht, A. and Snook, G. A. **Study of the results following rotary manipulation in the lumbar intervertebral disk syndrome.** Journal of Bone and Joint Surgery (American Edition) 1964 Apr; 44-A (3): 517-524 **Located in third floor stacks**

A study of results following rotatory manipulation in the lumbar intervertebral-disc syndrome. Journal of Bone and Joint Surgery 44A(3): 517-524, April 1964. The use of rotatory manipulation was studied in 39 patients with complaints of low back pain with sciatic radiation of pain, and at least one unequivocal objective neurological sign. All patients previous to the trial had received conservative treatment for their last attack. For comparison, twenty-two similar patients who received same conservative care without manipulation were also studied.

Abstract (unknown)

Back Pain

Fisk, J. **1982 Mennell-Travell distinguished lecture: The low back problem.** Manual Medicine 1986; 2 (2): 31-37 **Located in third floor stacks**

In summary, from these observations I think it is reasonable to propose that 1) the fusi motor system, at least in the lumbar spine, is not a segmented system; 2) the joint proprioceptor system from the dorso-lumbar level down can influence the degree of spindle sensitivity as far down as the hamstrings; and 3) that such sensitivity could lead to overload on the lower lumbar spine at a later date, particularly if the individual is programmed to bend with the spine rather than the hips and knees. Tight hamstrings may, therefore, be some of the chicken and some of the egg.

Abstract from publication

Back Pain

Grayson, M. F. **Manipulation in back disorders.** British Medical Journal 1986 Dec 6; 293 (6560): 1481-1482 **Located in third floor stacks**

Manipulation - literally, use of the hands - encompasses a variety of techniques, some of which should really be described as mobilization. This article refers to techniques applying either directly or indirectly a high velocity, small amplitude, straight or rotational thrust to a spinal segment beyond its normal range of movement.

Abstract from publication

Back Pain

Greenman, P. E. **Manual medicine in camptocormia: a case report.** Manual Medicine 1986; 2 (3): 93-95 **Located in third floor stacks**

SUMMARY: Camptocormia is an uncommon disorder characterized by forward flexion deformity of the body and marked restriction of backward bending movement while in the erect position. It has been most commonly reported in male military persons during World Wars I and II. The etiology is usually considered to be a psychological disorder with hysteria. The case reported here is the fifth reported in a female who had specific musculoskeletal dysfunction together with psychological difficulties related to the etiology of an automobile accident.

Abstract from publication

Back Pain

Hoehler, F. K., Tobis, J. S. and Buerger, A. A. ***Spinal manipulation for low back pain.*** Journal of the American Medical Association 1981; 245 (18): 1835-1838 **Located in third floor stacks**

A randomized clinical trial of rotational manipulation was conducted on 95 patients with low back pain selected for (1) the absence of any contraindications for vertebral manipulation, (2) the absence of any psychosocial problems that might affect the outcome of treatment, (3) the absence of any previous experience with manipulative therapy, and (4) the presence of palpatory cues indicating that manipulation might be successful. Patients were randomly assigned to one of two groups: an experimental group receiving manipulation therapy and a control group receiving soft-tissue massage. Comparison of the two groups indicated that (1) patients who received manipulative treatment were much more likely to report immediate relief after the first treatment, and (2) at discharge, there was no significant difference between the two groups because both showed substantial improvement.

Abstract from publication

Back Pain

Kenna, C. and Murtaglia, J. ***Practice tip: low back pain [demonstration].*** Australian Family Physician 1985 Jul; 14 (7): 710 **Located in third floor stacks**

Abstract N/A

Back pain

Kinalski, R., Kuwik, W. and Pietrzak, D. ***Comparison of the results of manual therapy versus physiotherapy methods used in treatment of patients with low back pain syndromes.*** Journal of Manual Medicine 1989; 4 (2): 44-46 **Located in third floor stacks**

SUMMARY: In a group of 111 in- and out- patients with low back pain syndrome treated in a medical rehabilitation department, manual therapy and physiotherapy methods were applied. Information of the erector spinae muscle strength, the Tomayer sign and the degree of pain were collected, analyzed and results were compared. The efficacy of manual therapy in stages I and II of intervertebral lumbar disc disease was confirmed.

Abstract from publication

Back Pain

MacDonald, R. S. ***Osteopathic diagnosis of back pain.*** Manual Medicine 1988; 3 (3): 110-113 **Located in third floor stacks**

SUMMARY: A diagnostic scheme for non-specific back pain is presented. It is consistent with

the osteopathic working hypothesis that most sorts of backache are the result of primary spinal dysfunction arising as a response to abnormal forces imposed on or generated within the musculoskeletal system. The ongoing interactions between the triad of physical stresses, vulnerability of the individual, and musculoskeletal dysfunction are discussed, and it is suggested that these may be more important in determining outcome than factors that can be assessed initially.

Abstract from publication

Back Pain

Mathews, J. A., Mills, J. B. and Jenkins, V. M. ***Low back pain: manipulation effective in some patients [letter; comment]***. Modern Medicine 1988 Dec; 56 (12): 82, 86 **Located in third floor stacks**

Abstract N/A

Back Pain

Mensor, M. C. ***Non-operative treatment including manipulation for lumbar intervertebral disc syndrome***. Journal of Bone and Joint Surgery (American Edition) 1955 Oct; 37-A (5): 925-936 **Located in third floor stacks**

Two decades have elapsed since Mixter and Barr brought to the attention of the medical profession the problem of herniation of the low lumbar intervertebral disc as one of the causes of low-back pain with sciatic radiation. The initial wave of enthusiasm for operative intervention as the specific therapy for the condition has ebbed, and operative intervention has assumed its rightful part in the treatment of the lesion.

Abstract from publication

Back Pain

Potter, G. E. and Cassidy, J. D. ***Diagnosis and manipulative management of post-partum back pain: a case study***. Journal of Manipulative and Physiological Therapeutics 1979 Jun; 2 (2): 99-102 **Located in third floor stacks**

The authors are engaged in the full-time practice of spinal manipulative therapy. In the past four years, many cases of post-partum back pain have been seen, and many of these seem to exhibit isolated sacroiliac fixation. Fixation is defined as loss of or reduced normal movement. Manipulative therapy in appropriate cases often leads to rapid and long lasting relief.

Abstract from publication

Back Pain

Rantanen, P. and Airaksinen, O. ***Poor agreement between so-called sacroiliac joint tests in ankylosing spondylitis patients***. Journal of Manual Medicine 1989; 4 (2): 62-64 **Located in third floor stacks**

SUMMARY: Different methods, which have been proposed to use in the clinical evaluation of sacroiliac joint pathology were compared in 26 patients with radiologically verified sacroilitis and chronic low back pain without any signs of neurological deficits. The Mennell's sign was positive when hip flexor force was diminished ($z=2.48$, $P=0.0064$) as well as sacroiliac joint compression and gapping tests had a close agreement ($\text{kappa-coefficient} = 0.87$). Instead, sacroiliac joint compression - gapping. Mennell's sign - diminished hip flexion force and Patrick's sign had not any interaction

between each other. It is suggested that these tests examine a different anatomical object and further clinical studies are needed before any of these tests can be nominated for sacroiliac joint test.

Abstract from publication

Back Pain

Reynolds, H. M. *Systems anthropometry and stereoradiography of the vertebral column*. Manual Medicine 1984; 2 (1): 43-48 **Located in third floor stacks**

SUMMARY: Clinical radiography of the vertebral column is utilized for investigation of pathology and positional geometry. Stereoradiography, a relatively new technical development, can measure the positional geometry of the skeleton to identify motion restrictions and asymmetry of movement. Research has shown that coupled motions in the vertebral column have a potential role in the diagnosis of low back pain patients. Data are presented to illustrate the complex nature of coupled motions in lumbar flexion and extension.

Abstract from publication

Back Pain

Sandler, S. *Innominate Rotation: fact or fiction*. British Osteopathic Journal 1982; 14 (2): 101-107 **Located in third floor stacks**

INTRODUCTION: I first started thinking about this problem as a third year student, when I found the concept of an innominate bone that had somehow shifted in its position on the sacrum either forward or backwards somewhat difficult a concept to swallow. The sacro-iliac (SI) joint is a deeply contoured joint deeply bound with strong interosseous ligaments, and further more under the influence of gravity, the sacrum is forced down wedged between the two ilia so as to transmit the body weight to the lower extremities. The joint is very difficult to palpate in the normal subject and even more so in the patient as he presents with pain and muscle spasm over surrounding soft tissues, so the idea of being able to accurately palpate one innominate or the other having shifted forwards or backwards by up to approximately ¼ inch or more, I found difficult to digest. In practice though, I found that if I used the diagnostic tests to the best of my ability and then attempted to thrust the said innominate back or forward to restore the "normal" position of the joint - not only did those boney positions appear to change, but the application of the principles over the last few years, I will now attempt to explain why I think we have been guilty of doing the right things, but for the wrong reasons. It is outside the scope of this paper to present a detailed discussion on the anatomy of the sacro-iliac joint. Instead, I have chosen a couple of the more relevant anatomical points that I think cannot be ignored.

Abstract from publication

Back Pain

Shuman, D. *Management of common disorders of the lower part of the back*. DO 1975; 15 (10): 140-142, 145-149 **Located in third floor stacks**

In this article, the author reviews management of back pain. A thorough history, including previous episodes or injuries, should be taken. The physical examination should include palpatory diagnosis, x-ray and leg length measurement. Treatments routines include manipulation, pain relievers, rest and orthopedic appliances, such as crutches, where indicated.

Back Pain

Soliday, H. L. ***Review of low back pain and its treatment in general practice.*** Osteopathic Medicine 1978 Dec; 3 (12): 25-27, 31-33, 36-38 **Located in third floor stacks**

Low back pain has been a persistent problem since man has walked erect. Regardless of whether an individual is a dock worker, a banker, or a housewife, low-back pain (LBP) will be affected at one time or another and can be an irritating one at that. The causes of LBP are as numerous as are the modes of diagnosis and treatment. Differential diagnosis of the lower spine is much more difficult than other orthopedic conditions because of the inaccessibility and the poor correlation between the symptoms and the actual pathologic changes. An attempt will be made to cover a few of these changes and methods of treatment.

Abstract from publication

Back pain

Tennent-Brown, W. ***Induced pain referral.*** British Osteopathic Journal 1982; 14 (1): 24-27 **Located in third floor stacks**

ABSTRACT: Patterns of pain referral induced from the posterior lumbar elements have been studied in normal volunteer subjects in an effort to clarify where pain is experienced when it is generated from facet joints, and how it differs from pain that emanates from the surrounding tissues. Thus the study had a two-fold purpose defined as: 1. to trace the exact area of pain referral from the lower and upper lumbar apophyseal joints. 2. to make a strict comparison of the distribution and intensity of pain experienced with intra-articular and pericapsular provocation.

Abstract from publication

Back Pain; Diagnosis

Greenman, P. E. and Tait, B. ***Structural diagnosis in chronic low back pain.*** Manual Medicine 1988; 3 (3): 114-117 **Located in third floor stacks**

SUMMARY: Chronic low back pain continues to present diagnostic and therapeutic challenges to the health care delivery system. The incidence of biomechanical dysfunction in 23 chronic low back pain patients was evaluated retrospectively. It was concluded that certain dysfunctions were noted frequently. It is suggested that evaluation for these dysfunctions might be of assistance in the diagnosis of these patients. Therapeutic efficacy of manual medicine procedures was not addressed in this study but needs to be considered.

Abstract from publication

Back pain; Leg

Potter, G. E. ***Diagnostic clinical trial.*** Journal of Manual Medicine 1989; 4 (1): 31 **Located in third floor stacks**

Case report of a 61 year-old male who complained of low back pain and leg pain.

Back pain; Manipulation Techniques

Brodin, H. ***Inhibition - facilitation technique for lumbar pain treatment.*** Manual Medicine 1987; 3 (1): 24-26 **Located in third floor stacks**

SUMMARY: The effect of a modified Mitchell's muscle energy technique was studied. 41 patients with pain from one or two lumbar segments with reduced mobility were organized in one

treated group and in one non-treated control group. Every week all patients reported their pain level at rest and during activity according to a 9-graded scale. After treatment for three weeks the pain reduction in the treated group was statistically greater than in the non-treated group. The mobility of the lumbar spine increased among those with reduced pain.

Abstract from publication

Back Pain; Manipulation Techniques; Posture; Research

Oostendorp, R. A. B. *Preliminary report on the use of the proprioceptive facilitating method versus the Williams method in the treatment of patients with non-specific low back pain*. Manual Medicine 1988; 3 (3): 106-109 **Located in third floor stacks**

SUMMARY: The purpose of this study was to examine the difference between the proprioceptive facilitating method (PFT) versus the Williams method (WT) in the treatment of patients with non-specific low back pain. Twenty patients were selected and divided into two groups at random. The scores on the items "pain" (visual analogue scale), "ecological reactions" (5-point scale) and "comfortable sitting and standing time" (in minutes) were checked to see whether the differences for the measurements before and after treatment were statistically significant ($p=0.05$: Student's t-test). The results of this study demonstrate that the PFT gives significantly better short-term results than WT. A supplementary study will be necessary to determine the long-term results. The results are discussed.

Abstract from publication

Back pain; Musculoskeletal System

Stodolny, J. and Mazur, T. *Effect of post-isometric relaxation exercises on the ilio-psoas muscles in patients with lumbar discopathy*. Journal of Manual Medicine 1989; 4 (2): 52-54 **Located in third floor stacks**

SUMMARY: In the pathology of degenerative disease of the intervertebral disc, muscle disorders play a very important role. In particular, contractures of ilio-psoas muscles play a significant role in lumbar disc disease. Kinesiotherapeutical programs, generally used in low back pains on the background of discopathy, do not respect this fact. Examinations in 80 patients, having low back pain on the background of lumbar discopathy were made and contractures of ilio-psoas muscles were exhibited in all the patients. Those patients were divided into two groups by random. In the one group the generally applied kinesiotherapeutical program was used, in the other this program was supplemented by post-isometrical relaxation exercise of ilio-psoas muscles. Using the post-isometrical relaxation exercises of the muscles appreciably influenced a reduction of contractures of the ilio-psoas muscles.

Abstract from publication

Back Pain; Musculoskeletal System; Somatic dysfunction

MacDonald, R. S. *Primary dysfunction of the spine*. Holistic Medicine 1988; 3 (1): 27-33 **Located in third floor stacks**

SUMMARY: Investigations of back pain have mainly sought a causative structural pathology: for most presentations this search has failed. It is suggested that the possibility of primary spinal dysfunction producing pain has been unreasonably neglected, and that more priority should be given to studies capable of revealing such dysfunction.

Abstract from publication

Back Pain; Sacrum

Greenman, P. E. *Innominate shear dysfunction in the sacroiliac syndrome*. Manual Medicine 1986; 2 (4): 114-121 **Located in third floor stacks**

Recently there has been an increased interest in the sacroiliac syndrome. There appear to be multiple variations to be found in dysfunctions of the sacroiliac joints. Unilateral alteration in the opposition of the joint surface of the innominate in relation to the sacrum in both a cephalic and caudal direction seem to be possible. Clinical evidence supports a superior innominate shear (upslip innominate) and an inferior innominate shear (downslip innominate). The anatomy of sacroiliac joint is reviewed as well as the current understanding of sacroiliac joint motion. Diagnostic criteria and therapeutic interventions for both superior and inferior innominate shears are presented. Results of a series of 12 cases superior innominate shear and 4 cases of inferior innominate shear are provided.

