2018 Membership Survey
And Strategic Plan
Musings from the Executive Director

On the cover of this issue, you see a graphic that capsulizes many of the words and phrases used to describe the Osteopathic Cranial Academy. It served as a starting point in our deliberations and as we begin to implement our Strategic Planning Initiative, we focus on so many of the words that call us to action. President Binkerd discusses this is greater detail in his column, yet any such look into the future still depends on the membership to support and encourage others to build on the 70 year history of the OCA. How will you do your part? Of course, many attend our courses during the year and take away practical information and techniques useful in your practice. However, are you advocating for Osteopathy in the Cranial Field (OCF) in dealings with patients and other practitioners? Opportunities for advocacy on the state, national and international levels are abundant.

Our Foundation Scholarship Program continues to expand as our members and others see the value of assisting physicians in training and residents with a scholarship to help defray half of the cost of our Introductory Course. Managed by the Osteopathic Cranial Academy Foundation, over 30 scholarships were granted last year but there is so much more that can be done and so many more students and residents that can be helped so that they can afford our courses. A new program of scholarships for residents to take some of our Intermediate Courses has been considered but have not yet been implemented because no one has stepped up to fund such a project. I would be pleased to speak with you or one of your patients who might have an interest in funding scholarships through the OCAF with a significant donation earmarked for these courses. Contact me at the Executive Office for more details.

I am pleased to report that our February Introductory Course, directed by Zinaida Pelkey DO FCA, sold out in late November with 52 participants and our Mesoderm Course, directed by Elliott Blackman DO FCA is approaching a full complement of 36 for the course. Our Advanced Fulford Course in April, directed by Paula Eschtruth DO FCA, has nearly sold out in January. The popularity of our courses and our Annual Conference (last year over 240 attended, largest in the history of the OCA) is commendable and shows that our members and others feel a need to learn Osteopathy in the Cranial Field at a primary and advanced level.

This year’s Conference in Norfolk, Virginia titled, “Discovering the Heart of Osteopathy,” chaired by Donald V. Hankinson, DO will explore the heart’s many dimensions and its relationship to Osteopathy in the Cranial Field. Our Sutherland Memorial Lecturer, Mark Rosen DO FCA, will relate his own quest for discovering how William Garner Sutherland DO DSc (hon) had an impact on his career and his life. More details about the conference, including the program and speakers appear elsewhere in this issue. Last year’s conference sold out and this year’s conference promised to be very popular. You can register online at www.cranialacademy.org/events/cme or by printing the registration form on page 6 and mailing it with your check or credit card information.

I hope to see many of you this year in Dallas for the American Academy of Osteopathy’s Convocation. Please stop by our booth and say hello as well as register for the June Intro Course or Annual Conference.

Respectfully submitted,
Sidney N. Dunn, Executive Director
Greetings fellow members of the OCA. In my last President’s Message I told you about the planned Board of Directors’ Strategic Planning Retreat to be held on the weekend of December 2 in Denver Colorado. As the result of your great response to the Membership Survey [http://cranialacademy.org/wp-content/uploads/2017/12/OCASurveyMemberResults.pdf] which was compiled and analyzed by our consultants, JVA, the Board was able to produce an ambitious plan for the next 4 to 5 years. To see a copy of that report please follow this link to the Strategic Planning Report [http://cranialacademy.org/wp-content/uploads/2018/01/OCA_StrategicPlanningReport121517toClient.pdf].

As the result of the membership (and non-membership) survey and the Strategic Planning Retreat, a couple of concepts were made very clear to the Board. The first is that the membership was overwhelmingly in support of continuing to require that successful completion of a 40 hour introductory course should be maintained as a requirement for membership. The second, that an alternative to an OCA “approved” course be considered as a pathway to membership. As the result of this input from the membership, the Credentials, Membership and Introductory Course Committees have been charged with creating a Task Force to consider and present to the Board, options for accomplishing these goals. Once presented, the Board will discuss and consider for approval in accordance with member input. This would be a big step for the OCA and before any definitive action would be taken, much consideration, discussion and consultation with membership must be undertaken.

I would ask each member to consider, what mechanism or pathway can you conceive that would hold to the clear desire of membership to retain the 40 hour Introductory Course requirement yet still, allow an alternative for those who have completed a “non-OCA approved” courses? This is a thorny question but I believe it can be accomplished if we are willing to work together.

The Paris Introductory Cranial Course (ICC) will again take place this coming May. This course has experienced several challenges and near setbacks over the course of the past three years. As so often happens, the best laid plans can get disrupted and/or completely derailed. Again this year, there were challenges that arose with the ability of the planned Director to fulfill that role. As the Board considered the resolution of this conundrum, to the rescue came Past President and longtime Introductory Course Director, Zina Pelkey, D.O., FCA. The Board unanimously approved Dr. Pelkey at our last meeting in December and she is already hard at work designing the course for May 2018. On a personal note, I could not be more pleased with Dr. Pelkey’s willingness and the Boards swift action.

Finally, I would like to put in a plug to the membership to get involved. In this case I mean, not only in the OCA but in the course and direction of the osteopathic profession as a whole. You are all aware that now is another one of those critical times in the life of our profession. The impending ACGME “merger” presents both potential opportunities and real changes. I have heard many members of the OCA express concerns about the direction of the AOA and the profession. I share some of those same concerns. Though I am confident in those leading this particular effort, I still have concerns about some of the predicted and unforeseen outcomes. If you want to be a part of assisting in insuring our existence and relevance, the method is involvement in the House of Delegates to the AOA. The constitution of the membership of the House of Delegates can be found the AOA Constitution and Bylaws [http://www.osteopathic.org/inside-aoa/about/leadership/Documents/aoa-constitution-and-bylaws.pdf], Article VI, Section 1. In short, members are selected from state societies, student representatives, AOA recognized specialty colleges. If you are a member of one of those classes, I would encourage you to seek nomination to the AOA House of Delegates to ensure that osteopathy remains an integral and defining part of the osteopathic profession. It is easy to sit on the outside and see the flaws. What is hard is committing to working within the existing structure to ensure change. Yet, it is incumbent upon the person who sees the issue or the danger, to take action and make the necessary effort to provide the corrections. No one else sees the danger that you may see or they would already be working on the solution. Please be that one to take action.

As always, I am most grateful for your support and your membership in the OCA. Without you as a member there would be no need for the OCA to exist.

Fraternally,

James W. Binkerd, DO
President of the Osteopathic Cranial Academy
International Proficiency Exam

Hello dear Colleagues from all over the World,

As International Associate Members of the Osteopathic Cranial Academy, you probably know that the OCA’s Exam of Proficiency is strictly reserved to the American DO’s.

Happily for you, an International Exam of Proficiency was created six years ago by a friendly collaboration between the French AMOC (Académie Médicale d’Ostéopathie Crânienne) and the SCTF Belgium.

If you are interested to pass this written, oral and practical exam in June 2018 (just before the Cranial Conference in Norfolk - Virginia) you have just to inform us.

If you pass... you’ll get an official International Certificate of Proficiency and your name will be published in the next OCA’s Directory!

Last detail: there is no charge for this exam.

Please send us a message to confirm, and we will contact you for further information.

Yours most fraternally,

Daniel Ronsmans, DO(UK)    Maurice Bensoussan, MD, DO, FCA    Eric Hupet, DO
President EurOCA & SCTFB    Vice-President EurOCA & AMOC    Board Member OCA, EurOCA & AMOC

Recommendations for Nominations

Return to the office of The Osteopathic Cranial Academy by December 15, 2017.

Suggested Nominees for Directorships of The Osteopathic Cranial Academy (2 will be nominated)
(Recognition of Proficiency is recommended)

Nominee: ___________________________ Rationale:______________________________

________________________________________

Nominee: ___________________________ Rationale:______________________________

________________________________________

Submitted by: _________________________ Date: __________________________

Osteopathic Cranial Academy Annual Conference 2018

Andrew Taylor Still wanted to know “what attributes of Life are located in the heart”. He referred to the heart as the “Fountain of Life”, from which the Rivers of Life flowed forth to “nourish the famishing fields” and to “import the attributes of life and knowledge”.

