2019 Annual Conference

“The Second Brain: An Exploration of The Gut-Brain Axis”

June 13-16, 2019

Marriott La Jolla Hotel

La Jolla, California
Musings from the Executive Director

As the calendar winds down toward the conclusion of my tenure with the Osteopathic Cranial Academy (OCA), my mind is flooded with so many memories over the past 13+ years. My first February Intro Course in Tampa, where I met Jim Binkerd for the first time and got to develop a friendship with him as I watched him rise through the system to become President of the OCA. I met Richard Feely, the Course Director at that February Intro who helped me understand the Cranial Academy Foundation and how it contributes to the benefit of the OCA. I had almost no knowledge of Osteopathy in the Cranial Field but the previous December, Herb Miller DO FAAO FCA treated me for the first time and it had an almost miraculous effect on my health. For the first time in 35 years, my eczema, which had plagued me for so long, healed and my twice-yearly bouts with bronchitis ended. I learned a little about how you treat and the effects it can have on better health.

Having been an association executive for over 30 years, I was familiar with the operations of a not-for-profit organization and its corollary foundation. I had planned many meetings over the years and had coordinated strategic planning sessions through my consultancy practice. Yet each step of the way, I could see how the work that you do to heal improves with each course you take and the organization improves its service level by the decisions the Board makes after “strategically charting its course”.

Leadership is not dictatorship…true leaders rely on others to assist and it is most evident in the committees that work to improve the OCA. Whether it be the Annual Conference, Intermediate Course, Bylaws or any of the myriad committees under the guidance of the Board, each contributes to the success of the OCA. One only needs to sit in on a committee conference call to hear the exchange of ideas…all with just one purpose, to make the OCA a better organization and more responsive to its members. To the committees and its members, I value your work since it makes my contribution more focused on the deliverables you establish for your courses and for the structure of your organization.

Now the countdown begins. Soon I will be in New Orleans for the February Intro and Pediatrics Courses. I may see many of you at the AAO Convocation in Orlando in March. Please stop by our Booth to say hello. Our Board will be gathering there for its Spring Meeting, working for the benefit of the membership.

In April, we return to Orlando for an Intermediate Course, The Cortex, directed by Maurice Bensoussan MD DO FCA. He bring his European faculty to the course and I strongly suggest that you register early since all of Maurice’s courses sell out. Look for registration information elsewhere in this issue.

I would be remiss if I did not acknowledge the valued work of Immediate Past President Dan Shadoan DO who coordinated the OCA effort with others to qualify non-boarded presenters at our courses. Working with the Vice President of Board Certification at the American Osteopathic Association Dan Williams DO, the AOA created a pathway for senior level presenters. The response by the OCA membership at our request, to write letters of support was instrumental in this important change.

Respectfully submitted,

Sidney N. Dunn, Executive Director
One of the opportunities within the privilege and charge of writing the President’s Message in the Cranial Letter is the recording of significant events in osteopathic history. One such event occurred in the interim since my last message. The most important thing to write about is how our membership responded to this event. The AOA, with little fanfare announced a pathway to achieve AOA Board Certification without osteopathic content on certifying exams. This would mean that anyone graduating from residency with no osteopathic content and with no osteopathic education or practice since their second year of medical school (at best) could be AOA boarded. While the leadership of the AOA was taking this action with apparent scant input from current membership and the AAO was considering its response, our membership took action. A grassroots response to the change in AOA board certification testing requirements was launched by the OCA membership.

Though the AOA leadership reports polling some 1000 nonmembers, there is little evidence on their website that current membership was engaged in the process. To our membership this process and its conclusion appear to go against the mission and vision of the AOA.

The AOA mission and vision statements are:

**Mission:** To advance the distinctive philosophy and practice of osteopathic medicine.

**Vision:** To be the professional home for all physicians who practice osteopathically.

Our membership began a letter writing campaign to express their dismay and disbelieve. It is difficult for our membership to understand how eliminating osteopathic content from our certifying exams (arguably our only reason to exist as a profession), “advance(s) the distinctive philosophy and practice of osteopathic medicine.” Further, it was equally dismaying that the supposed “home for all physicians who practice osteopathically” can be strengthened by the membership of those who have clearly demonstrated that an osteopathic practice holds no appeal to them.

In the experience of the Osteopathic Cranial Academy there are many skilled, osteopathically minded and dedicated osteopathic physicians both DO and MD among our membership. What separates an osteopathic physician from an allopathic one is not the initials of the degree behind their name. Likewise, having a DO after one’s name does not qualify that individual as osteopathic. We (The Osteopathic Cranial Academy) would agree that the AOA should be “the professional home for all physicians who practice osteopathically,” it is difficult to perceive how it can continue to do that if it solicits and supports those not committed to osteopathic practice at the expense of those who are.

It is important to note that our membership overwhelming responded against this change and our concern and objection has been thus far, ignored. Our members have been derided and some report threats. This does not make this process appear as a collegial and collaborative one.

As a student at Kirksville I had the privilege to meet Dr. Stedman Denslow and as a third year and fourth year medical student provided (with supervision of my faculty) osteopathic treatment to him during his terminal illness. One of the things I can still remember him say is that, there are many threats to the osteopathic profession but the most dangerous ones come from within the profession. It is sincerely hoped that the AOA has many long and productive years ahead as the “professional home” for physicians who are truly osteopathic. It is the expressed fear of the membership of the OCA that actions taken by the AOA such as this one, are signs that the AOA has chosen to become increasingly irrelevant. I personally hope this is not the case.