Abstract from publication

Back pain; Sclerotherapy

Bourdeau, Y. *Five-year follow-up on sclerotherapy / prolotherapy for low back pain*. Manual Medicine 1988; 3 (4): 155-157 **Located in third floor stacks**

SUMMARY: The aim of this retrospective study is to evaluate the efficacy of sclerotherapy as one of the modalities used in an orthopedic medicine practice to treat low back problems. A special attempt will be made to shed some light on the length of time the beneficial effects of this treatment modality lasts. A review of 43 patients, all referred by their family physicians, who presented with low back pain in 1982 was carried out with the help of a questionnaire sent to them in 1987. Out of the 24 who responded, 17 were considered to have had very good to excellent results. This study emphasizes the long-term beneficial effect of sclerotherapy, especially for chronic low back pain.

Abstract from publication

Back Pain; Somatic dysfunction

Kidd, R. *Pain localization with the innominate upslip dysfunction*. Manual Medicine 1988; 3 (3): 103-105 **Located in third floor stacks**

SUMMARY: All adult patients in a private orthopedic medical practice were screened for innominate upslips over a period of two years. Sixty-three were found, of which all presented with pain. With treatment, correction of the upslip was associated with an improvement or disappearance of pain. In those with upslips, pain was often felt in more than one area and at levels of the body remote from the sacroiliac joint. Also, the association of the upslips with the side of the body in which the pain was felt was essentially random. These findings raise questions as to how pain is produced with innominate upslips.

Abstract from publication

Back Pain; Thoracic Outlet Syndrome

Kenna, C. and Murtagh, J. *Practice Tip: Upper thoracic back pain [demonstration]*. American Family Physician 1985 Jun; 14 (6): 583 **Located in third floor stacks**

Abstract N/A

Brachial plexus

Kettelkamp, D. B. and Alexander, H. ***Clinical review of radial nerve injury.*** Journal of Trauma 1967 May; 7 (3): 424-432 **Located in third floor stacks**

CONCLUSIONS: Thirty-three radial nerve injuries associated with fractures of the humerus have been presented. Our cases confirm the opinions of Bohler, Crenshaw and others that early exploration primarily to establish the status of the radial nerve is rarely indicated. We believe that the method of treatment should be individualized depending on the patient's condition, other injuries, and status of the humeral fracture in an effort to obtain the maximum total function. Exploration of the radial nerve is rarely indicated in incomplete and delayed complete lesions. On the other hand, when there is a nerve injury, exploration of the radial nerve should be part of the operative treatment of the fracture. Exploration of the nerve may be necessary if there is no return of function after eight to 12 weeks, and preferably after the fracture has united. The hand and wrist should be splinted to avoid contractures from the time of injury until there is return of function or tendon transfer is done. Tendon transfer can be expected to give useful function in patients with no recovery. Ten cases of radial nerve injury of miscellaneous etiology have been presented. There were insufficient cases in each group to draw conclusions.

Abstract from publication

Child

Greenhouse, M. N. ***Neonatal asphyxia.*** Journal of the American Osteopathic Association 1949 Jul; 48 (11): 588-591 **Located in third floor stacks**

INTRODUCTION: By definition asphyxia indicates a lack of oxygen and increased carbon dioxide tension in the blood and tissues, while anoxia indicates a lack of oxygen. The term "neonatal asphyxia" is a time-honored and well-established misnomer. A far better term is "neonatal apnea." However, the former term, because of common and long-standing usage, is accepted and understood.

Abstract from publication

Child

Leatherwood, J. L. ***Battered-child syndrome: report of a case and review of the literature.*** DO 1978 Feb; 18 (6): 95, 98-102 **Located in third floor stacks**

SUMMARY: The battered child syndrome has been identified as a medical entity since 1962, although child abuse has been a social problem since society began. The physician must be thoroughly familiar with its etiology, pathology, epidemiology, and treatment, so he can help both the innocent victim and the abusing parent. Many private physicians find it difficult to report cases of suspected abuse to authorities, since they are trained to view the physician-patient relation as sacred. Also, a physician may be concerned over the possibility that he will frighten the parents of other battered children, so they will not bring them to him for medical care. These issues notwithstanding, it is in the best interest of the patient for the physician to involve the community in this social problem.

Abstract from

Child

Purse, F. M. ***Recent advances in the treatment of diarrhea of infancy.*** Journal of the American Osteopathic Association 1949; 48 (9): 469-472 **Located in third floor stacks**

Today a great deal more is known about the management of diarrhea; during the past few

years many articles on this subject have appeared in the literature. However, most of these are far beyond the scope of the average busy practitioner who sees most of his cases in the home and is without the benefit of elaborate laboratory facilities. The information presented in this paper will be of use to the general practitioner and the tyro in pediatrics, as well as the pediatrician.

Abstract from publication

Child

Rosen, H. and Sahu, S. ***Interview: the general practitioner and the neonatologist.*** Osteopathic Medicine 1977 Oct; 2 (10): 59-61 **Located in third floor stacks**

This article is an open dialogue that helps to clarify and define some concepts in neonatology / perinatology that may be of interest to the general practitioner.

Abstract from publication

Child; Ear, Nose & Throat

Nowinski, L. J. ***Hearing loss in children.*** Osteopathic Medicine 1976 Aug; 1 (2): 41-48 **Located in third floor stacks**

INTRODUCTION: This article will discuss the incidence of hearing loss in children, some of the difficulties that testing young children or infants presents, and some diagnostic techniques the physician can employ. Hearing loss, especially in children, is quite common. As a matter of fact, according to most studies, severe to profound hearing loss occurs as frequently as once in 1,000 births. Obviously, this identifies a large group of children - and this ration includes only the more serious or profound hearing losses.

Abstract from publication

Child; Hip

Coleman, S. S. ***When a child is born with hip problems.*** Patient Care 1983 Aug 15; 17 (14): 68-90 **Located in third floor stacks**

Review article on congenital dislocated hip. The article includes etiology, diagnosis, and management.

Child; Knee; Musculoskeletal System

Sweeting, R. C., Fowler, C. and Crocker, B. ***Anterior knee pain and spinal dysfunction in adolescence.*** Journal of Manual Medicine 1989; 4 (2): 65-68 **Located in third floor stacks**

SUMMARY: The underlying etiology of anterior knee pain is frequently not known, particularly in the adolescent. A review of 260 patients presenting with knee pain in a general orthopedic practice revealed 16 cases (6% of the total) as having similar clinical features with peripheral muscle weakness associated with segmental spinal dysfunction. This syndrome would appear to be as frequent as patellofemoral instability (15 cases). A treatment protocol is outlined which significantly improves the functioning of these patients, subjectively with reduction of complaints of pain and objectively with increase in muscle power as documented by testing with the Kin-Com as well as clinical by examination.

Abstract from publication

Child; Learning Disorders; Somatic dysfunction

Chandler, J. E. E. *Minimal brain dysfunction: some preliminary findings*. British Osteopathic Journal 1983; 15 (1): 7-14 **Located in third floor stacks**

SUMMARY: This speculative study represents an attempt to reappraise the characteristics of minimal brain dysfunction (MBD), recalling symptom patterns and recording palpatory findings in a sample of twelve children affected by the syndrome. A high proportion are found to exhibit certain abnormal characteristics as regards involuntary movements; common findings including: the cranium held in side-bending/rotation; rapid primary respiratory rate; parietal dysfunction; lack of extension cranially and unilateral resistance to shearing of the vault of the skull. It is suggested that MBD is the result of an organic brain lesion, which may be localized in the region of the angular gyrus.

Abstract from publication

Child; OB-GYN; Shoulder

Hibbard, L. T. *Coping with shoulder dystocia*. Contemporary OB/GYN 1982 Sep; 20 (NA): 229-231, 234-235, 237 **Located in Reference Office**

Skillful manipulation of trapped shoulders can prevent radical procedures and unnecessary complications. Here are descriptive, step-by-step methods for meeting this problem.

Abstract from publication

Child; Psychiatry

Melhado, J. *Battered and abused child*. Osteopathic Medicine 1976 Aug; 1 (2): 81-88 **Located in third floor stacks**

This paper will explore the following aspects of child abuse: (1) Definition of the term "abused child" and delineation of the varieties of abuse (2) The estimated incidence of child abuse (3) The responsibilities of the physician, including those directed by law, to the abused child (4) Examination of the reported social and psychological patterns of the child abuser and the home environment (5) The psychological effects of the abused child (6) Methods of treatment which have been reported.

Abstract from publication

Child; Substance Abuse

Brewer, L. G. *Children of alcoholics*. Osteopathic Medicine 1977 Dec; 2 (12): 99-106 **Located in third floor stacks**

INTRODUCTION: Our osteopathic concept has always been a holistic approach to the patient and his problems. With this approach has come the ready acceptance of the principle that illness in one member of the family affects the mental and physical health of the other family members. Alcoholism is a disease which affects not only the alcoholic but the entire family. Spouses of alcoholics have long been encouraged to participate in treatment, but the recognition of the fact that alcoholism in a parent severely affects the children of alcoholics has often been overlooked.

Abstract from publication

Chronic Obstructive Pulmonary Disease

Stiles, E. G. *Manipulation: chronic obstructive lung disease*. Osteopathic Medicine 1976 Nov; 1 (5): 60-61, 115 **Located in third floor stacks**

Good medical care should be afforded the patient with chronic obstructive lung disease. This article gives an osteopathic rationale for how we as D.O.'s can provide the patient with an additional management regimen. A patient with chronic obstructive lung disease has a basic problem of decreased efficiency of ventilation. The patient may also have symptoms of chronic cough, dyspnea, and difficulty raising sputum. The clinical findings consist of the chest being held in fixed inspiration, thus producing a barrel type chest. It is extremely important to provide specific manipulative care to try to reestablish more normal physiological motion of the rib cage, attempting to assist the patient to exhale more efficiently and thus assist the pulmonary recoil characteristics still present. Overall, manipulative therapy can secondarily decrease the energy demands on the patient due to impaired ventilation and increased utilization of the respiratory muscles. The author continues his focus specifically on the following anatomical regions: lower six ribs, diaphragm, upper thoracics, and cervical areas. The clinical experience of the author at Waterville Osteopathic Hospital suggest that well designed and regularly administered manipulative care, in addition to good medical care, can show a decrease in the amount of medications required, a decrease in the utilization of antibiotics during the winter months, and a decrease in the incidence of hospitalization once the musculoskeletal component of a patient's problem is treated.

Student abstract by Lindsay McBride (April 28, 2004)

Cranial Manipulation

Kappler, R. E. *Osteopathy in the cranial field: its history, scientific basis, and current status*. OP. The Osteopathic Physician 1979; 46 (2): 13-18 **Located in third floor stacks**

This article deals with the development of the cranial concepts in Osteopathy. The major belief of the author is that the student should have exposure to the cranial rhythmic impulse in order to understand the mechanism that is occurring in the body. The article also deals with some of the history behind William Sutherland in his pursuits in the cranial movement and the different organizations that were formed due to this belief. There were many skeptics in the cranial field as well as many physicians who had ingrained a direct technique approach. The direct technique is useless due to the cranial defense mechanism for high velocity low amplitude procedures. Some other contributors to the cranial field include Becker and Upledger with their studies on cranial rhythmic impulses.

Abstract (unknown)

Cranial Manipulation

Morey, L. W. J. *Uses of cranial manipulative therapy*. Osteopathic Medicine 1978 Jul; 3 (7): 43-44, 49-50, 52 **Located in third floor stacks**

Osteopathic manipulation of the cranium is a treatment modality employed to address both local somatic dysfunction of the cranium as well as systemic disorders. The author reviews the historical foundations and evolution of the cranial concept and explores its applications in the primary care setting. Three formal case presentations demonstrate patient response to cranial manipulation for the treatment of chronic headache, new onset headaches following parturition, as well as the reduction epileptic seizure activity. The author also includes anecdotal case material pertaining to cranial manipulation and the treatment of tinnitus, vertigo, amblyopia, diplopia, sinusitis, tic doloreux, hydrocephalus, pituitary dysfunction, child hyperactivity, personality change secondary to head trauma, blunted affect and depression.

Abstract from publication

Craniosacral

Dove, C. I. ***Orgin and development of cranio-sacral osteopathy.*** Holistic Medicine 1988; 3 (NA): 35-45 **Located in third floor stacks**

Craniosacral osteopathy is a controversial extension of contemporary osteopathic practice. It emerged in the USA in the 1940's, having taken the founder, William G. Sutherland (a student of A.T. Still) some 30 years to develop. Craniosacral osteopathy rests on an hypothesis which includes a rhythmic, although minute, pulsation of the central nervous system which causes a fluctuation of the cerebrospinal fluid, and which in turn moves the reduplications of the dura mater to produce small degrees of motion at the cranial sutures and influences the sacrum between the ilia. It is claimed that dysfunction of this mechanism can lead to widespread symptomatic sequelae. The mechanism appears to be especially vulnerable to trauma, particularly birth trauma, and certain infections. The techniques used to modify the function of this involuntary mechanism, which Sutherland called the primary respiratory mechanism, are very gentle. Research has tended to lend color to Sutherland's hypothesis rather than the reverse, and this body of research is discussed. Paradoxically, more research has been done in this area than in conventional osteopathy.

Abstract from publication

Craniosacral

Schulman, E. A. and Togli, J. U. ***Categorizing the causes of chraniofacial pain.*** Diagnosis 1983 Jun; 5 (6): 26-32 **Located in third floor stacks**

The intensity and distribution are significant factors that distinguish neuralgias from vascular diseaess, jaw problems, and a host of other causes.

Abstract from publication

Diabetes

Moren-Hybbinett, I., Moritz, U., Herrlin, K. and Schersten, B. ***Management of the painful diabetic shoulder.*** Manual Medicine 1987; 3 (2): 49-53 **Located in third floor stacks**

X-ray findings and response to treatment were studied in diabetic patients with moderate and severe shoulder symptoms. X-rays of the shoulder joint in 40 patients were normal in 43%, calcifications were found in 28%. Degeneration of the acromioclavicular and humeroscapular joints and osteopenia were present in smaller numbers. Physiotherapeutic treatment could not relieve pain or increase mobility in painful shoulders with restricted mobility.

Abstract from publication

Diagnosis

Jirout, J. ***Comments regarding the diagnosis and treatment of dysfunctions in the C2 - C3 segment.*** Manual Medicine 1985; 2 (1): 16-17 **Located in third floor stacks**

The examination of the rotational movement at the C2-C3 segment may lead to the detection of rotational active restriction when forced maximal inclination is introduced to the atlanto-occipital junction. The examination procedure is described. On the basis of experience with 200 patients, the symptoms, signs and results of manual treatment of this clinical syndrome are discussed.

Abstract from publication

Diagnosis; Back Pain

Greenman, P. E. and Tait, B. ***Structural diagnosis in chronic low back pain.*** Manual

Medicine 1988; 3 (3): 114-117 **Located in third floor stacks**

SUMMARY: Chronic low back pain continues to present diagnostic and therapeutic challenges to the health care delivery system. The incidence of biomechanical dysfunction in 23 chronic low back pain patients was evaluated retrospectively. It was concluded that certain dysfunctions were noted frequently. It is suggested that evaluation for these dysfunctions might be of assistance in the diagnosis of these patients. Therapeutic efficacy of manual medicine procedures was not addressed in this study but needs to be considered.