So our question is, what is the “Heart of Osteopathy?” What attributes of Life lie at the center of Dr Still’s Osteopathic Science? What are the core principles of Osteopathy that inform our work and give it the coherence and the power to promote Healing?

We will discover this by exploring the heart's many dimensions. The course will start in a state of balanced awareness and unfold from there: the emergence of the embryologic heart and its fluid physiology; the establishment of its fascial incarnate form; culminating in the emergence of the oneness of the spiritual potency, which is the Love from which all of Life emerges and to which all must return for Healing.

We hope that you will come and join us on this exciting journey to discover what principles of Natural Law are available to us at the Heart of Dr Still’s Science of Osteopathy. Perhaps, then, we will come closer to understanding that essential presence that Dr Still instructed us to search for in our patients, “Health”. Syllabus and Registration form follow on the next two pages.
# 2018 Annual Conference

**“Discovering The Heart of Osteopathy”**

Norfolk, Virginia

June 14-17, 2018

<table>
<thead>
<tr>
<th>Thursday, June 14</th>
<th>11:45 a.m.</th>
<th>The Powers of the Diaphragm</th>
<th>Andrew M. Goldman DO FCA</th>
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<tr>
<td>2:00 p.m.</td>
<td>Registration</td>
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<tr>
<td>3:45 p.m.</td>
<td>Welcome</td>
<td>Donald V. Hankinson DO and Thomas A. Moorcroft DO</td>
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<tr>
<td>4:00 p.m.</td>
<td>The Heart of Osteopathy</td>
<td>Donald V. Hankinson DO</td>
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<td>4:30 p.m.</td>
<td>The Heart and the Hand</td>
<td>Anthony G. Chila DO FAAO FCA</td>
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<td>5:15 p.m.</td>
<td>The Central Field</td>
<td>Anthony G. Chila DO FAAO FCA</td>
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<td>6:00 p.m.</td>
<td>Treatment of All Participants</td>
<td>Donald V. Hankinson DO</td>
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<td>6:30 p.m.</td>
<td>Student Lab</td>
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<tr>
<td>9:00 a.m.</td>
<td>The Heart and its Fluid Dynamics</td>
<td>Mark Schuenke PhD</td>
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<td>9:45 a.m.</td>
<td>Birth of the Heart</td>
<td>Andrew M. Goldman DO FCA</td>
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<tr>
<td>10:15 a.m.</td>
<td>Birth of the Heart</td>
<td>Andrew M. Goldman DO FCA</td>
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<td>11:00 a.m.</td>
<td>Discussion in Small Groups</td>
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<tr>
<td>11:15 a.m.</td>
<td>The Heart’s Living Form and Function in Osteopathic Practice</td>
<td>Ilene M. Spector DO FCA</td>
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<td>Ilene M. Spector DO FCA</td>
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<td>2:15 p.m.</td>
<td>The Heart as a Neuro-Endocrine Immune Organ</td>
<td>Hugh M. Ettlinger DO FAAO FCA</td>
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<tr>
<td>3:00 p.m.</td>
<td>The Heart as a Neuro-Endocrine Immune Organ</td>
<td>Hugh M. Ettlinger DO FAAO FCA</td>
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<td>4:15 p.m.</td>
<td>The Fountain of Life</td>
<td>Michael P. Burruano DO FCA</td>
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<td>5:00 p.m.</td>
<td>The Fountain of Life</td>
<td>Michael P. Burruano DO FCA</td>
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<tr>
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<td>The Heart’s Fascial Home</td>
<td>Mark Schuenke PhD</td>
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<td>9:45 a.m.</td>
<td>The Pericardium as the Dura of the Chest</td>
<td>Daniel A. Shadoan DO</td>
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<td>10:30 a.m.</td>
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<td>The Pericardium as the Dura of the Chest</td>
<td>Daniel A. Shadoan DO</td>
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<th>Sunday, June 17</th>
<th>12:00 p.m.</th>
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<th>Kim Tripp DO</th>
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<tr>
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<td>Unconditional Love – Higher Vibrational Frequency of Love</td>
<td>Paula L. Eschtruth DO FCA</td>
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<tr>
<td>9:30 a.m.</td>
<td>Unconditional Love – Higher Vibrational Frequency of Love</td>
<td>Paula L. Eschtruth DO FCA</td>
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<tr>
<td>10:30 a.m.</td>
<td>Love, Kindness and Presence with the Suffering Patient</td>
<td>Ilene M. Spector DO FCA</td>
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<tr>
<td>11:00 a.m.</td>
<td>Discussion in Small Groups</td>
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<tr>
<td>11:15 a.m.</td>
<td>Observing the Heart’s Light</td>
<td>Maria T. Gentile DO</td>
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<td>12:00 p.m.</td>
<td>The Universal Heart</td>
<td>Kim Tripp DO</td>
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**Conference Location**

Hilton Norfolk The Main

100 E. Main St.

Norfolk, VA 23510

(757) 763-6200

$149.00/plus tax per night

Rooms will be available until May 15, 2018 or until the block is sold whichever occurs first. After May 15, 2018, reservation requests will be confirmed on a space available basis.

As a courtesy to others:

Please NO CHILDREN OR PETS in the lecture hall
2018 Annual Conference Registration Form
Prerequisite: Successful completion of an approved 40-hour Introductory Course in Osteopathy in the Cranial Field

The OCA has requested that the AOA Council on Continuing Medical Education approve this program for 22.25 hours of AOA Category 1-A CME credits. Approval is currently pending. Specialty Board hours to be determined.

Name (Print) ____________________________________________________________

Address __________________________________________________________________________________________

City, State, Zip ___________________________________________________________________________ Phone: ____________________________

AOA# __________________________ Osteopathic College ___________________________ Year of Graduation ____________

Date and place of cranial course taken __________________________________________________________________________________________

Registration fee includes 22.25 Category 1-A AOA (anticipated), two lunches and Recognition Banquet. Circle appropriate fees.

- OCA Member (Postmarked on or before June 1, 2018) ............................................................................................. $850.00
- OCA Member (Postmarked after June 1, 2018) ............................................................................................................ $950.00
- OCA Member One Day Registration Fee ................................................................................................................... $400.00
- OCA Nonmember One Day Registration Fee ............................................................................................................. $450.00
- OCA International Member (Postmarked on or before June 1, 2018) ....................................................................... $700.00
- Resident ........................................................................................................................................................................ $400.00
- DO Student (Includes lectures, labs and lunches only) ............................................................................................  $250.00
- Retired Members ........................................................................................................................................................ $400.00
- Qualified Nonmember .................................................................................................................................................. $1,000.00

EXTRA Friday luncheon ticket for guest (Before June 1, 2018) ............................................................................... $45.00
EXTRA Saturday luncheon ticket for guest (Before June 1, 2018) ........................................................................ $45.00
EXTRA luncheon tickets for guests (After June 1, 2018) ............................................................................................ $50.00
EXTRA Saturday Recognition Banquet ticket for guest (Before June 1, 2018) .................................................. $75.00
EXTRA Saturday Recognition Banquet ticket for guest (After June 1, 2018) ........................................................ $80.00

Voluntary contribution to The Cranial Academy Foundation ................................................................................ $_____.00

Total............................................................................................................................................................................... $__________

Banquet menu preference (Check one): □ Fish □ Beef □ Vegetarian

Conference Manual: □ Paper Manual or □ PDF Manual or □ Both ($10 additional)

Paid by: Check _____ MasterCard/VISA/American Express# ____________________________ Exp. Date ____________

Security Code: __________ Signature: __________________________

All cancellations must be received in writing and are subject to an administrative fee of 15% of the total registration fee if received on or before June 1, 2018. Refunds will not be made for cancellations received after June 1, 2018, or for failure to attend. Meal tickets included with the registration fee are not refundable. There is no discount for persons not wishing to attend food functions. No personal taping is permitted. The Osteopathic Cranial Academy teaches the application of cranial osteopathic concepts to MDs, DOs and DDSs. It is the responsibility of ALL participants to use the information provided within the scope of their professional license.