Abstract from publication

Ear, Nose & Throat

Bush, L. M. *Elimination of surgery of ear, nose and throat*. Journal of the American Osteopathic Association 1926 Jun; 25 (9): 854-856 **Located in third floor stacks**

There is only one reasonable excuse for surgery in any part of the body: it is where a part of the body has become so diseased or deranged as to be a menace to the life or function of the whole body and where there is no other means of restoring the part to normal. I am not speaking theoretically when I make the statement that surgery of the ear, nose and throat is absolutely unnecessary except in very rare instances, if one properly understands the osteopathic treatment of diseases of this section of the body. Of course this proper understanding practically necessitates that a doctor devote his entire time to this specialty, as one cannot perfect the technic or acquire the necessary judgment in the many varying ailments without a great deal of practice and study. It is also necessary that one have a sincere desire to conserve potentially healthy tissue wherever possible.

Abstract from publication

Ear, Nose & Throat; Child

Nowinski, L. J. *Hearing loss in children*. Osteopathic Medicine 1976 Aug; 1 (2): 41-48 **Located in third floor stacks**

INTRODUCTION: This article will discuss the incidence of hearing loss in children, some of the difficulties that testing young children or infants presents, and some diagnostic techniques the physician can employ. Hearing loss, especially in children, is quite common. As a matter of fact, according to most studies, severe to profound hearing loss occurs as frequently as once in 1,000 births. Obviously, this identifies a large group of children - and this ration includes only the more serious or profound hearing losses.

Abstract from publication

Education

Anonymous. *AOA moves toward change for post-graduate training [news]*. Physicians Management 1988 Sep; 28 (9): 11 **Located in third floor stacks**

Abstract N/A

Education; Philosophy

Korr, I. M., et.al. *Design of the medical curriculum in relation to the health needs of the nation: a statement of the educational goals of the Texas College of Osteopathic Medicine, Fort Worth, Texas [pamphlet]*. NA 1980; NA (NA): 1-16 **Located in reference office**

Fascia

Hitchcock, M. E. *Myofascial considerations in the thoracic area*. Osteopathic Medicine 1978 Dec; 3 (12): 85-94 **Located in third floor stacks**

The importance of the body's soft tissues has become more widely recognized in recent years. Along with this comes better understanding of their functions in maintaining normal physical and chemical status. The object of osteopathic care in treating mechanical dysfunction or infection is to remove the sources of somatic disturbances that interfere with those communications that are part of the control and regulation of homeostasis. "A patient's condition can be improved by modifying or deleting an excessive reaction on the musculoskeletal system especially when such a reaction is related to the same levels of the central nervous system that supply innervations to the area of pathophysiologic disturbance."

Abstract from publication

Fascia; Fibromyalgia; Musculoskeletal System; Manipulation Techniques

Simons, D. G. *Myofascial pain syndromes due to trigger points: 2. Treatment and single-muscle syndromes*. Manual Medicine 1985; 1 (3): 72-77 **Located in third floor stacks**

SUMMARY: This is the conclusion of a two-part communication. Treatment of a single-muscle myofascial pain syndrome in a patient who is free of perpetuating factors can be refreshingly easy and the response dramatic. A progressive multi-muscle syndrome with multiple perpetuating factors can be frustratingly difficult. Three treatment methods are summarized: stretch and spray, Lewit's post-isometric relaxation, and trigger-point (TP) injection followed by active range of motion. Other techniques include ischemic compression, hot packs and massage, electrical stimulation at the trigger point, and massage, electrical stimulation at the trigger point, and ultrasound applied to the trigger point area. The goal is relief of pain that occurs with release of the increased tension of the taut muscle fibers. This restores full normal stretch range of motion of the muscle. However, pain relief obtained by these methods does not rule out serious visceral disease, especially in the case of chest or abdominal pain. Examples of common myofascial pain syndromes presented here include: the sternocleidomastoid muscles - headache; the infraspinatus muscle - shoulder pain; the scalene muscles - chest, upper back and upper extremity pain; the supinator muscle - tennis elbow; the quadratus lumborum muscle - low back pain; the gluteus minimus - "sciatica" ' and the soleus muscle - heel pain.

Abstract from publication

Fibromyalgia; Musculoskeletal System; Fascia;

Simons, D. G. *Myofascial pain syndromes due to trigger points: 1. Principles, diagnosis, and perpetuating factors*. Manual Medicine 1985; 1 (3): 67-71 **Located in third floor stacks**

SUMMARY: This is the first of a two-part communication on myofascial pain syndromes. Myofascial pain syndromes are commonly overlooked or misunderstood. They arise from trigger points in a muscle and/or its associated fascia. A trigger point (TP) is a hyperirritable spot that, for each muscle of the body, refers pain in a characteristic pattern. The referred pain is rarely located where its trigger point is found, but is usually projected to a distance. The pattern (distribution) of this referred pain is the key to locating a trigger point. Additional subjective findings that help distinguish a trigger point are 1) history of muscular strain at the onset of pain, 2) reproducible, exquisite point tenderness that causes a "jump sign" of the patient, and 3) reproduction of the referred pain pattern

by gentle steady pressure on the trigger point. More objective indicators are breakaway weakness of involved muscles and reduced range of motion due to tightness and pain whenever that involved muscle is passively or actively stretched. Completely objective findings that are diagnostic of a myofascial trigger point are 1) a palpable band of taut muscle fibers that contain the trigger point and 2) a local twitch response just of palpable band fibers elicited by snapping palpation of the trigger point. The initiating stress and the perpetuating factor, or factors, are usually different. When patients realize only temporary relief from specific myofascial treatment, perpetuating factors are frequently responsible. When present, the latter must be resolved and then the active trigger points inactivated for lasting relief. Mechanical perpetuating factors include muscular stresses such as those imposed by a short leg, a small hemipelvis, or short upper arms. Nutritional perpetuating factors, e.g. vitamin inadequacies, and the medical problems of hypometabolism and chronic infection may be critically important.

Abstract in publication

Fibromyalgia; Musculoskeletal System; Manipulation Techniques; Fascia

Simons, D. G. ***Myofascial pain syndromes due to trigger points: 2. Treatment and single-muscle syndromes.*** Manual Medicine 1985; 1 (3): 72-77 **Located in third floor stacks**

SUMMARY: This is the conclusion of a two-part communication. Treatment of a single-muscle myofascial pain syndrome in a patient who is free of perpetuating factors can be refreshingly easy and the response dramatic. A progressive multi-muscle syndrome with multiple perpetuating factors can be frustratingly difficult. Three treatment methods are summarized: stretch and spray, Lewit's post-isometric relaxation, and trigger-point (TP) injection followed by active range of motion. Other techniques include ischemic compression, hot packs and massage, electrical stimulation at the trigger point, and massage, electrical stimulation at the trigger point, and ultrasound applied to the trigger point area. The goal is relief of pain that occurs with release of the increased tension of the taut muscle fibers. This restores full normal stretch range of motion of the muscle. However, pain relief obtained by these methods does not rule out serious visceral disease, especially in the case of chest or abdominal pain. Examples of common myofascial pain syndromes presented here include: the sternocleidomastoid muscles - headache; the infraspinatus muscle - shoulder pain; the scalene muscles - chest, upper back and upper extremity pain; the supinator muscle - tennis elbow; the quadratus lumborum muscle - low back pain; the gluteus minimus - "sciatica" ' and the soleus muscle - heel pain.

Abstract from publication

Foot

Mrstik, L. L., Heleotis, C. H., Leonard, J. P. and Wood, J. P. ***Three-year survey of treatment of congenital talipes equinovarus at Detroit Osteopathic Hospital.*** Journal of the American Osteopathic Association 1987 May; 56 (9): 583-585 **Located in third floor stacks**

INTRODUCTION: Congenital talipes equinovarus is the most frequent of all the deformities of the foot. It is seen approximately once in every thousand births. The term 'talipes' denotes deformity of a foot; 'equinus' means plantar flexion; and 'varus' means inversion.

Abstract from publication

Foot

Norfolk, D. F. and Burton, A. K. ***Achilles tendonitis - a reasoned approach.*** British Osteopathic Journal 1983; 15 (1): 61-64 **Located in third floor stacks**

INTRODUCTION: The increase in the popularity of running as a sport or pastime may be expected to increase the incidence of runner's problems presenting to practitioners in physical medicine. An American survey of 232 patients attending a special runners clinic revealed that 29% presented with knee pain, 13% with posterior tibial compartment syndrome and 11% with Achilles tendon disorders. The purpose of this paper is to provide a short reasoned approach to the etiology and management of Achilles tendonitis (AT), with the emphasis on the multi-disciplinary aspects of both.

Abstract from publication

Gastrointestinal diseases

Axelrod, J. L. *Inflammatory bowel disease*. Osteopathic Medicine 1979 May; 4 (5): 21-30

Located in third floor stacks

SUMMARY: This case is presented to demonstrate the difficulty that sometimes occurs in differentiating between mucosal ulcerative colitis and Crohn's disease and also demonstrates how the diagnosis can be more readily obtained at an earlier time. It is problematic as to whether or not medical therapy could have been successful to avoid surgical intervention at a later date. Historically, about 50% of the patients with ileitis ultimately have a surgical procedure and recurrence after small bowel surgery ranges from 85% to 100%.

Abstract from publication

Gastrointestinal Diseases

Burns, L. *Osteopathic pathology of the stomach*. Journal of the American Osteopathic Association 1933; 33 (3): 111-112 **Located in third floor stacks**

INTRODUCTION: The diseases of the stomach which are due to infections, neoplasms, deformities and certain other abnormal conditions are described in ordinary textbooks on pathology, as nearly accurately as our present knowledge permits. The disease of the stomach due to certain circulatory disturbances and to abnormal structural relations of vertebrae, ribs and soft tissues are described only in osteopathic literature. Human case reports have been published and these are of great osteopathic interest. Studies made of experimental animals and of animals and clinic patients with accidental vertebral lesions have been reported for the laboratories of The A.T. Still Research Institute, and by C.P. McConnell, W.J. Deason, both colleges of osteopathy in Kirksville, and the Pacific College of Osteopathy in Los Angeles.

Abstract from publication

Gastrointestinal Diseases

Burns, L. *Vertebral lesions and gastric ulcers*. Journal of the American Osteopathic Association 1928 Nov; 28 (3): 187-189 **Located in third floor stacks**

This article admits there are many potential causes of gastric ulcers, but these are too often nebulous and poorly substantiated clinically. This researcher hypothesizes a positive correlation between thoracic vertebral lesions and the subsequent development of gastric ulcers. Guinea Pigs and rabbits were used as experimental subjects for this study. The subjects were born healthy, subsequently given variable thoracic lesions, and observed until their death, usually about a year post-injury. Post-mortem gastric mucosal histologic analysis was employed to determine presence of pathology, and to measure chemical composition of gastric secretions. The researchers noted that gastric ulcers, when present, were invariably accompanied by either a primary or secondary lesion involving the fifth, with or without the sixth, thoracic vertebra. Ninety-six human gastric analyses were

performed in the preparation of this paper, in an attempt to correlate gastric acid content with a particular disease process. This paper stated more human subjects were needed before a reasonable conclusion could be drawn from these human data.

Student abstract by John Drexler (March 31, 2004)

Gastrointestinal Diseases

Burns, L., Vollbrecht, W. J. and Stillman, C. ***Gastric changes immediately following certain vertebral lesions.*** Journal of the American Osteopathic Association 1928 May; 27 (9): 681-685
Located in third floor stacks

Osteopathic practitioners have often noticed the fact that gastric symptoms often follow traumatic lesions of the fifth to the seventh thoracic vertebrae very quickly. Vomiting is one of the frequent immediate symptoms, and this is often followed by frequent attacks of nausea and vomiting for as long a time as the lesion persists. Gastric discomfort and the various symptoms called "dyspepsia" often date from such a lesion and the patient may remember the occurrence distinctly. When such a lesion is produced by the long-continued action of some force other than trauma, the patient is not apt to realize that fact and the lesions are found only on examination. During the years 1904 -1914 some experimental work was done in the laboratory of physiology of the Pacific College of Osteopathy and reports of this work were published in the Journal of the American Osteopathic Association and in "Basic Principles" and "Nerve Centers" during these years. The findings may be summarized very briefly.

Abstract from publication

Gastrointestinal diseases

Hinders, A. ***Inflammatory bowel disease: a case report.*** DO 1978 Jun; 18 (10): 93-97
Located in third floor stacks

In the article, the case report of a 39-year-old white female is reviewed. Symptoms included diarrhea, weight loss and abdominal cramping. She had previously been diagnosed with Crohn's disease. Physical examination revealed abdominal distention, tympany, and general tenderness without palpable masses. X-ray revealed gross distention of the large intestine. When symptoms did not respond to treatment, a limited resection of the right colon and an ileocolostomy were performed. Later, the patient required a subtotal colectomy and ileostomy and responded well for about six months at which time she began having a bloody discharge from the anus. Conservative treatment failed to resolve the symptoms and an abdominal perineal resection was performed. At the time of the writing, the patient had recovered and returned to her everyday activities.

Gastrointestinal diseases

James, D. ***New look at surgery for Crohn's disease.*** Osteopathic Medicine 1977 Sep; 2 (9): 41-48
Located in third floor stacks

SUMMARY: Comparison of the findings in several large investigations now enables the results of surgery for transmural enteritis (TME) to be outlined in general terms. Early postoperative mortality is between 3% and 5%. This is the most emphatic feature of the surgical results. In the early postoperative course, the patient with TME is particularly liable to suffer from infective complications of fluid and electrolyte imbalance. Late mortality is low, and the chief cause of death is malnutrition in instances of very low extensive disease. Recurrence rate and reoperation rate-about one-third of all cases-are closely related. There may be more than one type of recurrence, and the later the recurrence develops after primary surgery, the better the prognosis. The symptomatic course of the

disease is more favorable after surgery than conservative management alone. Most patients, approximately 80% to 90%, are satisfied with their surgical outcome. The role of surgery is not to cure the patient, but to significantly relieve the patient symptomatically. Since no such claim can be made with conservative treatment, surgery will probably continue to play an active part in the management of this puzzling disease.

Abstract from publication

Gastrointestinal Diseases

Mattern, A. V. ***Gastro-duodenal ulcer and its non-surgical treatment.*** Journal of the American Osteopathic Association 1934; 33 (5): 188-191 **Located in third floor stacks**

SUMMARY: I believe that the osteopathic lesion plays an important role in the production and maintenance of peptic ulcer; that in a picked group of cases excellent results can be obtained by hygienic, dietetic and manipulative measures; that treatment should be long continued, the patient being kept under observation and control for two years at least; and that clinical proof of healing should be supplemented by x-ray findings and relief of spinal lesions.

Abstract from publication

Gastrointestinal Diseases

Stiles, E. G. ***Osteopathic approach to peptic ulcer disease.*** Osteopathic Medicine 1977 Jul; 2 (7): 57,61-62 **Located in third floor stacks**

In this paper, the importance of evaluating the musculoskeletal system as it relates to visceral pathology is highlighted by a discussion of peptic ulcer disease (PUD), the GI tract, and its ANS innervation. Peptic ulcer disease is defined as ulcers caused directly or indirectly by active gastric juice that contains acid and pepsin. Gastric secretion is caused by increase in the parasympathetic systems, which also stimulates motility. The sympathetic system acts to decrease acid secretion and motility. An evaluation of the musculoskeletal system should include the middorsal area, the atlanto-occipital and cervical areas since these are directly connect to the sympathetic and parasympathetic systems respectively. This article also emphasis the impact that dysfunctions in the lumbar, pelvis, and lower extremities have on the disease process. As impairment in the lymphatic systems could hinder the healing process, the thoracic cage, as well as the diaphragm, need to be addressed. In conclusion, proper medical care for the PUD patient includes diet, antacids, anticholinergics, and OMT considerations.

Student abstract by Elizabeth Wilfong (March 31, 2004)

Gastrointestinal diseases

Tweed, L. ***Changes in the gastric juice due to vertebral lesion.*** Journal of the American Osteopathic Association 1931 Nov; 31 (3): 83-85 **Located in third floor stacks**

In this article, the author reports research findings on vertebral lesion effects upon the acidity of the gastric juice.

Headache

Eedy, C. ***Osteopathic management of head pain.*** Journal of Alternative and Complementary Medicine 1987 Nov; 5 (11): 19-21 **Located in third floor stacks**

INTRODUCTION: In this paper I have attempted to present a comparison of standard medical

and osteopathic diagnosis and techniques, including some methods of pain control which I consider to fit in with the osteopathic concept of whole-person treatment. As there is considerable overlap between the field of standard medical treatment and osteopathy, I am in favor of osteopathic methods before the use of drugs or surgery, unless urgent medical attention is needed.

Abstract from publication

Headache

Lately, P. J. B. ***Attentive osteopath and migraine***. British Osteopathic Journal 1982; 14 (1): 51-55 **Located in third floor stacks**

INTRODUCTION: The adult migraine sufferer will rarely attain a complete and lasting cure from their distress if they are unable or unwilling to sustain, and help to conduct, a wide-ranging investigation of themselves. We, as practitioners, are able to add our own expertise, experience and support to that process. If, in addition to this, we have developed and studied techniques able to facilitate the patients efforts, insoluble migraine problems become rare.

Abstract from publication

Headache

Schmidt, I. C. ***Osteopathic manipulative therapy in management of migraine and other head pain***. Osteopathic Medicine 1979 Aug; 4 (8): 17-31 **Located in third floor stacks**

The osteopathic physician is so totally equipped to administer complete therapy for head pain that the absence of osteopathic manipulation, except when pain is attributable to cerebral tumor, abscess, hemorrhage, or severe trauma, would seem a disservice to the patient. It is unreasonable to assume that sedatives and analgesics designed to alleviate the acute episode should be the complete treatment when proper alignment of cervical vertebrae, temporomandibular articulation, and leveling of lumbosacral areas would add immeasurably to the holistic approach to treatment of migraine and other headaches.

Abstract from publication

Headache

Stiles, E. G. ***Manipulation: osteopathic evaluation of headache***. Osteopathic Medicine 1976 Oct; 1 (4): 49-50 **Located in third floor stacks**

Headache is a symptom, not a disease. It is one of the most common forms of pain. It has been estimated that up to 90% of the population is affected by headaches. Excellent discussions concerning the work-up and medical management of patients with cephalgia can be found in the medical literature. I propose to look at the symptom of headaches from an osteopathic standpoint and discuss how somatic dysfunction can play a significant role in the patient's clinical condition. The following common types of headaches will be discussed: (1) vascular; (2) tension; (3) combination vascular and tension; (4) sinusitis; and (5) allergic.

Abstract from publication

Headache

Stodolny, J. and Chmielewski, H. ***Manual therapy in the treatment of patients with cervical migraine***. Journal of Manual Medicine 1989; 4 (2): 49-51 **Located in third floor stacks**

SUMMARY: A group of 31 patients with a diagnosis of cervical migraine was studied from the

standpoint of their qualifications for manual therapy procedures. The patients were then submitted to this treatment and its results were analyzed. The obtained results permitted the determination of the frequency and levels of somatic dysfunction of the cervical spine in cervical migraine to be made. The treatment brought a decrease of pains in the cervical spine and head, improved the range of rotation movements of the spine and normalized the results of the Hautant and two-weight tests in most cases.

Abstract from publication

Headache

Upledger, J. E., Retzlaff, E. W. and Vredewoogd, J. D. ***Diagnosis and treatment of temporoparietal suture head pain.*** Osteopathic Medicine 1978 Jul; 3 (7): 19-21, 25-26 **Located in third floor stacks**

Recent evidence related to the microanatomy of the cranial suture offers the basis for a newly postulated mechanism for recurrent head pain and for mild to moderate cerebral dysfunction. A noncomplicated approach to the diagnosis and treatment of these problems is described.

Abstract from publication

Headache; Neck

Hildebrandt, J. and Argyrakis, A. ***Percutaneous nerve block of the cervical facets - a relatively new method in the treatment of chronic headache and neck pain.*** Manual Medicine 1986; 2 (2): 48-52 **Located in third floor stacks**

SUMMARY: Apophyseal joints (facet joints) of the cervical spine, ligaments and neck muscles play an important role in the development of headache and neck pain. These structures are innervated by the dorsal rami of the spinal nerves. Their exact course, especially in relation to the bony structures, is described in this paper. The treatment of this type of pain is generally conservative. If conservative treatment is rendered unsuccessful and the main problem is not a psychosomatic one, radio-frequency denervation of the facet joints is recommended. A partial percutaneous nerve block of the cervical facets (mostly C2-C3 and C3-C4) was performed in 35 patients suffering from chronic headache and neck pain. As the procedure has a low risk to the patient, it can be used on a larger scale, even if the pain is not always totally eliminated.

Abstract from publication

Hip; Child

Coleman, S. S. ***When a child is born with hip problems.*** Patient Care 1983 Aug 15; 17 (14): 68-90 **Located in third floor stacks**

Review article on congenital dislocated hip. The article includes etiology, diagnosis, and management.

Hypertension

Stiles, E. G. ***Osteopathic approach to the hypertensive patient.*** Osteopathic Medicine 1977 Apr; 2 (4): 41, 43, 45 **Located in third floor stacks**

SUMMARY: An osteopathic approach to the patient with hypertension was discussed with the idea of challenging the osteopathic physicians with the thought of what osteopathic management may offer their patients in addition to quality medical care. Hopefully, the patient will realize his health

potential and lead a more productive and active life once comprehensive osteopathic care is instituted.

Abstract from publication

Infection

Gunderson, T. G. and Gordon, R. M. ***Study of the influence of spinal lesions on the course of infection.*** Journal of the American Osteopathic Association 1932 Jun; 31 (10): 390-391 **Located in third floor stacks**

INTRODUCTION: This series of experiments was made for three reasons: First, to endeavor to determine whether interosseus lesions artificially produced in animals have any influence on the course of infectious disease; second, to determine whether such lesions would influence the production of protective antibodies; and third, to promote a better understanding of osteopathic principles as applied to bacteriology.

Abstract from publication

Insurance

Fitzgerald, M. ***Osteopathic hospital's solution to DRG's may be OMT.*** DO 1984 Nov; 25 **Located in third floor stacks**

Osteopathic manipulative treatment (OMT) is the osteopathic hospital's edge in dealing with diagnosis-related group (DRG) reimbursement, Edward G. Stiles, DO. suggested. By enhancing good medical and surgical care with OMT, osteopathic physicians should be able to treat patients more effectively and release them sooner. Consequently, as long as DRG reimbursement is based on allopathic standards, the osteopathic hospital that provides OMT should make a profit. Dr. Stiles told DOs who attended the 87th annual convention of the Indiana Association of Osteopathic Physicians and Surgeons.

Abstract from publication (introduction)

Knee; Musculoskeletal System; Child

Sweeting, R. C., Fowler, C. and Crocker, B. ***Anterior knee pain and spinal dysfunction in adolescence.*** Journal of Manual Medicine 1989; 4 (2): 65-68 **Located in third floor stacks**

SUMMARY: The underlying etiology of anterior knee pain is frequently not known, particularly in the adolescent. A review of 260 patients presenting with knee pain in a general orthopedic practice revealed 16 cases (6% of the total) as having similar clinical features with peripheral muscle weakness associated with segmental spinal dysfunction. This syndrome would appear to be as frequent as patellofemoral instability (15 cases). A treatment protocol is outlined which significantly improves the functioning of these patients, subjectively with reduction of complaints of pain and objectively with increase in muscle power as documented by testing with the Kin-Com as well as clinical by examination.

Abstract from publication

Learning Disorders; Somatic dysfunction; Child

Chandler, J. E. E. ***Minimal brain dysfunction: some preliminary findings.*** British Osteopathic Journal 1983; 15 (1): 7-14 **Located in third floor stacks**

SUMMARY: This speculative study represents an attempt to reappraise the characteristics of

minimal brain dysfunction (MBD), recalling symptom patterns and recording palpatory findings in a sample of twelve children affected by the syndrome. A high proportion are found to exhibit certain abnormal characteristics as regards involuntary movements; common findings including: the cranium held in side-bending/rotation; rapid primary respiratory rate; parietal dysfunction; lack of extension cranially and unilateral resistance to shearing of the vault of the skull. It is suggested that MBD is the result of an organic brain lesion, which may be localized in the region of the angular gyrus.

Abstract from publication

Leg; Back pain

Potter, G. E. *Diagnostic clinical trial*. Journal of Manual Medicine 1989; 4 (1): 31 **Located in third floor stacks**

Case report of a 61 year-old male who complained of low back pain and leg pain.

Manipulation Techniques

Kent, J. M. *Safe, useful manipulative techniques (includes readers comments)*. Patient Care 1984 Aug 15; 18 (14): 137-189 **Located in third floor stacks**

These straightforward applications of muscle energy manipulation may help you resolve dysfunction causing such discomfort as low back pain or tension headache.

Abstract from publication

Manipulation Techniques

Maitland, J. and Goodliffe, H. *Alexander technique*. Nursing Times 1989 Oct 18; 85 (42): 55-57 **Located in third floor stacks**

Becoming more aware of how we use our bodies in daily life can help us cope better with stress and tension. Jean Maitland and Harvy Goodliffe describe how the Alexander technique can be of particular help to nurses.

Abstract from publication.

Manipulation Techniques

Stedman, N. *Getting straight*. Health 1985 Nov; 17 (11): 65-66 **Located in Reference Office**

How the Alexander technique slapped my body back into line.

Abstract from publication.

Manipulation Techniques; Back pain

Brodin, H. *Inhibition - facilitation technique for lumbar pain treatment*. Manual Medicine 1987; 3 (1): 24-26 **Located in third floor stacks**

SUMMARY: The effect of a modified Mitchell's muscle energy technique was studied. 41 patients with pain from one or two lumbar segments with reduced mobility were organized in one treated group and in one non-treated control group. Every week all patients reported their pain level at rest and during activity according to a 9-graded scale. After treatment for three weeks the pain reduction in the treated group was statistically greater than in the non-treated group. The mobility of the lumbar spine increased among those with reduced pain.

Abstract from publication

Manipulation Techniques; Fascia; Fibromyalgia; Musculoskeletal System

Simons, D. G. *Myofascial pain syndromes due to trigger points: 2. Treatment and single-muscle syndromes*. Manual Medicine 1985; 1 (3): 72-77 **Located in third floor stacks**

SUMMARY: This is the conclusion of a two-part communication. Treatment of a single-muscle myofascial pain syndrome in a patient who is free of perpetuating factors can be refreshingly easy and the response dramatic. A progressive multi-muscle syndrome with multiple perpetuating factors can be frustratingly difficult. Three treatment methods are summarized: stretch and spray, Lewit's post-isometric relaxation, and trigger-point (TP) injection followed by active range of motion. Other techniques include ischemic compression, hot packs and massage, electrical stimulation at the trigger point, and massage, electrical stimulation at the trigger point, and ultrasound applied to the trigger point area. The goal is relief of pain that occurs with release of the increased tension of the taut muscle fibers. This restores full normal stretch range of motion of the muscle. However, pain relief obtained by these methods does not rule out serious visceral disease, especially in the case of chest or abdominal pain. Examples of common myofascial pain syndromes presented here include: the sternocleidomastoid muscles - headache; the infraspinatus muscle - shoulder pain; the scalene muscles - chest, upper back and upper extremity pain; the supinator muscle - tennis elbow; the quadratus lumborum muscle - low back pain; the gluteus minimus - "sciatica" ' and the soleus muscle - heel pain.

Abstract from publication

Manipulation Techniques; Musculoskeletal System

Lewit, K. *Postisometric relaxation in combination with other methods of muscular facilitation and inhibition*. Manual Medicine 1986; 2 (4): 101-104 **Located in third floor stacks**

SUMMARY: At first post isometric relaxation was simply the application of Greenman's and Mitchell's muscle energy technique to muscles. It could be shown that the minimum force used during the isometric phase for mobilization produced better results than maximum force also when only increased muscle tension was present. A further improvement of this technique consists in combining it with other methods of muscular facilitation and inhibition, in particular with eye movements, inspiration and expiration; the latest suggestion is to use the force of gravity (gravity-induced relaxation according to Zbojan). The advantage of such combinations lies (1) in increased effectiveness due to a summation of physiological stimuli, (2) in making both resistance and relaxation automatic and (3) in making the techniques more suitable for self treatment, gravity-induced relaxation being self treatment from the outset. With increased experience it appears that if increased muscle tension is due to disturbed function, stretch is not essential and is merely the result of relaxation; it should therefore never be carried out against resistance. Stretch is only necessary if there is true irreversible contracture due to (morphological) connective tissue change.

Abstract from publication

Manipulation Techniques; Musculoskeletal System

Zusman, M., Edwards, B. C. and Donaghy, A. *Investigation of a proposed mechanism for the relief of spinal pain with passive joint movement*. Journal of Manual Medicine 1989; 4 (2): 58-61 **Located in third floor stacks**

SUMMARY: The hypothesis that passive joint movement (PJM) relieves pain of spinal origin by arousing to clinically effective levels a pain control system encoded by opioid peptides was

preliminarily investigated. Following treatment with a particular method of PJM patients received, by random assignment, an intravenous dose of either naloxone or physiological saline. Before and after treatment with PJM, and following the injection, patients recorded the intensity of their pain using the absolute visual analogue scale. Analysis of the three sets of pain scores for the two groups in this sample revealed a statistically significant result for treatment with PJM only. The result for the opioid hypothesis was not significant, but may have been influenced by several factors and would therefore appear to warrant further investigation.

Abstract from publication

Manipulation Techniques; Posture; Research; Back Pain

Oostendorp, R. A. B. *Preliminary report on the use of the proprioceptive facilitating method versus the Williams method in the treatment of patients with non-specific low back pain*. *Manual Medicine* 1988; 3 (3): 106-109 **Located in third floor stacks**

SUMMARY: The purpose of this study was to examine the difference between the proprioceptive facilitating method (PFT) versus the Williams method (WT) in the treatment of patients with non-specific low back pain. Twenty patients were selected and divided into two groups at random. The scores on the items "pain" (visual analogue scale), "ecological reactions" (5-point scale) and "comfortable sitting and standing time" (in minutes) were checked to see whether the differences for the measurements before and after treatment were statistically significant ($p=0.05$: Student's t-test). The results of this study demonstrate that the PFT gives significantly better short-term results than WT. A supplementary study will be necessary to determine the long-term results. The results are discussed.