The Osteopathic Cranial Academy
3535 E. 96th St. #101  Indianapolis, IN 46240
Phone: (317) 581-0411  FAX: (317) 580-9299
E-mail: info@cranialacademy.org

You may also register online at www.cranialacademy.org
Cranial Osteopathic Findings and ALF
Annette Hulse DO

Many osteopaths have heard of the ALF (Advanced Lightwire Functional) family of dental appliances developed by Darick Nordstrom DDS and used by dentists around the globe. Osteopathy and ALF treatment are inherently compatible. Dr. Nordstrom studied with several osteopathic masters while he was developing the appliance; the ALF is as much as 

osteopathic appliance as it is a dental appliance.

The language and paradigm of dentistry is very different from the language and paradigm of osteopathy, however, making communication and input on treatment decisions difficult in both directions. As ALF treatment becomes more widespread, the need for ALF-literate osteopaths will grow. I share patients with several different dentists and have worked with each of these dentists to co-treat in their offices. This article lays out my experience about how osteopathic findings can be translated and communicated to the dentist so as to give the patient the greatest benefit from ALF treatment. I have described the findings as I experience them below; of course, other osteopaths may perceive differently.

Enhancing Motion

As an osteopath, the goal when assessing the ALF is simple. The ALF is designed, first and foremost, to support and enhance the primary respiratory mechanism (PRM). So the most important question is “does the ALF enhance motion”? Second is “how does it improve the quality of the motion”? And lastly (if necessary), “where specifically is motion improved better or less well than other places”?

As an aside, my personal experience is that paying close attention to how and where the motion changes can significantly has significantly honed my perceptive skills, as well as giving the information to provide specific feedback to the dentist. So when delving deeper into ALF considerations, the osteopath has the benefit of professional growth as well as providing the best healing experience for the patient.

In osteopathy, we treat at different levels, or layers, of the body. In the cranium, we can describe these layers to include the bones, the membranes (dura), the parenchyma of the brain, and the fluids. For the rest of this discussion, I will be talking about findings at the fluid level. (Note: If you don’t normally treat at the fluid level, or are not sure whether you are in the fluids or not, you can repeat a 40-hour Introductory Class, or take one of the OCA intermediate classes, such as The Cranial Base or The Next Step; ask your table trainers to help you refine your perceptive skills and find these different layers.)

Cranial Strains

Working with cranial strains is probably the most misunderstood element in the osteopathic part of ALF treatment. Cranial strains are one of the first things we learn in cranial osteopathy. In addition, cranial strain patterns can be abstracted, explained with an understanding of the mechanisms of Newtonian physics, so it fits well into an intellectual or cognitive framework of osteopathy. This often makes cranial strains the easiest part of cranial osteopathy for the dentist to learn, and then becomes the common language between the dentist and the osteopath. For ALF evaluation, however, cranial strains are usually a false “diagnosis”. Because the ALF enhances motion, strain patterns that are present will become more apparent, or sometimes even will become noticeable for the first time. The cranial strain isn’t caused by the ALF, it’s enhanced by the ALF. And because the primary goal of the ALF is to enhance motion, that’s a great thing. Most importantly, the ALF should NOT be adjusted to correct for the cranial strain, with a possible exception if the patient has worsening symptoms (e.g., increase in tinnitus); I haven’t seen this, but that doesn’t mean it can’t happen. Rather, the ALF should be adjusted to optimize motion (and yes, that will often make the strain more obvious), and let the PRM adjust the expression of the strain in the bones at its own pace. Of course, the osteopathic treatment can and should be directed to treat the strain, it’s just the ALF adjustment that should avoid this trap.

For purposes of cranial strain, the strain is typically felt in the bone layer. When the osteopath goes underneath that to the fluid layer, the experience will be very different. A properly adjusted ALF may make a bone-layer torsion (for example) more apparent, but the fluid inhalation/exhalation will be full and symmetrical. Obviously, if the ALF introduces a strain pattern at the fluid layer, then the ALF needs to be adjusted. I rarely see this, however. If the osteopath sees a patient for the first time after the ALF has already been placed and notices an obvious cranial strain, she should assume that it was there beforehand.

Activation and PRM Motion

Once the osteopath feels the cranial rhythm (primary respiratory mechanism), then he should pay attention to the quality of the movement. The first place to pay attention is the quality of motion at the end of the inspiratory (external rotation) phase. This should feel familiar, since it’s how osteopaths are taught to assess articular joints, feeling the end range of motion. The quality of feel at the end of the inhalation phase gives information about how to adjust activation of the ALF, as described below.

When the patient shows a good inhalation/exhalation but it fades at the end of inhalation, the ALF needs more activation. Think of this as blowing up a balloon from 25% to 50% - it’s swelling with inhalation but the endpoint isn’t full yet. This is most likely just before the patient sees the dentist for the next ALF adjustment, or when the patient is overdue for an adjustment.

When the inhalation/exhalation phase is full and plump but has a “wobble” in it (most commonly somewhere during the
inhalation phase), the ALF is over-activated. This is very common. Dentists get caught in the fallacy that if a little is good, then more is better; they may resist input on this. If a patient has a robust vitality in his system, he can usually handle an over-activation (although there may be some discomfort, headache, or other side effects the first few days after the dental visit), but can usually be mitigated with an osteopathic treatment. A more fragile patient, however, will have difficulty accommodating to an over-activated ALF.

When the patient shows a nice, healthy, full, plump fluid-level inhalation and exhalation phase, the ALF is appropriately activated.

Treat to the ALF

Sometimes the patient will have an ALF appliance that is removable; in other cases, the appliance is permanently (or semi-permanently) in place. This is a combination of 1) exact design of the appliance, 2) the specifics of the patient, and 3) the dentist’s preference. In an ideal world, the osteopath will be working side-by-side with the dentist. This usually isn’t a feasible option, but I highly encourage all osteopaths to connect with and co-treat with each dentist at least once. If the dentist has taken a 40-hour cranial course, then help them feel the difference between the different feels of various degrees of activation; it can be a huge learning experience for them. Most typically, the osteopath will see the patient in his or her own office within a week or so after an ALF adjustment. In some cases, it’s advantageous for the patient to see the osteopath before an ALF adjustment, usually if the dentist requests specific guidance, or if the patient is routinely restricted immediately after ALF adjustment to try to isolate what is happening.

If the osteopath is working side-by-side with the dentist, or if the ALF is removable, then it can be very educational to observe the difference in the PRM with the ALF in and out. For therapeutic purposes, however, I strongly encourage all osteopaths to treat with the ALF in place. The appliance is designed to work with the PRM, and is designed to be worn most or all of the time. Therefore, the patient will get the best treatment possible by optimizing the PRM of patient-and-ALF unit.

Fine Tuning

Now that we have discussed different ways to evaluate if/how the ALF is enhancing motion, the next step is fine-tune the feedback to the dentist. I use 3 different contacts to hone in on specifics of how an ALF might need to be fine-tuned; these are described below.

The first contact is focused on the occiput. Using an occiputotemporal contact, my focus is on the internal and external rotation of the two halves of the occiput. This will be a change of attention for most physicians, since we typically think of the occiput as a midline bone and its movement in terms of flexion/extension. It may help to start with attention on the thumbs contacting the mastoid processes and find the internal/external rotations of the temporal. The lateral occiput, at the occipital-temporal junction, will follow this same internal-external rotation. Try it on several patients to get a feel for how the occiput moves in that internal/external rotation.

For evaluation of the ALF, in my experience the internal-external rotation of the occiput reflects structures in the molar region. When the rotation is restricted in external rotation, the molar area needs more width and/or more height. In the osteopathic office, the osteopath may be able to differentiate which gives better response by feeling the how the external rotation changes with either slight outward pressure on the molars, or with a piece of paper or one width of a cotton swab placed on the molar surfaces with the patient gently biting down. Molar width is usually easier for the dentist to achieve, since that is a simple adjustment of the ALF; more height usually entails a different appliance, which may or may not be consistent with other objectives in the dental treatment plan.

The second contact I use is an intraoral contact. With the thumbs resting on the two maxillae just lateral to the premaxillary suture below the nose, the pointer fingers go inside the mouth to the inferior surface of the maxillae (see Figure 2). From this position, test the compliance of the maxillary suture (the ability of the 2 maxillae to externally rotate with special attention to restrictions at that suture). Especially if the patient has a history of orthodontia, the osteopath may need to treat to decompress the maxillary suture. If after treatment the suture remains stiff or the maxillary suture is still compressed, then the osteopath can ask the dentist for more anterior width. The full process may take several osteopathic treatments and ALF adjustments, so we are simply looking for incremental improvement over time.

The last contact I use is focused on the maxilla and the face (see Figure 3). Frankly, the findings from this contact will direct the osteopathic treatment to a much greater degree than impacting the ALF adjustment. Nonetheless, sometimes there are findings that require communication with the dentist. Specifically, from this contact I am looking at the movement of the maxilla – the internal and external rotation of the maxillary body. This contact may give information if there are right/left differences or to identify a specific location on one side where a restriction in motion is occurring.

Last but not least is the mandible. From an osteopathic standpoint, ALF adjustments that involve the mandible are mostly about the occlusion or the “bite” and therefore adjustment decisions will be primarily within the purview of the dentist. However, the osteopath will add considerable value to the patient and dentist by balancing the mandible before adjustments that may influence the occlusion (e.g., by treating the sphenomandibular ligaments, the stylomandibular ligaments, and especially the lateral pterygoids).
Caveats

Osteopathic Treatment. The above discussion is focused on the how osteopathic diagnostic findings can be communicated to the dentist as input to the design and adjustment of the ALF. For all patients, there will also be findings that require osteopathic treatment, which is well beyond the scope of this paper. In some cases, the osteopathic treatment will be primary driver of change, with the ALF supporting the unwinding. In other cases, the ALF will be the primary driver, with osteopathic treatment supporting the ALF treatment goals. In either case, the osteopath will want to seek specialized training. Advanced CME classes in treating the mouth, face, and head in general, and coordinating with ALF treatment in particular, are offered by a number of organizations, including the Osteopathic Cranial Academy.

Complicated Cases. This paper outlines the basics of osteopathic input to the ALF adjustment process. When treating complex and/or fragile patients, the input to the dentist will need to go beyond what is outlined here. Experience and additional training will help the osteopath/dentist team learn to manage more complex cases.

An Osteopathic Approach to Ophthalmic and Optometric Disorders: Part 7

Anthony Capobianco, DO

Patient 39, an 82-year-old male, complained of intermittent horizontal diplopia (visualizing side-by–side images). Those were present during focusing at two distances: the priest at church and at productions at a local concert hall. Upon bilateral palpatory scan (a simultaneous globe and orbit contact previously described, along with the remainder of the techniques explained in initial segments of this article series) his right eye, the one also worse for cataract formation, was sensed as protuberant with a decreased ROM. This prompted OMT to the right eye: the OD was medial superior CW, orbit and membrane CCW, projection anterior, and periorbita restricted at the 9 and 10 o’clock positions. The visually relevant intraoral structures, and ethmoid were released, in addition to the above, followed by an abbreviated Venous Sinus Technique (VST), and occipital CV4. (For all osteopathic findings, unless otherwise specified, the technique approaches herein involved directly engaging restrictive barriers, the rationale for and specifics having been described in earlier parts of these articles, as well.) Three days later, bilateral sensing again localized the right eye as being the most restricted. The OD globe was medial superior CW, orbit and membrane CCW, projection anterior medial superior, however, only identifiable after a perpendicular fluctuation, midway between contacts, was detected and followed to release. The periorbita was restricted at 9 and 10 o’clock. The relevant intraoral structures, abbreviated VST (revealing a right greater than left condylar compression), occipital CV4 and ethmoid releases, followed.

Seen the following week, church attendance in the interim, he requested eye OMT again, since he stated he continued to improve, specifically with regards to the frequency and duration of the diplopia. His OD globe was medial inferior CW, orbit CW, membrane CCW, projection posterior medial superior, and the periorbita restricted at 10 and 11 o’clock. OMT for the ethmoid and intraoral structures, an abbreviated VST, and occipital CV4 followed. Addressed as well was a pectoralis majoris myofascial inflammation, on the left, probably from forgotten mechanical trauma. A week later he presented for more ocular OMT since he continued to subjectively have improvements for his diplopia. His OD globe was medial inferior CW, orbit CW, membrane CCW, projection posterior medial superior, and the periorbita restricted at 10 and 11 o’clock. OMT for addressing the intraoral structures, abbreviated VST, occipital CV4 and the ethmoid, followed this. OMT for left rib cage restrictions involvement in gynecomastia took place, as well. The following week he reported improvement of all symptoms: again the OD and left costochondritis were addressed, in addition to a chronic left shoulder osteoarthritis and impingement syndrome. His OD globe was superior lateral CCW, orbit CW, membrane CCW, projection anterior lateral inferior, and the periorbita was restricted at 9 and 10 o’clock. OMT for the other structures, as above, were repeated. The next week, still improving, his OD globe was lateral inferior, orbit and membrane CCW, projection anterior superior posterior, and periorbita restricted at 8 and 9 o’clock. The above intraoral, ethmoid, abbreviated VST and occipital CV4 OMT was repeated. Since he still had some discomfort, his left chest wall, specifically the fourth costochondral joint and intercostal muscles and fascia were addressed, also. At the next visit a week later, he reported improvement of all symptoms: again the OD and left costochondritis were addressed, in addition to a chronic left shoulder osteoarthritis and impingement syndrome. His OD globe was superior lateral CCW, orbit CW, membrane CCW, projection anterior lateral inferior, and the periorbita was restricted at 9 and 10 o’clock. OMT for the other structures, as above, were repeated. The next week, still improving, his OD globe was lateral inferior, orbit and membrane CCW, projection anterior superior posterior, and periorbita restricted at 8 and 9 o’clock. The intraoral, abbreviated VST, occipital CV4 and ethmoid OMT, followed. Chronic left shoulder tendinitis concerns were addressed, as well. The next week he reported even more diplopia progress, as well as a severe sore throat which turned out to be Strep antigen positive. His OD globe was lateral inferior CCW, orbit CW,
membrane CCW, projection anterior superior medial, and the periorbita restricted at 9 and 10 o'clock. The intraoral, ethmoid, abbreviated VST and occipital CV4 OMT followed. The following week he presented with bronchospastic symptoms but reported continued improvement visually. In addition to addressing his allergic pulmonary concerns, his OD globe was superior medial CCW, orbit CW, membrane CCW, projection anterior medial superior, and periorbita restricted at 10 and 11 o'clock. OMT for the additional structures followed, as above. The next week, still improving, his OD was medial inferior CW, orbit and membrane CCW, projection medial superior anterior, and the periorbita restricted at 9 and 10 o'clock. The above structures were addressed, and in addition, the temporoparietal and petrosphenoid areas were found to be more restricted on the right and released directly, as per Dr. Blood's temporoparietal approach (in Part 2 of this series) for improving CN 6 trophism, and hence right lateral rectus extra ocular muscle (EOM) functioning. Residual coughing was addressed via homeopathy and nebulized respiratory epithelium intracellular antioxidant, glutathione 212 2 ml (200mg/ml). The next week he reported the diplopia, when present, was extremely short – lived, if at all. In addition to a discussion on current symptoms of GERD, the OD was inferior medial CW, orbit and membrane CCW, projection anterior medial superior, and projection restricted at 10 and 11 o'clock. In addition, the other structures and procedures, as above, were administered. The week following he had a very brief incidence of double vision while driving and looking at the rear license plate of the automobile ahead of him. The OD globe was lateral superior CCW, orbit CW, membrane CCW, projection posterior medial superior, and periorbita restricted at 8 and 9 o'clock. OMT involving the intraoral structures, ethmoid, abbreviated VST and occipital CV4, followed. Attention to GERD symptoms was included in the visit, as well. His history was similar at the next week’s visit. His OD globe was now lateral inferior CCW, orbit CW, membrane CCW, projection anterior medial superior, and periorbita restricted at 10 and 11 o'clock. The above additional OMT was performed, as well. He then repeated an insight he had voiced the prior week: perhaps his eye condition was related to his cervical spine? The following week he reported rare, less–than–a–second diplopia, and only with television viewing. The decision was made to listen to the patient as medical wisdom often dictates, about possible cervical involvement, whereby the C–spine was addressed with indirect techniques, direct HALV, the Still Exaggeration technique to the C – spine proper, and the occipito-atlantal junction with indirect technique, as the atlas was displaced anteriorly. Moist heat via a hydrocolator and cervical traction preceded the OMT. Homeopathic attention again was directed to his GERD, which was improving since the prior visit.