Abstract from publication

Musculoskeletal System; Back pain

Stodolny, J. and Mazur, T. *Effect of post-isometric relaxation exercises on the ilio-psoas muscles in patients with lumbar discopathy*. *Journal of Manual Medicine* 1989; 4 (2): 52-54 **Located in third floor stacks**

SUMMARY: In the pathology of degenerative disease of the intervertebral disc, muscle disorders play a very important role. In particular, contractures of ilio-psoas muscles play a significant role in lumbar disc disease. Kinesiotherapeutical programs, generally used in low back pains on the background of discopathy, do not respect this fact. Examinations in 80 patients, having low back pain on the background of lumbar discopathy were made and contractures of ilio-psoas muscles were exhibited in all the patients. Those patients were divided into two groups by random. In the one group the generally applied kinesiotherapeutical program was used, in the other this program was supplemented by post-isometrical relaxation exercise of ilio-psoas muscles. Using the post-isometrical relaxation exercises of the muscles appreciably influenced a reduction of contractures of the ilio-psoas muscles.

Abstract from publication

Musculoskeletal System; Child; Knee

Sweeting, R. C., Fowler, C. and Crocker, B. *Anterior knee pain and spinal dysfunction in adolescence*. *Journal of Manual Medicine* 1989; 4 (2): 65-68 **Located in third floor stacks**

SUMMARY: The underlying etiology of anterior knee pain is frequently not known, particularly in the adolescent. A review of 260 patients presenting with knee pain in a general orthopedic practice revealed 16 cases (6% of the total) as having similar clinical features with peripheral muscle

weakness associated with segmental spinal dysfunction. This syndrome would appear to be as frequent as patellofemoral instability (15 cases). A treatment protocol is outlined which significantly improves the functioning of these patients, subjectively with reduction of complaints of pain and objectively with increase in muscle power as documented by testing with the Kin-Com as well as clinical by examination.

Abstract from publication

Musculoskeletal System; Fascia; Fibromyalgia

Simons, D. G. *Myofascial pain syndromes due to trigger points: 1. Principles, diagnosis, and perpetuating factors*. Manual Medicine 1985; 1 (3): 67-71 **Located in third floor stacks**

SUMMARY: This is the first of a two-part communication on myofascial pain syndromes. Myofascial pain syndromes are commonly overlooked or misunderstood. They arise from trigger points in a muscle and/or its associated fascia. A trigger point (TP) is a hyperirritable spot that, for each muscle of the body, refers pain in a characteristic pattern. The referred pain is rarely located where its trigger point is found, but is usually projected to a distance. The pattern (distribution) of this referred pain is the key to locating a trigger point. Additional subjective findings that help distinguish a trigger point are 1) history of muscular strain at the onset of pain, 2) reproducible, exquisite point tenderness that causes a "jump sign" of the patient, and 3) reproduction of the referred pain pattern by gentle steady pressure on the trigger point. More objective indicators are breakaway weakness of involved muscles and reduced range of motion due to tightness and pain whenever that involved muscle is passively or actively stretched. Completely objective findings that are diagnostic of a myofascial trigger point are 1) a palpable band of taut muscle fibers that contain the trigger point and 2) a local twitch response just of palpable band fibers elicited by snapping palpation of the trigger point. The initiating stress and the perpetuating factor, or factors, are usually different. When patients realize only temporary relief from specific myofascial treatment, perpetuating factors are frequently responsible. When present, the latter must be resolved and then the active trigger points inactivated for lasting relief. Mechanical perpetuating factors include muscular stresses such as those imposed by a short leg, a small hemipelvis, or short upper arms. Nutritional perpetuating factors, e.g. vitamin inadequacies, and the medical problems of hypometabolism and chronic infection may be critically important.

Abstract in publication

Musculoskeletal System; Fascia; Fibromyalgia

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Abstract in publication

Musculoskeletal System; Manipulation Techniques

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SUMMARY: At first post isometric relaxation was simply the application of Greenman's and Mitchell's muscle energy technique to muscles. It could be shown that the minimum force used during the isometric phase for mobilization produced better results than maximum force also when only increased muscle tension was present. A further improvement of this technique consists in combining it with other methods of muscular facilitation and inhibition, in particular with eye movements, inspiration and expiration; the latest suggestion is to use the force of gravity (gravity-induced relaxation according to Zbojan). The advantage of such combinations lies (1) in increased effectiveness due to a summation of physiological stimuli, (2) in making both resistance and relaxation automatic and (3) in making the techniques more suitable for self treatment, gravity-induced relaxation being self treatment from the outset. With increased experience it appears that increased muscle tension is due to disturbed function, stretch is not essential and is merely the result of relaxation; it should therefore never be carried out against resistance. Stretch is only necessary if there is true irreversible contracture due to (morphological) connective tissue change.

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Abstract from publication

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SUMMARY: This is the conclusion of a two-part communication. Treatment of a single-muscle

myofascial pain syndrome in a patient who is free of perpetuating factors can be refreshingly easy and the response dramatic. A progressive multi-muscle syndrome with multiple perpetuating factors can be frustratingly difficult. Three treatment methods are summarized: stretch and spray, Lewit's post-isometric relaxation, and trigger-point (TP) injection followed by active range of motion. Other techniques include ischemic compression, hot packs and massage, electrical stimulation at the trigger point, and massage, electrical stimulation at the trigger point, and ultrasound applied to the trigger point area. The goal is relief of pain that occurs with release of the increased tension of the taut muscle fibers. This restores full normal stretch range of motion of the muscle. However, pain relief obtained by these methods does not rule out serious visceral disease, especially in the case of chest or abdominal pain. Examples of common myofascial pain syndromes presented here include: the sternocleidomastoid muscles - headache; the infraspinatus muscle - shoulder pain; the scalene muscles - chest, upper back and upper extremity pain; the supinator muscle - tennis elbow; the quadratus lumborum muscle - low back pain; the gluteus minimus - "sciatica" ' and the soleus muscle - heel pain.

Abstract from publication

Musculoskeletal System; Research

Patterson, J. K. *Survey of musculoskeletal problems in general practice*. Manual Medicine 1987; 3 (2): 40-48 **Located in the third floor stacks**

SUMMARY: A series of 1037 patient/episodes is presented, in whom the presenting symptom was pain in or seeming to arise from the spine. These are reviewed from a number of aspects: age/sex distribution in both first attacks and recurrences, age/sex distribution in cervical and lumbar problems, sex/regional distribution in relation to previous therapies, laterality of radiation in male and female, results of therapy in relation to the number of treatments in cervical, thoracic and lumbar problems, regional distribution in relation to mode of onset of an attack and its amenability to treatment, and again to the duration of symptoms prior to therapy, and finally the influence of weight on the incidence of recurrences. Assessment of various aspects of musculoskeletal medicine is widely acknowledged to be fraught with difficulties. Perhaps this is most apparent in attempting to evaluate the relative efficacy of different therapies. The chief obstacle to this is the fact that it is rarely possible to validate a diagnosis in this group of conditions, without which currently acceptable methods of statistical analysis are rendered inapplicable. This view is stated clearly in the DHSS Report of the Working Group on Back Pain, 1979 (Appendix F), issued by the Department of Health and Social Security. It is a view further endorsed by Wyke and Nachemson, as has been previously discussed. It is the writer's view that such limitation is not best ignored, nor best treated by the assumption that there is nothing that can be done in this area of much-needed research. Surely, what is required is the accumulation of more and more evidence with regard to diagnosis and therapy in this heterogeneous group of painful disorders, and it is on this basis that this paper is presented. Any hypothesis must be first stated and then put to the test. The results of this review, without any claim to statistical significance, strongly suggest that a number of hypotheses, diagnostic and therapeutic, currently widely masquerading as facts, should be reappraised.

Abstract from publication

Musculoskeletal System; Somatic Dysfunction

Stiles, E. G. *Manipulation: a tool for your practice*. Patient Care 1984 May; 18 (9): 16-25, 30-32, 35, 39-42 **Located in third floor stacks**

You may be able to pick up a number of useful, safe techniques from one well-conducted tutorial. So says Edward G. Stiles, DO, a recognized expert in the field. We invited Dr. Stiles to explain and demonstrate manipulative techniques to a group largely composed of allopathic

physicians, all members of the Patient Care Board of Editors. The result? Lively discussion, greater understanding between osteopathic and allopathic physicians, and - in the minds of some participants, at least - an awakened interest in the potential of manipulative therapy. Here, Dr. Stiles outlines the principles of a versatile type of manipulation; in an accompanying article, he demonstrates the application of these principles of anterior chest wall pain.

Abstract from publication

Musculoskeletal System; Somatic Dysfunction

Thabe, H. *Electromyography as tool to document diagnostic findings and therapeutics results associated with somatic dysfunctions in the upper cervical spinal joints and sacroiliac joints*. Manual Medicine 1986; 2 (2): 53-58 **Located in third floor stacks**

The nocireaction caused by a somatic joint dysfunction proceeds predominantly via the dorsal ramus of the spinal nerve that supplies the autochthonous back muscles. This is electromyographically demonstrated by continued spontaneous activity in the respective segmental muscle. If the afferent information from the restricted joint is blocked with local anesthetic injection, the spontaneous activity disappears. The same result can be achieved with injection into the corresponding segmental muscle with a delay of four minutes, however. Mobilization techniques on the contrary, do not have the same spontaneous effect, yet are able to lower spontaneous activity significantly. Manipulation (thrust techniques) results in the immediate disappearance of spontaneous activity.

Abstract from publication

Musculoskeletal System; Somatic dysfunction; Physical Examination

Beal, M. C. and Dvorak, J. *Palpatory examination of the spine: a comparison of the results of two methods and their relationship to visceral disease*. Manual Medicine 1984; 1 (2): 25-32 **Located in third floor stacks**

SUMMARY: Fifty patients were examined by two examiners without knowledge of their histories or diagnoses, representing two different approaches to examination of the musculoskeletal system. On average, both examiners selected two sites per patient that were at the same vertebral level for somatic (segmental) dysfunction; however, examiner B averaged 9.3 and examiner D 8.1 sites per patient. The level of agreement is substantially improved if 1) agreement is based upon selection for the absence as well as the presence of somatic dysfunction (average 72%) or 2) the examination sites are grouped together (70%). This study is based on the observations of the examiners, with regard to the location of sites of somatic dysfunction, and the level of agreement of the relationship of their findings to structural problems and visceral disease.

Abstract from publication

Musculoskeletal System; Somatic dysfunction; Back Pain

MacDonald, R. S. *Primary dysfunction of the spine*. Holistic Medicine 1988; 3 (1): 27-33 **Located in third floor stacks**

SUMMARY: Investigations of back pain have mainly sought a causative structural pathology: for most presentations this search has failed. It is suggested that the possibility of primary spinal dysfunction producing pain has been unreasonably neglected, and that more priority should be given to studies capable of revealing such dysfunction.

Abstract from publication

Myofascial Release

Sola, A. E. and Williams, R. L. *Myofascial pain syndromes*. Neurology 1956; 6 (2): 91-95

Located in third floor stacks

Pain is a common patient complaint, and much of the pain falls into the category of myofascitic syndromes. Small abnormally sensitive areas of tenderness in the muscle or connective tissue can be found in these patients as trigger points that specifically radiate the pain to the area of complaint. Predisposing factors for these areas appear to be stress, either acute or chronic mechanical stress, psychogenic stress, or organic stress. These areas are set up as a reflex cycle beginning with a noxious stimulus at the trigger point. Although trigger points can be seen in any muscle, certain muscles are encountered more frequently than others. Discussed specifically are levator scapulae, infraspinatus, quadratus lumborum, tensor fascia lata, and anterior tibialis muscles in reference to the trigger point locations, as well as the area of radiation of pain.

Abstract (unknown)

Myofascial Release; Pain

Travell, J. and Rinzler, S. H. *Myofascial genesis of pain*. Postgraduate Medicine 1952 May; NA (NA): 425-434 **Located in third floor stacks**

Classic article outlining trigger points and the pain cycle. Illustrations of pain areas and where the trigger points that correspond to pain areas are located.

Neck; Headache

Hildebrandt, J. and Argyrakos, A. *Percutaneous nerve block of the cervical facets - a relatively new method in the treatment of chronic headache and neck pain*. Manual Medicine 1986; 2 (2): 48-52 **Located in third floor stacks**

SUMMARY: Apophyseal joints (facet joints) of the cervical spine, ligaments and neck muscles play an important role in the development of headache and neck pain. These structures are innervated by the dorsal rami of the spinal nerves. Their exact course, especially in relation to the bony structures, is described in this paper. The treatment of this type of pain is generally conservative. If conservative treatment is rendered unsuccessful and the main problem is not a psychosomatic one, radio-frequency denervation of the facet joints is recommended. A partial percutaneous nerve block of the cervical facets (mostly C2-C3 and C3-C4) was performed in 35 patients suffering from chronic headache and neck pain. As the procedure has a low risk to the patient, it can be used on a larger scale, even if the pain is not always totally eliminated.

Abstract from publication

Neurology

Buerger, A. A. *Experimental neuromuscular models of spinal manual techniques*. Manual Medicine 1983; 1 (1): 10-17 **Located in third floor stacks**

The objective of this paper is to develop possible physiologic models for some of the manual techniques defined in the following manuscript. Before suggesting models for these manual techniques, one must define the requirements for acceptable models. First, they must be supported by controlled experiments, using animals or humans; hopefully, these experiments should have been reported by more than one laboratory. Second, the physiologic effect must be alterable by manual treatments.

Abstract from publication

Neurology

Lamb, C. ***Neuropathy: the symptoms are the key.*** Patient Care 1985 Mar 15; 19 (5): 113-134 **Located in third floor stacks**

Distal weakness. General weakness. Burning feet. Tingling in the extremities. Restless legs. The symptoms may be all you have to go on in sorting true neuropathy from other conditions.

Abstract from publication

OB-GYN

Mantero, E. and Crispini, L. ***Static alterations of the pelvic, sacral, lumbar area due to pregnancy. Chiropractic treatment.*** Edizioni Minerva Medica 1982; NA (NA): 59-68 **Located in Reference Office**

SUMMARY: Complications in pregnancy at term are numerous and have been the subject of close investigation in many instances. By contrast, little attention has been paid to lumbosacral pain. This may be polymorphous in part, and present at the termination of pregnancy or in the puerperium. Radiopelvimetry in the early stages of labor gives an idea of the lumbosacral and pelvic situation. This examination is not performed as a matter of routine, however, and requires special techniques and exact obstetric indication in cases of doubtful prognosis. Lateral projection with the patient erect is personally regarded as giving the most meaningful picture. A review of 110 most recent radiopelvimetrics performed at the Magenta Hospital from the orthopedic and chiropractic as opposed to the obstetric standpoint, coupled with a comparison in 20 cases of radiograms obtained with the same technique soon after birth due to the onset of lumbar pain, showed that the lateral projection offers useful diagnostic information in terms of both prevention and therapy.

Abstract from publication

OB-GYN; Shoulder; Child

Hibbard, L. T. ***Coping with shoulder dystocia.*** Contemporary OB/GYN 1982 Sep; 20 (NA): 229-231,234-235,237 **Located in reference office**

Skillful manipulation of trapped shoulders can prevent radical procedures and unnecessary complications. Here are descriptive, step-by-step methods for meeting this problem.

Abstract from publication

OMT Under Anesthesia

Clouse, W. E. ***Treatment of low-back pain with the use of caudal anesthesia.*** Journal of the American Osteopathic Association 1949 Mar; 8 (1): 377-378 **Located in third floor stacks**

INTRODUCTION: The purpose of this paper is to set forth some of the known principles of the treatment of acute low-back pain with the use of caudal anesthesia as an aid in the institutional approach to this problem. A brief review of etiology and pathology is in order so that this relatively new approach may be considered from the standpoint of selection of patients, routine diagnostic procedures, and therapeutic follow-up.

Abstract from publication

OMT Under Anesthesia; Research; Pain

Brodin, H. ***Cervical pain and mobilization***. Manual Medicine 1985; 2 (1): 18-22 **Located in third floor stacks**

SUMMARY: Specific i.e. localized mobilization of painful cervical mobile segments with restricted mobility and typical end feel, (final resistance to passive movement), produced good therapeutic results. Reduction of pain, i.e. minimum two steps of a nine-graded symptom scale, was greater than in the two control groups. Also the mobility increased a little. No significant correlation between reduction of pain and increased mobility was found. Examination and treatment was mainly of osteopathic character. One control group received salicylate (Premaspin Laake) and another had salicylate, special information ("cervical school") for three hours and mock manual therapy. The therapeutic results were the same in these two groups. Neither personality tests nor the social, economical and vocational conditions revealed any differences between the three groups.

Abstract from publication

Otitis Media

Galbreath, W. O. ***Acute otitis media including its postural and manipulative treatment***. Journal of the American Osteopathic Association 1929 Jan; 28 (5): 377-379 **Located in third floor stacks**

In this article, the author reviews acute otitis media and how to treat it posturally. He also demonstrates manipulative treatments that can be used to relieve the symptoms. Incision of the drum membrane is also discussed.

Otitis Media

Marasa, F. K. and Ham, B. D. ***Case reports involving the treatment of children with chronic otitis media with effusion via craniomandibular methods***. Journal of Craniomandibular Practice 1988 Jul; 6 (3): 256-270 **Located in third floor stacks**

The temporomandibular joint, the muscles derived from the first bronchial arch, and the middle ear all have a close anatomical and embryological relationship. The authors felt that altering the position and relationship of the temporomandibular joint and the muscles of mastication might produce some effect on patients suffering from chronic otitis media with effusion. This paper presents five cases, four with good success and one failure (possibly due to a lack of compliance). A discussion follows giving possible anatomical and physiological reasons for the success of the procedures.

Abstract from publication

Otitis Media

Reid, C. C. ***Osteopathic treatment of the ear***. Journal of the American Osteopathic Association 1922 Feb; 21 (6): 359-360, 368 **Located in third floor stacks**

In this article, the author describes the anatomy of the outer ear, ear canal, and the middle ear. He demonstrates the appropriate manipulations techniques that have proven most effective in treating abnormal ear conditions and gives a list of exercises that the patient can use at home to improve atency to the Eustachian tube and to bring about free cicculation to all the arteries flowing to the external auditory canal and middle ear, to restore vibratory ability to the drum head, and to secure drainage and ventilation to this part of the ear.

Original abstract

Pain; Myofascial Release

Travell, J. and Rinzler, S. H. *Myofascial genesis of pain*. Postgraduate Medicine 1952 May; NA (NA): 425-434 **Located in third floor stacks**

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Abstract from publication

Philosophy

Anonymous. *As the twig is bent [pamphlet]*. Sutherland Cranial Teaching Foundation /Denver, CO 1983; NA (NA): 11 **Located in Reference Office**

Abstract N/A

Philosophy

Anonymous. *Interpretation of osteopathic concept prepared by committee at Kirksville*. Journal of Osteopathy 1953; 60 (10): 7-10 **Located in third floor stacks**

This article outlines the basic concepts of osteopathic medicine. These are the body is a unit, the body possess self-regulatory mechanisms, that structure and function are reciprocally inter-related and that rational therapy is based upon understanding these concepts. The musculoskeletal lesion is also discussed.

Philosophy

Anonymous. *You probably think all doctors are MDs. If so, you're wrong*. DO 1985 Jan; 26 (1): 85 **Located in third floor stacks**

Half the media believe that MDs are the only comprehensive health-care professionals in America. Yet 25 million Americans visit another type of fully-trained and licensed physician or surgeon for medical care. Their doctor is a DO or osteopathic physician.

Abstract from publication

Philosophy

Chandler, L. C. *Physiological integration as the basis for recovery from disease and its osteopathic implication*. Journal of the American Osteopathic Association 1950 Feb (Internists' Supplement); 5 (1): 305-315 **Located in third floor stacks**

SUMMARY: No one knows, unfortunately, how often osteopathic structural correction may be the determining influence in illness. Still less does anyone know how frequently the balance is so close between adequate resistance to infection and failure to resist that a slight improvement in the integration of the body's myriad activities will determine the issue. Those who have practiced skillfully as osteopathic physicians have seen advancing critical illness, both acute and chronic, turned toward recovery by osteopathic treatment. They have seen large clienteles go through serious epidemics of infectious disease with a strikingly lower incidence of the epidemic disease than the general population suffered. It seemed certain that the better marshalling of life's inherent powers in persons having osteopathic care gave them protection that others did not have. The effect of maintaining structural normality in preventing degenerative diseases is most difficult to measure but many of us are empirically convinced that it has great value. It is most unfortunate that many members of the profession, in these accomplishments, have not given adequate attention to the distinction between the effects of skillful structural correction and so-called "general treatment" that Dr. Still called "engine wiping." Determining how to give the least "manual labor" and waste of the physician's time would add greatly to the community services that the osteopathic profession could render. [Abstract truncated at 200 words]

Abstract from publication

Philosophy

Greenman, P. E. *Models and mechanisms of osteopathic manipulative medicine*. Osteopathic Medical News 1987 May; 4 (5): 1, 11-14, 20 **Located in third floor stacks**

CONCLUSION: To ascertain A.T. Still's opinion of osteopathic manipulative medicine as practiced today would be of considerable interest. Many of the procedures described herein were apparently unknown during Still's time. However, I would submit that they are all consistent with Still's basic premise and reflect the expansion of our knowledge in this field of medicine in a fashion similar to the increase in medical and surgical management over the same period of time. I would suspect that he would be somewhat less than pleased with the limited application of this science and art within the practice of osteopathic medicine today. The constructs of model, method, and activating force described herein can provide the osteopathic physician with many different approaches to a patient. The more approaches available to the practitioner, the more effective he or she can be in patient care. Osteopathic manipulative medicine can be viewed as a tool box. The more tools you have in the box, the more effective you can be. If you only have a hammer in the tool box, you'll be surprised of how often objects resemble nails. We should all try to increase the capacity of our "medical tool boxes" to enhance our ability to serve our patients.

Abstract from publication

Philosophy

Harakal, J. H. *Rationale for manipulative medicine*. Journal of Craniomandibular Practice 1984; 2 (3): 250-252 **Located in third floor stacks**

Articulations in the cranial, spinal, and pelvic regions, as well as those of the appendages, are designed for specific functions and movements, and all the tissues in the area will perform their jobs best when the articulations are physiologically sound. When the movements of any of these articulations are compromised by disease, trauma, or other problems, the tissues will become subject

to dysfunction and pain. Manipulation of the altered structures is helpful for restoring these articulations to their normal limits of movement and can also help to speed healing by returning the tissues to a more normal state.

Abstract from publication

Philosophy

Katz, J. *California osteopaths: on the mend [news]*. Los Angeles Times 1987 Aug 18; NA (NA): 1,3,18 **Located in Reference Office**

Abstract N/A

Philosophy

Korr, I. M. *Osteopathic principles: a way of life [editorial]*. DO 1987 May; 28 (5): 25-27 **Located in third floor stacks**

Abstract N/A

Philosophy

Luke, E. A. *What is osteopathy?* Boulevard Banner 1989 Jul; NA (NA): 10 **Located in Reference Office**

The author of this article discusses the history of osteopathic medicine and its philosophy.

Philosophy

MacDonald, R. S. *Medicine, osteopathy and the management of pain*. Holistic Medicine 1988; 3 (1): 15-18 **Located in third floor stacks**

INTRODUCTION: The topics and authors in the remainder of this Issue reflect some present preoccupations of a Guest Editor sitting uncomfortably on the fence between osteopathy and conventional medicine - a fence which he believes could be dismantled with advantage to both disciplines. As they take on training in osteopathy, medical doctors quickly come to recognize the void in their previous practice, both conceptual and methodological, into which osteopathy so comfortably fits. They also realize that as osteopathy achieves acceptance by orthodoxy, which could lead to cooperation and real progress in developing the therapy, so it is revealed that isolation has become a habit which will not be broken until the insecurity and suspicion of organized medicine has dispersed within the ranks of non-medical osteopaths.

Abstract from publication

Philosophy

Magoun, H. I. e. *Work of our hands [pamphlet]*. NA 1969; NA (NA): 1-14 **Located in Reference Office**

Abstract N/A; Photograph of W.G. Sutherland

Philosophy

Stiles, E. G. *Establishing a hospital based osteopathic medicine service*. Osteopathic

Medicine 1977 Jan; 2 (1): 21-23, 27-29 **Located in third floor stacks**

Hospitals throughout the country are continually faced with problems that must be solved. Osteopathic hospitals are no exception, but many of the problems are unique for our profession. Hospitals are made up of many components: patients, staff members, administrators, and members of the board of trustees. Each of these essential components is daily affected by the challenges facing osteopathic hospitals and each must contribute to solutions if our profession is to continue to grow and remain viable. Let us examine some of the problems facing our hospitals.

Abstract from publication

Philosophy

Walsh, J. *Medicine at Michigan State (I): Educators and legislators*. Science 1972 Sep 22; 177 (4043): 1085-1087 **Located in third floor stacks**

This article discusses how the Michigan legislature dealt with a growing public concern about health care by expanding medical education on their college campuses.

Philosophy

Walsh, J. *Medicine at Michigan State (II). The architecture of accountability*. Science 1972 Oct; 178 (4056): 36-39 **Located in third floor stacks**

This article discusses ways the Michigan Legislature and Michigan State University found the financial means to bring both an allopathic and osteopathic medical school to the same campus.

Philosophy

Walsh, J. *Medicine at Michigan State (III): conditioning for innovation*. Science 1972 Oct 20; 178 (4056): 288-291 **Located in third floor stacks**

A growing trend in medical education is to use community health facilities for clinical teaching. This alternative permits more involvement with community health problems and gives students and residents a broader perspective than the university teaching hospitals.

Philosophy

Walsh, J. *Medicine at Michigan State (IV): osteopaths and allopaths*. Science 1972 Oct 27; 178 (4056): 377-380 **Located in third floor stacks**

Two medical schools occupy the same campus at Michigan State University (MSU). There is an allopathic and an osteopathic school. This article outlines the difficulties this arrangement creates and the implications for the future.

Philosophy; Education

Korr, I. M., et.al. *Design of the medical curriculum in relation to the health needs of the nation: a statement of the educational goals of the Texas College of Osteopathic Medicine, Fort Worth, Texas [pamphlet]*. NA 1980; NA (NA): 1-16 **Located in Reference Office**

Abstract N/A

Physical Examination; Musculoskeletal System; Somatic dysfunction

Beal, M. C. and Dvorak, J. *Palpatory examination of the spine: a comparison of the results of two methods and their relationship to visceral disease*. Manual Medicine 1984; 1 (2): 25-32 **Located in third floor stacks**

SUMMARY: Fifty patients were examined by two examiners without knowledge of their histories or diagnoses, representing two different approaches to examination of the musculoskeletal system. On average, both examiners selected two sites per patient that were at the same vertebral level for somatic (segmental) dysfunction; however, examiner B averaged 9.3 and examiner D 8.1 sites per patient. The level of agreement is substantially improved if 1) agreement is based upon selection for the absence as well as the presence of somatic dysfunction (average 72%) or 2) the examination sites are grouped together (70%). This study is based on the observations of the examiners, with regard to the location of sites of somatic dysfunction, and the level of agreement of the relationship of their findings to structural problems and visceral disease.

Abstract from publication

Piriformis Syndrome

Cameron, H. U. *Piriformis syndrome*. Canadian Journal of Surgery 1988; 31 (4): 210
Located in third floor stacks

In this article, the symptoms, etiology, treatment and surgical treatment of piriformis syndrome are reviewed.

Piriformis syndrome; Somatic dysfunction

Arkuszewski, Z. *Joint blockage: a disease, a syndrome or a sign?* Manual Medicine 1988; 3 (4): 132-134 **Located in third floor stacks**

SUMMARY: Some practitioners believe that joint blockage (somatic dysfunction) is a condition that can be cured by manipulation. This attitude makes it difficult for manual therapists to communicate with other physicians who do not apply manual procedures for the treatment of back or neck pain, cervical migraine or vertigo and other spondylogenic disorders. Many of the facts fundamental to manual medicine prove that in the conditions not only is the joint play disturbed but also, or even mainly, proprioception, motor patterns, the autonomous nervous system and the psyche are impaired in the patients affected. The author discusses all these factors and comes to the conclusion that joint blockage is only one of many signs of nervous system dysfunction.

Abstract from publication

Posture

Burton, A. K. *Sitting: Theoretical considerations and potential solutions*. British Osteopathic Journal 1982; 14 (2): 133-137 **Located in third floor stacks**

INTRODUCTION: The theoretical considerations of sitting were considered in the first section of this paper. Since publication a number of other office chairs, purporting to offer good sitting postures or features, have come to hand and an appraisal of these, related to the theoretical concepts, is presented here.

Abstract from publication

Posture; Research; Back Pain; Manipulation Techniques

Oostendorp, R. A. B. *Preliminary report on the use of the proprioceptive facilitating method versus the Williams method in the treatment of patients with non-specific low back pain*. Manual Medicine 1988; 3 (3): 106-109 **Located in third floor stacks**

SUMMARY: The purpose of this study was to examine the difference between the proprioceptive facilitating method (PFT) versus the Williams method (WT) in the treatment of patients with non-specific low back pain. Twenty patients were selected and divided into two groups at random. The scores on the items "pain" (visual analogue scale), "ecological reactions" (5-point scale) and "comfortable sitting and standing time" (in minutes) were checked to see whether the differences for the measurements before and after treatment were statistically significant ($p=0.05$: Student's t-test). The results of this study demonstrate that the PFT gives significantly better short-term results than WT. A supplementary study will be necessary to determine the long-term results. The results are discussed.

Abstract from publication

Psychiatry

Dunn, F. E. *Diagnostic criteria in the common psychiatric disorders*. Journal of the American Osteopathic Association 1952 Nov; 52 (3): 200-204 **Located in third floor stacks**

SUMMARY: Diagnostic criteria in the psychiatric disorders most commonly seen in general practice have been presented with the aim of orienting the non-psychiatrist. No attempt has been made to relate the symptoms discussed to the dynamics of personality.