The following week he was excited to reported on a noticeable shift of improvement he related to the cervical OMT after watching a play production. The prior approach was therefore repeated. The following week he reported continued OD improvement, and in addition, acute pain in his other (OS) eye, which he attributed to dehydration. His OS global sclera was tender and released via fingertip OMT at the 10 o'clock position. Not recalling the cervical strategy, the usual eye sequence was performed. The OD globe was medial superior CW, orbit CW, membrane CCW, projection medial superior posterior, and periorbita restriction at the 10 and 11 o'clock positions. The intraoral structures, ethmoid, abbreviated VST and occipital CV4 OMT, followed. Three weeks later he reported further improvement; this time the cervical strategy was recalled and repeated, plus a right condylar decompression and occipital CV4, primarily with the intention of releasing intraosseous occipital lesioning. The next week, still improving, and presenting with cervical pain, the same craniocervical approach was taken. In addition to OMT, homeopathic injections of the right C6-C7 and C5-C6 facets with Neuroalg-Rheum® was administered. At the follow up visit a week later, still improving, it was mutually decided to return to ophthalmic OMT. His OD globe was superior medial CW, orbit and membrane CCW, projection posterior medial superior, and the periorbita restricted at 9 and 11 o'clock. The ethmoid, intraoral, abbreviated VST and occipital CV4 OMT concluded the visit. At the following visit he reported that compared to eight months ago at the onset when he had diplopia for more than five minutes watching a play, at a current play he had only a couple of seconds of diplopia. Any episode with television viewing was as brief, if at all, and double license plate images were no longer an issue as well. At this visit both the OD and C spine were addressed with OMT. His OD globe was superior inferior CCW, orbit CW, membrane CCW, projection anterior media superior, and periorbita restricted at 11 and 12 o'clock. The intraoral and ethmoid was addressed, and in lieu of the abbreviated VST and occipital CV4, C spine OMT was administered. Complete resolution of the diplopia ensued. Neck OMT is not an uncommon regional consideration for visual system disease.

Patient 40, a 65-year-old male presented with acute onset of left diplopia for two days. It was constant, horizontal and worse for left gaze. The diagnosis was left microvascular ischemic CN 6 palsy secondary to a CVA (cerebrovascular accident) to it, between the brain and the lateral rectus it innervates. Allopathically, he lacked cardiovascular risk factors and discernable trauma or illness. He admitted to disequilibrium. Osteopathically he was found to have an extremely high degree SBS compression with a left internally rotated, and out of phase temporal bone, with secondary thoracic breathing. His cervical arthrosis was evident with extreme restriction in range of motion accompanied also by a cervico-thoracic junction flexion deformity with pain. OMT including percussion assistance to all the membranes and bones articulating to including the temporal, and entire skull, was immediately undertaken. At the next visit four days later, he reported visual improvements already taking hold the day before, and without homeopathy, which followed. With this visual system stroke, barring uncontrolled diabetes, recovery is not normally expected until three to six months. At this visit attention was paid to the compressed SBS more directly; it was also strained in a superior vertical, left lateral and left torsion pattern. Percussion supplemented OMT was also applied cranially. Seen three days later, the left internally restricted temporal, now in phase, was treated, as was the
left parietal which was significantly restricted, as well. Frequent, weekly to monthly, regional and global cranial, cervical and thoracic OMT followed with excellent results. Seen about a year after these visits he presented with all neuromusculoskeletal complaints, however, improved to a remarkable degree, including disequilibrium; and his left eye had only slight peripheral vision impairment. His right scapular, right SI, cervical and cervicothoracic areas were addressed, as well as his left eye, locally. His OS globe was medial inferior CCW, orbit and membrane CW, projection medial anterior, and periorbita restricted at 2 and 3 o’clock. The intraoral structures were also addressed with direct action; it was palpatorily noted that his left pterygoid fossa was unusually narrow, barely able to accept a pinky tip for release of the SPG, which was attainable just the same. The next week he presented with continuing progress of all symptoms, visual and otherwise. His OD globe was medial inferior CW, orbit and membrane CCW, projection anterior lateral superior, and periorbita restricted at 9 and 12 o’clock. The ethmoid, intraoral structures, abbreviated VST and occipital CV4, were performed, followed by attention to the left rib cage, at the conclusion of the visit.

Patient 41, a 41-year-old mother of two disabled young children presented with multiple problems: insomnia, recurring neuromusculoskeletal symptoms, including numbness and weakness of her right cervical, thoracic and upper extremity areas, as well as chronic bilateral visual disturbances. She stated that visual loss in the OS began with a left eye retinal vein occlusion, due to severe stress, ten years prior. One year prior to this visit, bilateral visual disturbances, despite the lack of floaters or any known eye pathology, began in addition to her left eye acuity worsening. Her brain MRI taken one year before presenting was negative for Multiple Sclerosis (MS), or any other conventionally discernable pathology. Bilateral palpatory scanning revealed the OS globe to be protuberant with a decreased CRI, less than the OD. The OS globe was also lateral inferior CW, orbit CCW, membrane CW, projection anterior lateral, and the periorbita restricted at 2 and 8 o’clock. The OD globe was CCW, orbit CW, membrane CCW, projection medial superior, and periorbita restricted at 11 and 12 o’clock. The visually related intraoral structures were also addressed, as was a transverse shearing ethmoidal strain (most are on this plane, or primarily so). A marked SBS strain “scoliosis capitis” is common in patients with spinal scoliosis since the three osseous structures comprising the SBS, the occiput, the third cranial vertebra, sphenoid, second, and dorsum sellae, first, are “irregular and structurally modified vertebrae” and compression were also present. The superior vertical, left lateral, left torsion and right sidebending rotation were also approached. In addition, lower extremity, pelvic, thoracic and cervical restrictions were addressed.

About a month later, having been cured of Strep A pharyngitis, after a past history of Strep B pharyngitis, primarily by osteopathy and homeopathy, despite multiple course of antibiotics, she once again requested help with her bilateral “visual disturbances.” Because of time constraints during this follow up visit, from the previous initial one, the OS was selected for OMT, since it was the eye that had suffered with a visual field deficit (measured via perimetry) following the left retinal vein occlusion incident. The OS globe was medial inferior CCW, orbit CW, membrane CCW, projection medial anterior superior, and periorbita restricted at the 2 and 3 o’clock positions. The intraoral structures were also released. Again, since all SBS strain patterns are usually more severely restricted with spinal scoliosis, the sphenoid and occiput being modified cervical vertebrae that underlie a scoliotic cranium, regional SBS OMT with direct action techniques, with the aid of postural (bilateral dorsiflexion) and respiratory assistance, was undertaken. The SBS was severely strained in a superior vertical, left lateral, left torsion and right side bending rotation, with a 90 per cent compression pattern. An abbreviated VST, occipital CV4 and direct ethmoid release followed. Two weeks later she excitedly presented for ophthalmic OMT because since the previous visit she reported her left eye was beginning “to work more.” After HVLA of a restricted right SI, anterior ilium, and C spine, exam revealed the OS globe was medial superior CW, orbit and membrane CCW (upon direct simultaneous release of the globe and orbit she reported a sensation she equated with a total body release), projection medial superior posterior (direct release of which elicited contralateral eye lacrimation, or epiphoria, an apparent visceral – visceral reflex mechanism), and periorbita restricted at 2 and 3 o’clock. The eye-related intraoral structures were directly released; of note was that she had ipsilateral lacrimation upon direct release of the suture between the palatine and maxilla, which underscores this structure’s influence upon SPG functioning. Direct release of the ethmoid, externally approached, concluded the visit. Two weeks later she presented with the complaint of bilateral EOM pains, worse with motion, including a focus of pain and tenderness in her left medial inferior frontal bone. She denied any recent or past trauma of the left orbit. This stage was probably a waypoint in OMT that would indicate the need for further OMT to complete the treatment from the visit before, the patient being “half-treated” so to speak. The OS globe was inferior lateral CW, orbit CCW, membrane CW, projection medial superior, and periorbita restricted at 9 and 12 o’clock. The OD globe was superior medial CCW, orbit CW, membrane CCW, projection medial superior, and periorbita restricted 4 and 12 o’clock. OMT for all the above was undertaken. Percussion assisted direct release of the localized left inferior medial frontal bone followed. Query two days hence revealed that all pain had decreased although a spot that wasn’t painful was now so. Again, this could indicate a stage in healing or un-layering and the possible need for further OMT. The findings in these two cases, for example, would suggest the most severe ocular pathology is associated with extreme displacements of the orbital projection, a torsional strain and a displacement in the coronal plane as well.

Patient 42, a 58-year-old female acupuncturist presented with the disconcerting complaint of spasms of her lower left lid around four times an hour following dental work involving Novocain™, along with upper, and lower respiratory symptoms. (In addition to mechanical trauma, neurologic symptoms following dental work should prompt one to consider the possibility of neuralgia or myalgia caused by locally blocking anesthetics containing...
epinephrine, which can induce ischemia.\textsuperscript{214} Intraoral OMT, especially involving the floor of the mouth and tongue, for venous and lymphatic drainage to resolve this, is a viable consideration.) The globe was medial and inferior while the globe and orbit was CW and the membrane was CCW. Her OS orbital projection was displaced laterally superiorly. The left zygoma was restricted as well as the maxilla, which was also medial and internally rotated with a massive multilobular torus palatinus or tori palatini (including a paternal family history thereof). Postural and respiratory assistance was utilized for release. The left SPG was restricted and tender. A week later she reported relief with OMT. At that visit the OS globe was protuberant upon scanning, the globe and membrane were CCW, the globe CW, the left maxilla was internally rotated and superior, the left palate was restricted and the left SPG was tender and restricted. The left frontosphenoidal suture was restricted along with left sphenoid intraosseous lesioning being noted. These were released inclusive of the Cant Hook technique and its variation for the lateral sphenoid. At her next visit one month later she reported the absence of all eye symptoms. After an interim visit devoted to her right knee problem, the next visit a few weeks following the prior ophthalmic-oriented one, revealed a bilateral palpatory ocular scan positive for a restricted, protuberant OD. The same globe was medial, superior and CW, orbit CCW and the membrane CW. The projection was medial and superior, and after the orbit and globe were treated with direct approach, the projection was re-assessed and now found to be more laterally and physiologically oriented. The right periorbita was restricted at 12 o'clock and also addressed. A right intraosseous sphenoid strain was treated via the bilateral greater wings contact technique for the sphenoid and with the Cant Hook addendum. The right palatine sutures were also directly released as above. Lastly, an occipital CV4 was performed. The patient reported that about a week after the last of the two visits for her eye, she was better and has remained so, even as of around a year later.

Patient 43, a 71-year-old male, presented with multiple chronic neuromusculoskeletal concerns including a trauma-induced subconjunctival hemorrhage of the temporal portion of his right eye, from a piece of wood contusing it the day before. The OD globe was medial and superior CCW, orbit and membrane CCW, the projection medial and superior, and the periorbita restricted at 9 and 10 o'clock. Wanting something to do further for his eye prompted a prescription of homeopathic Arnica CM, one pellet (#35 size) every one to two hours, as needed, which was dispensed on site. By the next day his wife reported his eye was around 25% better; by the following day he was 60% better. At the next visit, four days later his eye was 98% better: only a faint patch on the sclera remaining. Amid another more pressing concern for his left cervical spine, he said that on the morning of the visit he noticed a slight burning in the right eye. His OD globe was medial, superior CCW, orbit CW, membrane CCW, the projection being medial and superior, and the periorbita restricted at 9 and 11 o'clock. All were released, including the C spine, followed by two facet injections of homeopathic Neuralgo-Rheum™, the restrictions of which were apparently helping perpetuate the ipsilateral eye dysfunction. Over the course of two days he was reportedly without any remaining eye symptoms, and remained so for many months following, without sequelae.

Patient 44, a 27-year-old female who had a history of successful infertility treatment with SBS OCF OMT for an SBS strain pattern, including a high degree compression, often with Percussor® assistance cranially, and bioidentical hormone replacement for hypothalamo-pituitary-ovarian axis dysfunction. She reported seeing movements out of her peripheral vision, for three to four days. A history of left eye floaters, causing blurry vision, was present for three months. She stated that if her head was not aligned with her vision, her eye muscles felt “pulled” or strained. She relayed a history of ipsilateral TMJ dysfunction and nightly reading of an electronic media tablet (Kindle™) in bed, prior to the onset of symptoms. On exam her OS globe was medial inferior CCW, membrane CCW, orbit CW, projection anterior lateral with the periorbita restricted at 1 and 2 o’clock. Next, all intraoral structures, as per above, were released, followed by the ethmoid, as above, as well. This was followed by percussion assistance to release the cranial sutures/membranes. Following the visit, the sensation of straining, which had been declining prior to the OMT, was gone by the next day as was the blurriness and visualizations of movements in her peripheral field of vision. Many months later the symptoms were still absent.

According to her caretaker – daughter, Patient 45, a 97-year-old woman hit her forehead against a fireplace mantle after stumbling, trying to navigate furniture, without alteration of consciousness before or after. Unable to be seen, homeopathic Arnica was prescribed from her home kit, the 200C potency, PO, every ten to twenty minutes while awake for two days. On the third day following the injury she was seen for OMT. At that time her PERRLA was normal and her left frontal area was ecchymotic around the size of a quarter. Her OD globe was CCW, orbit CW, membrane CCW, projection lateral superior, and periorbita restricted at the 9 and 11 o’clock positions. The intraoral and ethmoid structures were also released with direct approaches. It was advised to continue Arnica four times a day for the next three days. Recovery was swift and uneventful.

Patient 46, a 14-year-old girl, sustained a traumatic brain injury (TBI) upon capsizing and subsequently hitting her head against a centerboard while sailing at summer camp, many states away and a significant distance from home. The camper immediately had retrograde amnesia for quite a number of seconds followed by a pounding headache, restlessness, anxiety and hematoma on the posterior right parietal area. She went on to develop intermittent nausea, short-term memory loss, inability to focus, the sensation of movements out of her peripheral vision. Many months later the symptoms were still absent. Patient 47, a 70-year-old male, presented with an acute closed head injury or concussion symptoms. Her CT scan was normal. The writer advised visual system rest by withholding smart phone or media screen activities. On exam she was found to have a contra coup with