Abstract from publication

Psychiatry

Gall, W. J. and Hill, C. *Obstetrician-gynecologist as the primary person in marriage and sex counseling*. DO 1975 Dec; 16 (4): 131-138 **Located in third floor stacks**

Abstract from article

Psychiatry

McCabe, D. L. *Psychiatry in general practice*. Osteopathic Medicine 1979 Sep; 4 (9): 23-34 **Located in third floor stacks**

CONCLUSION: Within the past two decades, the picture of psychiatry has shifted from the psychodynamic model of treatment to include much greater use of biologic and psychopharmacologic treatment in a medical model. This shift to a more medical model makes it more practical for the general practitioner to meet the challenge of treating psychiatric disorders. Many patients are not good candidates for formal psychotherapies, but respond well to the biologic approach with supportive brief psychotherapy. If the general practitioner does not care to set aside time for protracted psychotherapy with patients who require individual, group, marriage, or family therapy, the patients should be referred to appropriate psychiatrists or psychologists. Today, the physician treating psychiatric disorders must view the patient comprehensively and take into consideration not only psychological factors in the etiology but also biological factors, including heredity, metabolic deficiencies, organicity, toxicology, and nutrition. It is not enough to ameliorate the symptoms with neuroleptics. The physician must go further and determine the cause of the psychopathology, whether psychological or biologic, and actively treat it.

Abstract from publication

Psychiatry; Child

Melhado, J. ***Battered and abused child***. *Osteopathic Medicine* 1976 Aug; 1 (2): 81-88

Located in third floor stacks

This paper will explore the following aspects of child abuse: (1) Definition of the term "abused child" and delineation of the varieties of abuse (2) The estimated incidence of child abuse (3) The responsibilities of the physician, including those directed by law, to the abused child (4) Examination of the reported social and psychological patterns of the child abuser and the home environment (5) The psychological effects of the abused child (6) Methods of treatment which have been reported.

Abstract from publication

Research

DiFabio, R. P. ***Clinical assessment of manipulation and mobilization of the lumbar spine. A critical review of the literature***. *Physical Therapy* 1986 Jan; 66 (1): 51-54 **Located in third floor stacks**

The widespread use of manual therapy techniques suggests some degree of success in their application. In this article, I review the applied clinical research on the effectiveness of using manipulation or mobilization of the lumbar spine. The literature reviewed indicates highly equivocal results when the goal of therapy was to decrease pain and increase motion. Because of a high incidence of spontaneous recovery from low back syndromes, performance measures may appear to improve significantly when proper controls are not used. Evaluation of the therapeutic effects of manual therapy is complicated by potentially confounding variables when used with other physical therapy procedures. I discuss the need for further, well-designed studies.

Abstract from publication

Research; Back Pain; Manipulation Techniques; Posture

Oostendorp, R. A. B. ***Preliminary report on the use of the proprioceptive facilitating method versus the Williams method in the treatment of patients with non-specific low back pain***. *Manual Medicine* 1988; 3 (3): 106-109 **Located in third floor stacks**

SUMMARY: The purpose of this study was to examine the difference between the proprioceptive facilitating method (PFT) versus the Williams method (WT) in the treatment of patients with non-specific low back pain. Twenty patients were selected and divided into two groups at random. The scores on the items "pain" (visual analogue scale), "ecological reactions" (5-point scale) and "comfortable sitting and standing time" (in minutes) were checked to see whether the differences for the measurements before and after treatment were statistically significant ($p=0.05$: Student's t-test). The results of this study demonstrate that the PFT gives significantly better short-term results than WT. A supplementary study will be necessary to determine the long-term results. The results are discussed.

Abstract from publication

Research; Musculoskeletal System

Patterson, J. K. ***Survey of musculoskeletal problems in general practice***. *Manual Medicine* 1987; 3 (2): 40-48 **Located in the third floor stacks**

SUMMARY: A series of 1037 patient/episodes is presented, in whom the presenting symptom

was pain in or seeming to arise from the spine. These are reviewed from a number of aspects: age/sex distribution in both first attacks and recurrences, age/sex distribution in cervical and lumbar problems, sex/regional distribution in relation to previous therapies, laterality of radiation in male and female, results of therapy in relation to the number of treatments in cervical, thoracic and lumbar problems, regional distribution in relation to mode of onset of an attack and its amenability to treatment, and again to the duration of symptoms prior to therapy, and finally the influence of weight on the incidence of recurrences. Assessment of various aspects of musculoskeletal medicine is widely acknowledged to be fraught with difficulties. Perhaps this is most apparent in attempting to evaluate the relative efficacy of different therapies. The chief obstacle to this is the fact that it is rarely possible to validate a diagnosis in this group of conditions, without which currently acceptable methods of statistical analysis are rendered inapplicable. This view is stated clearly in the DHSS Report of the Working Group on Back Pain, 1979 (Appendix F), issued by the Department of Health and Social Security. It is a view further endorsed by Wyke and Nachemson, as has been previously discussed. It is the writer's view that such limitation is not best ignored, nor best treated by the assumption that there is nothing that can be done in this area of much-needed research. Surely, what is required is the accumulation of more and more evidence with regard to diagnosis and therapy in this heterogeneous group of painful disorders, and it is on this basis that this paper is presented. Any hypothesis must be first stated and then put to the test. The results of this review, without any claim to statistical significance, strongly suggest that a number of hypotheses, diagnostic and therapeutic, currently widely masquerading as facts, should be reappraised.

Abstract from publication

Research; OMT Under Anesthesia ; Pain

Brodin, H. *Cervical pain and mobilization*. Manual Medicine 1985; 2 (1): 18-22 **Located in third floor stacks**

SUMMARY: Specific i.e. localized mobilization of painful cervical mobile segments with restricted mobility and typical end feel, (final resistance to passive movement), produced good therapeutic results. Reduction of pain, i.e. minimum two steps of a nine-graded symptom scale, was greater than in the two control groups. Also the mobility increased a little. No significant correlation between reduction of pain and increased mobility was found. Examination and treatment was mainly of osteopathic character. One control group received salicylate (Premaspin Laake) and another had salicylate, special information ("cervical school") for three hours and mock manual therapy. The therapeutic results were the same in these two groups. Neither personality tests nor the social, economical and vocational conditions revealed any differences between the three groups.

Abstract from publication

Sacrum

Bourdillon, J. F. *Torsion-free approach to the pelvis*. Manual Medicine 1987; 3 (1): 20-23 **Located in third floor stacks**

SUMMARY: An approach is described to the treatment of dysfunctions of the pelvis without taking into specific consideration the so called torsions, or the superior or inferior sacral shears (unilateral sacral flexion or extension). The necessary preliminary treatment of the sacrum as an atypical lumbar vertebra is alluded to and the treatment of the ilio-sacral dysfunctions is described in detail.

Abstract from publication

Sacrum

Langloh, N. D., Johnson, E. W. and Jackson, C. B. **Traumatic sacroiliac disruptions**. Journal of Trauma 1972 Nov; 12 (11): 931-935 **Located in third floor stacks**

SUMMARY: Sacroiliac disruptions result from serious trauma, and the associated injuries frequently require prompt surgical management. Internal hemorrhage is common: visceral injury should be ruled out before hemorrhage can be assumed to be retroperitoneal. Management of sacroiliac disruptions depends on the stability of the joint. Late or permanent disability is frequent, and prognosis should be guarded.

Abstract from publication

Sacrum; Back Pain

Greenman, P. E. **Innominate shear dysfunction in the sacroiliac syndrome**. Manual Medicine 1986; 2 (4): 114-121 **Located in third floor stacks**

Recently there has been an increased interest in the sacroiliac syndrome. There appear to be multiple variations to be found in dysfunctions of the sacroiliac joints. Unilateral alteration in the opposition of the joint surface of the innominate in relation to the sacrum in both a cephalic and caudal direction seem to be possible. Clinical evidence supports a superior innominate shear (upslip innominate) and an inferior innominate shear (downslip innominate). The anatomy of sacroiliac joint is reviewed as well as the current understanding of sacroiliac joint motion. Diagnostic criteria and therapeutic interventions for both superior and inferior innominate shears are presented. Results of a series of 12 cases superior innominate shear and 4 cases of inferior innominate shear are provided.

Abstract from publication

Sclerotherapy

Leedy, R. F. **Basic techniques of sclerotherapy**. Osteopathic Medicine 1977 Aug; 2 (8): 15-16, 18-20, 22, 109-110, 113-114 **Located in third floor stacks**

The principle of using an irritant to stimulate the production of nature's repair tissue (fibrous connective tissue) has been known and used for a long time. A blow will irritate tissues and produce a lump (fibrous connective tissue); a burn will produce scar tissue (fibrous tissue); and a chemical will irritate and produce connective tissue. More than a hundred years ago hernias were treated successfully by injection of controlled chemical irritants. About 1937, Dr. Earl H. Gedney introduced the idea of using sclerosing injection techniques for ligaments of joints (particularly in the low back) that sprain recurrently. Ligament weakness and stretching were recognized then, as now, as principle underlying causes of joint instability that lead to recurrent sprain-subluxation. This continued sprain mechanism commonly resulted in arthritis, "slipped disk syndromes," sciatica, and other problems. Some of Dr. Gedney's co-workers began to experiment with the new treatment and gradually they developed their own techniques and skill. The new technique has progressed slowly-but steadily. It has encountered the usual disbelief and even active opposition. About 1946, an orthopedic surgeon, Dr. George S. Hackett, began using and experimenting with technique and, in 1956, he wrote a book titled Joint Ligament Relaxation Treated by Fibro-Osseous Proliferation. Dr. Gedney called the technique sclerotherapy and Dr. Hackett proposed the name prolotherapy. Today, the ligament injection of controlled chemical irritants is called sclerotherapy in osteopathic medicine and prolotherapy in other fields. In sclerotherapy, solutions injected into a soft tissue produce hardening, thickening, and toughening - a sclerosis. The term is applied to joint ligaments and tendons only discussed in this article. In the current technique, a standard chemical irritant is injected in a well-established pattern to produce a local, predictable result with no systemic effect. Exceptions are solutions that contain washed pumice, which causes a mechanical irritation. This active principle is that of local tissue irritation to stimulate proliferation of fibrous connective tissue.

Abstract from publication

Sclerotherapy

Mack, R. A. ***Sclerotherapy: rich in medical history***. DO 1989 Mar; 30 (3): 145-146 **Located in third floor stacks**

In this article, the author reports on a lecture given to the members of the American Osteopathic Academy of Sclerotherapy (AOAS) at the annual American Osteopathic Association (AOA) convention in 1988. The lecture was given by Dr. Andrew Kulik. In the lecture, he reviewed the history of sclerotherapy. He traced its origins to the fifth century B.C. and Hippocrates. In more modern times, documented use of sclerotherapy in the United States dates back as early as 1832. Osteopathic studies involving sclerotherapy began in the 1930s by Dr. Earl Gedney at the Philadelphia College of Osteopathic Medicine.

Sclerotherapy; Back pain

Bourdeau, Y. ***Five-year follow-up on sclerotherapy / prolotherapy for low back pain***. Manual Medicine 1988; 3 (4): 155-157 **Located in third floor stacks**

SUMMARY: The aim of this retrospective study is to evaluate the efficacy of sclerotherapy as one of the modalities used in an orthopedic medicine practice to treat low back problems. A special attempt will be made to shed some light on the length of time the beneficial effects of this treatment modality lasts. A review of 43 patients, all referred by their family physicians, who presented with low back pain in 1982 was carried out with the help of a questionnaire sent to them in 1987. Out of the 24 who responded, 17 were considered to have had very good to excellent results. This study emphasizes the long-term beneficial effect of sclerotherapy, especially for chronic low back pain.

Abstract from publication

Shoulder; Child; OB-GYN

Hibbard, L. T. ***Coping with shoulder dystocia***. Contemporary OB/GYN 1982 Sep; 20 (NA): 229-231, 234-235, 237 **Located in reference office**

Skillful manipulation of trapped shoulders can prevent radical procedures and unnecessary complications. Here are descriptive, step-by-step methods for meeting this problem.

Abstract from publication

Somatic dysfunction

Patterson, M. M. and Steinmetz, J. E. ***Long-lasting alterations of spinal reflexes: A potential basis for somatic dysfunction***. Manual Medicine 1986; 2 (2): 38-42 **Located in third floor stacks**

SUMMARY: The long lasting nature of certain abnormal autonomic and musculoskeletal activity patterns has been recognized for many years. In clinical practice, the after effects of periods of abnormal afferent inputs have often been termed the "neural scar" due to the seemingly permanent changes which many physicians have observed even after long periods of treatment. Possible causes of such changes could be peripheral alterations or changes within the nervous system itself. Recent work on long-lasting changes in the excitability of the spinal reflex pathways has shown that relatively short periods (15-30 min) of fairly intense afferent input to the spinal reflex pathways can cause increases in the neural excitability which lasts for several hours. This phenomenon is known as spinal

fixation. The work reported here extends these findings to show that stimulation periods of from 45 - 90 min which cause no observable locomotion problems in rats, can have effects on reflex excitability problems in rats, can have effects on reflex excitability which are seen up to 72 h later following normal living patterns and locomotion. Thus, the excitability alterations are apparently masked by descending brain influences but remain despite such activity. The implications of this work for manipulative therapy and clinical observations of the effects of abnormal function include the necessity to take possible long-lasting reflex alterations into account in determining ongoing therapy.

Abstract from publication

Somatic dysfunction; Back Pain

Kidd, R. *Pain localization with the innominate upslip dysfunction*. Manual Medicine 1988; 3 (3): 103-105 **Located in third floor stacks**

SUMMARY: All adult patients in a private orthopedic medical practice were screened for innominate upslips over a period of two years. Sixty-three were found, of which all presented with pain. With treatment, correction of the upslip was associated with an improvement or disappearance of pain. In those with upslips, pain was often felt in more than one area and at levels of the body remote from the sacroiliac joint. Also, the association of the upslips with the side of the body in which the pain was felt was essentially random. These findings raise questions as to how pain is produced with innominate upslips.

Abstract from publication

Somatic dysfunction; Back Pain; Musculoskeletal System

MacDonald, R. S. *Primary dysfunction of the spine*. Holistic Medicine 1988; 3 (1): 27-33 **Located in third floor stacks**

SUMMARY: Investigations of back pain have mainly sought a causative structural pathology: for most presentations this search has failed. It is suggested that the possibility of primary spinal dysfunction producing pain has been unreasonably neglected, and that more priority should be given to studies capable of revealing such dysfunction.

Abstract from publication

Somatic dysfunction; Child; Learning Disorders

Chandler, J. E. E. *Minimal brain dysfunction: some preliminary findings*. British Osteopathic Journal 1983; 15 (1): 7-14 **Located in third floor stacks**

SUMMARY: This speculative study represents an attempt to reappraise the characteristics of minimal brain dysfunction (MBD), recalling symptom patterns and recording palpatory findings in a sample of twelve children affected by the syndrome. A high proportion are found to exhibit certain abnormal characteristics as regards involuntary movements; common findings including: the cranium held in side-bending/rotation; rapid primary respiratory rate; parietal dysfunction; lack of extension cranially and unilateral resistance to shearing of the vault of the skull. It is suggested that MBD is the result of an organic brain lesion, which may be localized in the region of the angular gyrus.

Abstract from publication

Somatic dysfunction; Musculoskeletal System

Stiles, E. G. *Manipulation: a tool for your practice*. Patient Care 1984 May; 18 (9): 16-25,30-32,35,39-42 **Located in third floor stacks**

You may be able to pick up a number of useful, safe techniques from one well-conducted tutorial. So says Edward G. Stiles, DO, a recognized expert in the field. We invited Dr. Stiles to explain and demonstrate manipulative techniques to a group largely composed of allopathic physicians, all members of the Patient Care Board of Editors. The result? Lively discussion, greater understanding between osteopathic and allopathic physicians, and - in the minds of some participants, at least - an awakened interest in the potential of manipulative therapy. Here, Dr. Stiles outlines the principles of a versatile type of manipulation; in an accompanying article, he demonstrates the application of these principles of anterior chest wall pain.