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the contra region being the anterior right frontal bone and contiguous tissues, including an accumulation of excess Potency, all perceived as hardness or restriction to palpation. Regionally, the membranes were severely restricted giving an SBS diagnosis as a high degree compression. After a number of minutes release was obtained with a light, but mindfully expansive and deep, contact. A left sacroiliac anterior torsion strain was released via HVLA, as well. Two days later she reported relief from all symptoms and the head pain, nausea and blurriness, right greater than left, were overall improved. Acetaminophen and Ondanstron were allowed for pain and nausea, respectively. For the first time since the concussion, the night of the OMT she slept well (an excellent barometer for improvement of neurological impairment215). At that visit, local eye OMT commenced. The bilateral palpatory scan revealed the OD globe was protuberant with a decreased ROM/Potency. The globe was medial inferior CCW, orbit CCW, membrane CW, projection lateral superior inferior, and the periorbita was restricted at 10 and 11 o’clock. The ethmoid and intraoral structures were then addressed. The right condylar part was decompressed as well as cervical and thoracic restrictions. A proprietary combo of homeopathy, Traumatic Brain Injury®, was dispensed to be taken orally every ten minutes while awake, for the remainder of that day. Immediately following this she had a headache but not as severe. The next day she was without nausea and the vision was a “little blurry.” The following day headache persisted and nausea was a 3/10 with visual blurriness, right greater than left. The next morning she reported even less blurriness, no nausea, but had a severe headache unrelieved by two Tylenol™. That afternoon after a ten-mile bike ride (not advised) her nausea was a 6/10. The following day she was seen: her OD globe, orbit and membrane had the same pattern; her projection was lateral superior and the periorbita was restricted at 4 and 8 o’clock. The ethmoid, intraoral, abbreviated VST and occipital CV4 followed. The next day her pain and nausea were improved. Four days later she was seen again. The OD globe, orbit and membrane had the same pattern, however the projection was postero-lateral superior, with the periorbita restricted at 9 and 8 o’clock. The ethmoid, intraoral, abbreviated VST and occipital CV4 were performed. The next visit a day later revealed all remaining symptoms were improved. The right greater than left eye blurriness remained and since the headache was bilaterally temporal, the intraosseous sphenoid via the bilateral great wing contacts technique was performed (the right was more compressed). The SBS was examined and found to be superior vertical and right lateral, with a high degree of compression. She admitted to a menstrual history (menarche 11 years old) of headaches, and uterine cramping, which led this author, prior to further history taking, to surmise that the restricted cranial mechanism, might at least partly be to due to the trauma of labor and delivery and not solely from this trauma. In light of the head pain a complete VST and direct superior vertical OMT with a patient activated bilateral foot dorsiflexion followed, with instructions for follow-up the next day. At that visit she reported she had no head pain since, and blurriness was less too. Her superior vertical and right lateral strain was now absent. A complete VST was performed. The next day she was seen again, being seen frequently because of a pending trip to Europe. She had some head pain and nausea “after a good day.” On the day of the visit some head pain persisted but without nausea. Again she was without the superior vertical and right lateral strain of the SBS. Again a complete VST was performed. In the course of the five-day interval before her next visit, most hours were free of pain, nausea and blurriness. The same pattern was present and so a complete VST was completed just in time for her flight. She was doing so well she felt an immediate follow-up appointment was deemed unnecessary. It is often difficult to convince an asymptomatic patient to follow – up: often the best course for future compliance is for the patients to learn this for themselves. This case prompts a needed commentary on traumatic brain injury (TBI). After much clinical experience it can be stated that undo caution is placed on cranial osteopathy and closed head injuries involving TBI, in terms of when to begin treatment216.

Two weeks later she reported an overall decrease in all symptoms in terms of frequency, intensity and duration. For her continuing head pain a regional approach was taken. The symptom of paroxysms of disequilibrium prompted exam of both her temporal bone motions and positions. An abbreviated VST followed by unphysiologic motion technique for her left, internally rotated, in phase, temporal bone, left occipitomastoid (OM) suture spread, and lastly, a frontal lift and spread was performed. She went away to another camp for school about a week after being seen and continued with improvements, as above, until “bumping” her head with another child’s head when bending forward at the same moment. She immediately experienced nausea, increased frontal pain and a loss of short-term memory. In light of her distance away, she was sent to the hospital for evaluation and owing to the radiation from the last CAT the decision was made to send her back to the camp under observation. She could finally be seen three days after and a regional approach was again taken. An abbreviated VST and a direct approach to her lateral, left torsion, inferior vertical and right side bending rotation of the SBS were performed. Both temporals were moving freely and symmetrically placed. Since she was old enough (greater than 9 years old for reasons discussed early on in this article series), an occipital CV4, and a frontal lift and spread followed. As often happens, while exploring the reasons for relatively minor trauma in eliciting major symptoms, during this session, she remembered falling on her occiput in an ice rink at around five years old. This sequence of maneuvers was repeated three days later and the child did not have any symptoms until a headache, following a yoga session, three weeks later. Concussion resolved, occasional baseline headaches prompted follow – up for birth and acquired trauma.

Being successfully osteopathically treated for an atypical chronic neuropathy and multiple musculoskeletal issues (gabapentin, prescribed elsewhere, three times a day to once a day). Patient 47, a 37 – year – old teacher, presented to a visit upset over having a circumscribed degenerated visual field, or scotoma, which would persist after shifting her visual focus in an under lit room. Bilateral palpatory
scan revealed her OD globe was protuberant with a decreased ROM that was consistent with her history of her perception that this was a bilateral symptom: the OD being worse than the OS. Her OD globe was inferior medial CW, orbit CW, membrane CCW, projection medial superior anterior, and periorbita restricted at 10 and 11 o’clock. The ethmoid, intraoral, abbreviated VST and occipital CV4 OMT followed. A right shoulder subacromial bursitis and coracobrachialis tendonitis was addressed as well.

Two weeks later she was seen again and reported an improvement in her ocular symptoms. Except for the periorbita now restricted at 2 and 12 o’clock, all the other findings (with increases in ROM and decreases in tenderness), and OMT were repeated. Musculoskeletal issues were also addressed again. Upon return three days later, she excitedly stated she was now 90 percent improved. The palpatory scan, as above, revealed an OD globe no longer protuberant and restricted. The ocular/orbital and membrane pattern was the same but significantly improved, the projection was now medial superior, and the periorbita restricted at the same locations. The rest of the OMT as before was administered. Four days later upon return, she happily stated that she had forgotten to mention her floaters were gone as well! Except for the periorbita now restricted at 11 and 12 o’clock, the same findings and OMT were performed again. A week later, still improving, she requested what she felt would be the last eye OMT session needed. The OD ocular/orbital/membrane pattern was the same. The projection was anterior medial superior and the periorbita was restricted at 1 and 9 o’clock now. As before the above OMT completed the visit. Recovery complete, the focus during the next visit a couple of days later were for the still improving neuromusculoskeletal system concerns and a right eye ocular migraine characterized by periorbital “tension” and “pushing” retro-orbitally. This visit revealed that the OD globe was now superior medial CW, orbit CCW, membrane CW, projection anterior medial superior, and periorbita restricted at the 12 and 1 o’clock positions, a pattern different than the previous scotoma/floaters one, probably representing her “baseline” one for her ocular migraines. This appeared to be so because soon after the treatment, her ocular migraine was already easing significantly.

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Body and Occlusal Balance
Vivianne Vallée Cussac DDS Ortho DO

A human being subject to gravity needs to maintain orthostatic balance. Maintaining controlled and balanced posture calls for a combined use of articular fascial, muscular, and neurological structures, as well as a variety of sensors including the eyes, ears, feet, and teeth. While examining patients in a standing position (suffering from brachialgia, lumbago, cervicalgia, etc.) I noticed that their bodies were not straight and generally did not remain within their cone of balance. Instead, they tended to be turning too much in a particular direction. I interpreted this movement as being directly related to the pain they were experiencing. I found it useful to observe how the body behaved when the patient was in a standing position, looking straight at the horizon. When I placed my hands on their hips and then their shoulders, I felt certain imbalances (forward, backward, rotation, sideways movement) which I considered to be overly pronounced. Out of curiosity, I asked patients to close their teeth. When they did this, I noticed a change in their movement. I drew the conclusion that their dental occlusion when not in a balanced standing position was incorrect, because it became even more pronounced. I noticed that the patient’s dental contacts functioned in quadrants. For example, when the neurological information from the dental contacts in the rear quadrant was not as strong as that obtained from the three others, the patients shoulder moved towards the rear. When the teeth were clenched, this created an interface between different interdental contacts, and caused the body to react, as is the case with the podal sensors and upper surface of the tongue. Using the power of the sensitive neurologic system, I offer to treat their bodily posture and podal, dental, and lingual sensors at the same time.

History:
Patient G, aged 33, works in Information technology and is a semi-professional weightlifter. He presents with pain in his lumbar spine, right knee and right ankle. He complains of a dull pain in his neck and left shoulder. He struggles to bend forwards. He is unable to breathe through the nose, feels suffocated and can only open the rib cage to breathe by raising his shoulders. He is unstable when lifting his weights and compensates for this by moving his right foot forward slightly. Weightlifting performance had been affected for the past year. The patient had been attending a physiotherapy clinic for 6 months.

Physical Exam:
Patient feels pressure on the left side when standing with the right foot and arm forward, has the sensation of lacking balance when lifting weights. He compensates for imbalance by turning sideways and moving the right foot forward. Right knee cannot flex in the same way as left. Feeling of weakness in right arm.