Abstract from publication

Somatic dysfunction; Musculoskeletal System

Thabe, H. ***Electromyography as tool to document diagnostic findings and therapeutics results associated with somatic dysfunctions in the upper cervical spinal joints and sacroiliac joints.*** Manual Medicine 1986; 2 (2): 53-58 **Located in third floor stacks**

The nocireaction caused by a somatic joint dysfunction proceeds predominantly via the dorsal ramus of the spinal nerve that supplies the autochthonous back muscles. This is electromyographically demonstrated by continued spontaneous activity in the respective segmental muscle. If the afferent information from the restricted joint is blocked with local anesthetic injection, the spontaneous activity disappears. The same result can be achieved with injection into the corresponding segmental muscle with a delay of four minutes, however. Mobilization techniques on the contrary, do not have the same spontaneous effect, yet are able to lower spontaneous activity significantly. Manipulation (thrust techniques) results in the immediate disappearance of spontaneous activity.

Abstract from publication

Somatic dysfunction; Physical Examination; Musculoskeletal System

Beal, M. C. and Dvorak, J. ***Palpatory examination of the spine: a comparison of the results of two methods and their relationship to visceral disease.*** Manual Medicine 1984; 1 (2): 25-32 **Located in third floor stacks**

SUMMARY: Fifty patients were examined by two examiners without knowledge of their histories or diagnoses, representing two different approaches to examination of the musculoskeletal system. On average, both examiners selected two sites per patient that were at the same vertebral level for somatic (segmental) dysfunction; however, examiner B averaged 9.3 and examiner D 8.1 sites per patient. The level of agreement is substantially improved if 1) agreement is based upon selection for the absence as well as the presence of somatic dysfunction (average 72%) or 2) the examination sites are grouped together (70%). This study is based on the observations of the examiners, with regard to the location of sites of somatic dysfunction, and the level of agreement of the relationship of their findings to structural problems and visceral disease.

Abstract from publication

Somatic dysfunction; Piriformis syndrome

Arkuszewski, Z. ***Joint blockage: a disease, a syndrome or a sign?*** Manual Medicine 1988; 3 (4): 132-134 **Located in third floor stacks**

SUMMARY: Some practitioners believe that joint blockage (somatic dysfunction) is a condition that can be cured by manipulation. This attitude makes it difficult for manual therapists to communicate with other physicians who do not apply manual procedures for the treatment of back or

neck pain, cervical migraine or vertigo and other spondylogenic disorders. Many of the facts fundamental to manual medicine prove that in the conditions not only is the joint play disturbed but also, or even mainly, proprioception, motor patterns, the autonomous nervous system and the psyche are impaired in the patients affected. The author discusses all these factors and comes to the conclusion that joint blockage is only one of many signs of nervous system dysfunction.

Abstract from publication

Spondylitis

Schlapper, B. D. ***Ankylosing spondylitis: an osteopathic approach to diagnosis and treatment.*** Osteopathic Medicine 1979 Dec; 4 (12): 15-16, 19-22, 24 **Located in third floor stacks**

SUMMARY: Ankylosing spondylitis (AS) is a very gratifying condition to recognize and treat because so much can be accomplished toward ameliorating symptoms and preventing spinal deformity. Since there is no cure for AS, the objectives of treatment are to relieve pain, prevent spinal deformity, and maintain the highest functional capacity possible of the patient. The following plan should be instituted: 1) Drug therapy - salicylates are the most simple and cheapest of the anti-inflammatory drugs with added analgesic effects as well. Indomethacin, Phenylbutazone, Ibuprofen and the newest drug, Sulindac, are all proven nonsteroidal anti-inflammatory medications which have been successfully used for moderate to severe spinal or peripheral joint involvement. 2) Exercise programs with postural instructions to promote the maintenance of a straight spine at home, at work, and in bed. 3) Rest periods adapted to the individual patient depending on the disease severity. 4) Osteopathic manipulation therapy, if done in a conservative manner on a monthly basis, may help strengthen the extensor muscles of the spine, to avoid further tendency for the AS patient to stoop. With early diagnosis, adequate patient-physician management, and patient compliance, a satisfactory functional capacity with minimal deformity can be maintained in most patients.

Abstract from publication

Sports Medicine

Wright, R. M. ***Osteopathic medicine's place in sports worldwide.*** Osteopathic Medicine 1979 Mar; 4 (3): 15-19, 23-26 **Located in third floor stacks**

SUMMARY: In this article, I have presented many conditions of the athlete and his problems. You, as an osteopathic physician, have something to offer. Starting back at the time of the century when A.T. Still offered osteopathic medicine to the world and up until today, giving something to the athlete that no one else can give to him, making a champion out of a man who would have been a failure, is something you can do. I know it is asking a lot, but I know many times you may say to yourself, I am but one, what can I do? My answer is that history shows repeatedly that one man can start a wave of action. The leadership of strong moral men will call forth the power of the people, that true power of the nation. Remember the greatest thing in life is spending it for something that will outlast you. This is a true example of Dr. Thomas L. Northup whom we honor today.

Abstract from publication

Substance Abuse; Child

Brewer, L. G. ***Children of alcoholics.*** Osteopathic Medicine 1977 Dec; 2 (12): 99-106 **Located in third floor stacks**

INTRODUCTION: Our osteopathic concept has always been a holistic approach to the patient and his problems. With this approach has come the ready acceptance of the principle that illness in one member of the family affects the mental and physical health of the other family members.

Alcoholism is a disease which affects not only the alcoholic but the entire family. Spouses of alcoholics have long been encouraged to participate in treatment, but the recognition of the fact that alcoholism in a parent severely affects the children of alcoholics has often been overlooked.

Abstract from publication

Surgery

Larson, N. J. ***Manipulative care before and after surgery.*** Osteopathic Medicine 1977 Jan; 2 (1): 41-43, 47-49 **Located in third floor stacks**

The practice of osteopathic medicine requires as many variations as there are differences in the presenting clinical problems. Even though the concept of the constant relationship of the spinal segmental changes and visceral disease is apparent and consistent, there is a great variation in how this is of practical importance. The following discussion will involve the osteopathic palpatory and manipulative procedures as they can be applied. We will consider applied osteopathy in the diagnosis and /or treatment of three common clinical problems: cholelithiasis, anterior wall infarct, and pelvic endometritis.

Abstract from publication

Surgery

Stiles, E. G. ***Osteopathic treatment of surgical patients.*** Osteopathic Medicine 1976 Sep; 1 21-23 **Located in third floor stacks**

As osteopathic physicians at Waterville Osteopathic Hospital have learned, osteopathic care can provide benefits to the patient, the surgeon, and the hospital once osteopathic care is incorporated into total health care management. Osteopathic care can benefit the patient by providing him with the best possible clinical condition prior to surgery. Postoperative osteopathic care could decrease the incidence of complications, enhance healing, and thereby shorten the duration of the patient's hospitalization. The following is a brief summation of the rationale for designing osteopathic care for the surgical patient.

Abstract from publication

Temporomandibular Joint Disorders

Downs, J. R. ***Treating TMJ dysfunction.*** OP. The Osteopathic Physician 1976 Mar; 43 (3): 106-107, 111, 113 **Located in third floor stacks**

Pain associated with dysfunction of the temporomandibular joint was pointed out by Costen in 1934 and became widely known under his name. Although his syndrome has been proven incorrect, he served, nonetheless, to focus attention upon the temporomandibular joint and the muscles of mastication as potential etiological areas for head and neck pain. In spite of all the recent interest and increased knowledge, most physicians and dentists are not well informed about diagnosis or treatment of the temporomandibular pain dysfunction syndrome. If doctors knew more about this syndrome, the pain and suffering experienced by many patients could be relieved earlier and faster.

Abstract from publication

Temporomandibular Joint Disorders

Gillespie, B. R. ***Dental considerations of the craniosacral mechanism.*** Journal of Craniomandibular Practice 1985 Sep-Dec; 3 (4): 380-384 **Located in third floor stacks**

An important relationship occurs between dentistry and the cranial concept. Restriction or distortion of the temporal and mandibular bones affect the delicate cranial motion and result in many systemic symptoms. The driving force of the entire cranosacral mechanism comes from inherent motion of the brain and spinal cord. As the brain and cerebral spinal fluid move, the dural membranes guide the cranial bones. Because the dura attaches to the sacrum, the sacrum moves in union with the cranium. Since structure and function are closely related, trauma, stress, posture, and other factors effect the cranial motion and vice versa. Common dental treatment may have an adverse effect on the cranosacral cycle. Restriction of the maxillary bone motion may occur as a result of a difficult maxillary extraction, prostheses, ill-fitting gear, or tight dentures. Diagnosis of cranial restriction is primarily accomplished by keen manual palpation. Craniomandibular therapy consists of gentle manipulation of the cranial tissues to release the tension in the mechanism. Palpation of bones and change of the dural membranes directs the cranial tissues into a position of greater ease and less stress. Treatment may include manipulative techniques in conjunction with removable mandibular appliances, exercises, and lifestyle changes. By understanding the cranosacral mechanism, dentistry will assume a greater role in the general health of the patient.

Abstract (unknown)

Temporomandibular Joint Disorders

Larson, N. J. ***Osteopathic manipulative contribution to treatment of TMJ syndrome.*** Osteopathic Medicine 1978 Aug; 3 (8): 15, 17-18, 21-22, 24-25, 27 **Located in third floor stacks**

The temporomandibular joint (TMJ) syndrome is an appropriate title for the various complaints associated with the temporomandibular articulation. The variabilities in the cause-effect relationships are probably responsible for the extreme divergence of symptoms associated with this joint dysfunction. Although dental malocclusion is the most common and obvious cause for this disorder, there are other factors that may be involved, especially somatic dysfunctional disorders of the skull and the cervical and upper thoracic spine. These disorders provide considerable opportunity for specific osteopathic manipulation to provide effective treatment for patients suffering from TMJ syndrome.

Abstract from publication

Thoracic Outlet Syndrome

Barker, M. E. ***Manipulation in general medical practice for thoracic pain syndromes.*** British Osteopathic Journal 1983 Dec; 15 (2): 95-97 **Located in third floor stacks**

CONCLUSION: In General Practice definite cardiac pain presents less than two or three times a month, many more patients present with non-cardiac chest pains. Examination of the thoracic spine is recommended as a routine and may help in the diagnosis of atypical chest or abdominal pains. The recognition of the 'thoracic disc syndrome' and its appropriate treatment can render the patient a great service, the patient's fears of serious pathology can be allayed and extensive investigation avoided.

Abstract from publication

Thoracic Outlet Syndrome

Ingesson, E. E. U., Ribbe, E. B. and Norgren, L. E. H. ***Thoracic outlet syndrome - evaluation of a physiotherapeutical method.*** Manual Medicine 1986; 2 (3): 86-88 **Located in third floor stacks**

SUMMARY: Surgical treatment of Thoracic Outlet Syndrome (TOS) as a resection of the first

thoracic rib has been established for many years. Conventional conservative treatment in this group of patients, however, has often failed, while this treatment had been given diffusely to the shoulder-neck region. A conservative treatment is presented, consisting of a general and a specific part, focused towards the upper thoracic aperture. 50% of the patients responded to treatment and at follow-up six months later 70% of these were still improved. The duration of symptoms was significantly shorter in the responding group than in the non-responding group. No difference in age or sex was found.

Abstract from publication

Thoracic Outlet Syndrome

Ribbe, E. B., Lindgren, S. H. S. and Norgren, L. E. H. ***Clinical diagnosis of thoracic outlet syndrome - evaluation of patients with cervico-brachial symptoms***. Manual Medicine 1986; 2 (3): 82-85 **Located in third floor stacks**

SUMMARY: Symptoms and signs from the cervico-brachial region are very common in clinical practice and often raise diagnostic difficulties. Thoracic Outlet Syndrome (TOS) is one of the causes of these symptoms. In this paper 315 patients with cervico-brachial symptoms were evaluated; 207 were judged to have TOS and 108 did not have TOS. The symptoms and signs of the patients were evaluated, and it was shown that in 94% of TOS-patients the diagnosis was established on at least three of the following four symptoms and signs: 1) Aggravation of symptoms with the arm in the elevated position, 2) Ulnar paresthesias, 3) Brachial plexus tenderness, and 4) A positive "Hands up test". 33% of the non-TOS patients had this combination, but they also had signs of some other obvious disorder. TOS should be a diagnosis of exclusion and in uncertain cases treatment should be focused towards other causes of cervico-brachial symptoms before surgery with rib resection is performed.

Abstract from publication

Thoracic Outlet Syndrome; Back Pain

Kenna, C. and Murtagh, J. ***Practice Tip: upper thoracic back pain [demonstration]***. American Family Physician 1985 Jun; 14 (6): 583 **Located in third floor stacks**

Abstract N/A

Whiplash Injuries

Bogduk, N. ***Anatomy and pathophysiology of whiplash***. Clinical Biomechanics 1986; 1 (2): 92-101 **Located in third floor stacks**

Whereas the symptoms of whiplash injury are frequently poorly understood or misrepresented as due to neurosis, a review of the literature reveals a considerable amount of biomechanical and experimental data that substantiate a diverse organic basis for these symptoms, including disorder commonly not considered or sought for in the investigation of whiplash. Moreover, formal studies fail to substantiate the notion of "litigation neurosis" being the cause of prolonged symptoms. This review synthesizes the anatomy and pathology of whiplash, and the pathophysiology of symptoms, into what can be construed as the organic basis for whiplash.

Abstract from publication

Whiplash Injuries

Holding, R. A. ***Osteopathic thinking - whiplash injuries, part II***. British Osteopathic Journal 1984 Jun; 16 (1): 46-48 **Located in third floor stacks**

In part I, whiplash injuries were defined as an acceleration or deceleration force that produced profound physiological shock as well as changes in direction of tension within the neuro-facial-muscular system of the individual. The sequellae of the whiplash injuries as described by Dr Rollin Becker, D.O., and as found clinically were listed as: (1) Abnormal suspension of the sacrum between the ilia by the sacro-iliac ligaments, anterior and posterior longitudinal ligaments and the dural attachments at the second sacral segment. (2) Effects on the fascial system of the body. This entailed an understanding that the WHOLE body will have been accelerated or decelerated in the accident and the fluid-filled fascial envelopes will be deformed by this stress, producing shift in their balanced tension. This leads from abnormal physiology to abnormal function to abnormal structure, if not corrected. (3) Effects on previously existing stresses and strains within the patients from the inertia or points of contact. Obviously the stresses found in a hypolordotic individual will be very different from a scoliotic individual under the same circumstances. (4) Effects on the spinal meninges. The continuity of the dural tension between the head and sacrum with only attachments at the bodies of the 2nd and 3rd cervical segments means that the dural system is particularly susceptible to these types of strain. Hence its mobility is affected, making it less able to accommodate other mechanical stresses imposed on it, as well as having a braking effect on cerebrospinal fluid fluctuation.

Abstract from publication

Whiplash Injuries

Holding, R. A. *Osteopathic thinking in whiplash injuries, part I*. British Osteopathic Journal 1983 Dec; 15 (2): 131-134 **Located in third floor stacks**

Osteopathic and allopathic literature on whiplash injuries was reviewed. The injury is concluded to be a potent maintaining factor of the recipient's ill-health rather than the symptoms described in the literature.

Abstract from publication