Practitioner:
Standing examination with teeth apart: right anterior rotation of the pelvic girdle, right anterior rotation of the shoulder girdle, elevation of the left shoulder due to exaggerated tonus, leaning backwards on both sides.
Standing examination with teeth together: right anterior rotation of the pelvic girdle, accentuated right anterior rotation of the shoulder girdle, posterior leaning backwards on both sides.

Skull examination: dysfunction side bending right.

**Treatment Plan:**
It is a whole body balance treatment. Occlusal and postural imbalances are corrected in several stages:

- **Connection to the Sutherland fulcrum based on the “spring method”** (Prof. M. Bensoussan MD DO FCA). The advantage of this technique is that it allows a neutral state to be achieved throughout the body (tension-free state). Lesions give way, and the body regains symmetry.

- **Stimulating the lemniscal pathways of conscious sensitivity, which carry epicritic sensations and proprioceptive information,** making use of the similar behavior exhibited in the feet, tongue, and dental occlusion of a standing patient. This allows neurological information from these three receptors to be combined and optimized. The receptors in the soles of the feet and the upper anterior section of the tongue are normalized by following neurological sensors back to their sensory cortices.

- **Use of the “quadrantal method” for the occlusal plane.** Signals triggered through tooth contact tend to follow a quadrantal pattern. Quadrant 1: right first premolars and canines. Quadrant 2: right molars. Quadrant 3: left first premolars and canines. Quadrant 4: left molars. When one of these quadrants sends signals that are different from those sent by the three others, the occlusal receptor is defective and disrupts posture. Normalizing the occlusal plane involves removing voids and achieving the same neurological intensity for each quadrant by varying the volume of signals being sent to the sensory cortex relating to the teeth. The treatment of lemnisical pathways can be considered complete when these three systems have been balanced, aligned, and held until a balanced MRP is achieved.

To ensure that the occlusal quadrants continue to work in harmony, an occlusal plate is installed. This plate is created based on dental imprints and wax bites taken from the patient following a full-body osteopathic treatment, to ensure that their body’s standing position is correct and that it moves only within its normal movement cone. This plate is designed to suit the mandibular profile of the patient’s mandible (freeway space, swallowing, etc.). The mandible must remain uninhibited in all three spatial dimensions. The equipment used is carefully selected so as to avoid any incompatibility with the patient. The plate is adjusted during each treatment session to prolong the effects of the treatment. The patient’s body adjusts to this reprogramming of the occlusal plane. Worn by the patient during sleep and for one hour when standing. As part of an osteopathic treatment of postural imbalance, orthodontic devices are used to help in loosening the dental sensor. A number of wake up sensors exercises are prescribed to the patient. Treatment of the occlusal receptor is considered completed when the four quadrants are balanced. The plate is removed when the body can no longer accept the device (typically after around 12 months).

The patient was filmed from three positions: from behind, from the right side, and from the left side. There were three different occlusal configurations: teeth not touching, teeth touching and teeth clenched.

An orthogonal reference point was projected onto the wall by means of a laser to assess progress made from one session to another.

**Clinical result:**
After one month of treatment, the patient was no longer suffering from continuous pain, and was more flexible. His balance improved as the sessions went on. He felt that his footing was more stable. Tooth contact was adjusted. The differences in posture between the three tooth configurations (not touching, touching, and clenched) were greatly reduced. The patient’s general condition improved as the sessions went on.

**Practitioner:** Standing examination with teeth apart and teeth together: Pelvic girdle is correctly aligned, slight dip in right of shoulder girdle, no rotation or winding.

Skull examination: no more dysfunction.

**Diagrams of results:** Progression of the patient’s body balance.

The diagrams show the range of movement of the tragus in relation to a vertical line passing through the tragus point and the external malleolus. They show how the body has been straightened.

The variation in the horizontal axis of the patient’s tragus confirms that his posture has been improved.
Patient was a 13-year-old male that had broken his mandible falling off a bicycle in August 2015. The body of the mandible was fractured through the right cuspid area. This fracture was fixated by a bone plate and screws. The left condylar neck was also fractured but not fixated with any hardware. The patient had fixed orthodontic braces on the upper teeth at the time of the accident. These were utilized with bars attached to the mandibular teeth to wire the jaws together. He jaws were wired shut for 6 weeks and then heavy elastics were used to hold the jaws together for another 6 weeks.

Then in the summer of 2016 the patient was involved in another bicycle accident. This time the left anterior alveolar process of the maxilla was fractured. The upper left condylar incisor, lateral incisor, cuspid and first bicuspid were pushed in palatally. Fixed orthodontic braces were placed on the maxillary teeth to align and stabilize the displaced teeth. The braces were removed in January 2017.

When the patient presented at our office on August 24, 2017, he was experiencing increasing chronic pain in both TMJ’s and throughout the lower jaw and face bilaterally. Daily frontal headaches had developed that would radiate over the entire head. He experienced crepitus and intermittent popping of both TMJ’s. There was left ear pain. All the teeth were generally sore especially when eating.

Examination revealed a 42 mm jaw opening (norm 46-50 mm), a 9 mm left lateral jaw movement (norm 10-12 mm) and a 10 mm right lateral jaw movement. There was TMJ pain with all jaw movements and crepitus could be palpated in both TMJ’s. Popping of the TMJ’s was not present at examination. Cranial palpation displayed a traumatic left torsion pattern. The left temporal bone was in external rotation and the right temporal bone was lesioned in internal rotation. He had a broad flexion type facial appearance and the midlines of the jaws were centered in the cranium.

Radiographic evaluation revealed that all fractures were healed. The mandibular condyles were centered in the fossae. There was thinning of the cortical plate over the lateral pole of both condyles.

Treatment for this patient would normally involve placement of an acrylic, mandibular orthotic over the lower posterior teeth. This would separate the teeth allowing the mandible to function without interference from the occlusion. The patient was in the process of losing his primary molars and an orthotic could not be placed. It was decided to bond composite restorative material on the occlusal surface of the lower primary 2nd molars. These teeth had enough root structure remaining and were stable enough support the composite material. This would function like an orthotic separating the occlusion and allowing the mandible freedom of movement, facilitating cranial manipulations to treat the temporal bones and SBS.

Treatment was started on September 13, 2107 by bonding the composite material on the lower primary 2nd molars. Cranial treatment that day involved releasing vertical strains from the head down the body (Key Lesions as taught by Conrad Speece, DO). The RTM was balanced. The patient returned on September 28, 2017 and stated that the left ear pain, TMJ pain and the headaches were much improved. Key lesions were again treated, the RTM balanced and a left lateral strain of the SBS was released. The temporal bones were treated but the right one remained restricted in function. The bite was balanced on the composite material. The next appointment was October 19, 2017 and at this time all the left ear pain, tooth soreness and TMJ pains were alleviated. Headaches were continuing to improve and were not occurring every day. One Key lesion remained and this was treated. The SBS was balanced and a V-spread was performed on the right OM. The right temporal bone was then able to be disengaged from the occiput and free to reestablish a normal relationship with the cranium. The mandible was decompressed and balanced to the temporal bones. The bite was again rebalanced on the composite material. On November 09, 2017 the patient returned for the next appointment. Headaches continued to decrease, becoming less often and less intense. The left lateral strain required further treatment. The temporal bones were neutral in function and freely moving. An intraosseous strain of the mandible was treated and the mandible balanced to the cranial base. The composite material did not need equilibrating.

Our last appointment with the patient was on December 21, 2017. At this time the headaches were gone. The cranium was functioning well and did not require treatment. The patient stated that he had some soreness in the left TMJ. The upper left primary 2nd molar had exfoliated causing the bite to become higher on the right side. Equilibrating the composite material on the right to balance the bite bilaterally resolved the problem. The patient stated that the left TMJ pain felt better and the bite was comfortable. The patient was dismissed and asked to call if any of the symptoms returned. The remaining composite material was left on the teeth as they would be lost over the next 3-4 months. The permanent first molars had erupted into occlusion at the height of the composite build ups and would support the mandible in the new position established with our treatment.

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In Memoriam
Robert E. Kappler DO FAAO FCA
October 20, 2017

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April 26, 2018 Teachings of Robert Fulford II Course
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Course Director: Richard F. Smith DO
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