On a brighter note, the process of searching for our new Executive Director is fully underway and by the time this is published you will likely begin seeing ads appearing in the appropriate trade journals and job sites, perhaps even in this Cranial Letter. The search committee wishes to cast the broadest possible net in hopes of attracting the most qualified candidates. Though we wish Sid well and are extremely grateful for his service to our organization, to find someone as skilled as he will surely take a village. This is where the membership of the Osteopathic Cranial Academy can be of assistance. Do you know of a qualified candidate who would make a good Executive Director of us? Do you have patients who can be good resources to help us find such a candidate? The committee wishes to invite and encourage the membership to please pass those names and contacts on to the committee. You may have those candidate view the job description see how to apply at https://cranialacademy.org/executive-director/ or, they can contact the committee at jobs@cranialacademy.org.

Finally, I hope to see you all at our Annual Conference is San Diego, June 13-16.

All my best to the osteopathic profession,

James W. Binkerd, DO
President of the Osteopathic Cranial Academy
December 18, 2018

Dear AOA Board of Trustees:

The Board of Directors of the Osteopathic Cranial Academy are united in our call for all physicians, regardless of board certification, be allowed to present OMM courses for CME.

While Board Certification is nearly universal in other specialties, it is not so among those who practice OMM as their primary specialty. This is especially true for DOs trained before the 1990s. The practice of osteopathy retains a close connection to our profession’s history. Age and experience are highly valued, especially by younger, NMM certified DOs seeking to learn from experts in the field. While the lack of board certification may be an indicator of falling behind current medical trends in most specialties, this is simply not true for OMM. There are many physicians without board certification who may never work in a school, hospital or other facility who have much to teach and are constantly learning and growing in the field of osteopathy.

Ironically, the proposed CME presenter requirements would allow those with a terminal degree, including Chiropractors, Doctorates in Physical Therapy and others to present for CME, while excluding fully licensed General Practice DOs and MDs (which are terminal degrees) regardless of clinical or post graduate experience.

The Osteopathic Cranial Academy along with the Sutherland Cranial Teaching Foundation and other component societies of the AAO, have many senior faculty who have always practiced as osteopathic GPs. If the AOA is unable to create a pathway for them to teach for CME, these organizations may be forced to look outside the DO world for CME sponsorship. According to the AAFP website, they only require that an AAFP member be involved in the planning of the CME event to ensure that it is medically relevant. However, this would not be an ideal situation for any of us and would send the wrong message to the MDs outside our profession.

There are numerous options to resolve this situation. One is simply to eliminate the requirement of Board Certification for CME presenters, or at least eliminate it for courses on osteopathic manipulation. Another possibility would be to allow those DOs and MDs who are Fellows of the Cranial Academy or have successfully passed the Osteopathic Cranial Academy Proficiency exam to present for CME. Alternatively, the BOS could opt to simply review presenters CVs, teaching history, and ethical conduct in order to retain oversight on a case by case basis.
The AOA is in a difficult situation due to the combination of the decoupling of membership and board certification, and the coming availability of ABMS specialties to all DOs. The AOA has always been a membership organization and its operating budget has come mostly from dues. The only thing that will attract anyone to osteopathy is osteopathy. The other specialties should understand this. We need to look to strengthen our own brand, the brand of osteopathy. It is exactly what is needed in this opioid crisis, in an era when doctors’ satisfaction is plummeting and patients are increasingly seeking options besides medications and surgery.

The survival of the AOA and osteopathic institutions is based not on moving further away from osteopathy to meet an MD standard (that will lead to complete amalgamation) but in reinvigorating osteopathy within the profession. It does not mean that every DO must practice OMM, but it means that every DO must support the practice of OMM as if their survival depended on it because, we believe it does.

One way to do this is to make sure that the most experienced teachers, regardless of board certification are able to teach the next generation via CME courses. There are, of course, many other strategies being pursued throughout the profession. The AOA, COCA, AACOM, the State Societies, and, of course, the AAO and the rest of the specialties united in defense of osteopathy would create a protected profession that could enter the ACGME environment without being absorbed and eliminated.

We are hopeful that the Board of Trustees can find a workable solution that satisfies the BOS as well as the needs of the Osteopathic Cranial Academy and other osteopathic groups because at this juncture we certainly need to find common ground. The practice of osteopathy will always survive, but American DOs are in a special place in the world as the original DOs, the only ones with full medical licensure. This is something too precious to lose.

Follow up Message from OCA President

On behalf of the Board of Directors of the Osteopathic Cranial Academy, we want to thank you for your concerted efforts through letter and email writing to the AOA leadership on the recent issues that have arisen. Your efforts were Herculean, impactful and have been effective in at least one area. The AOA has just released their new guide on Continuing Medical Education. Your efforts in letting them know your concerns regarding their “Appendix D” have borne fruit. Please see the full guide at this link.


The new Appendix D I copy hear for your review.

“Appendix D: Criteria for Category 1-A and 2-A Presenters

CME presenters must be appropriately credentialed to give Category 1-A or 2-A CME. Certification is a marker of excellence and individuals holding current AOA or ABMS board certification are automatically qualified to be Category 1-A or 2-A lecturers within their area of certification. The BOS recognizes that there are other individuals without AOA or ABMS board certification who may be qualified to give Category 1-A or 2-A CME (e.g. physician experts without board certification, international medical faculty, licensed psychologists, physical therapists, etc.). Therefore, CME lectures may also qualify for Category 1-A or 2-A credit if presented by an individual who has been properly credentialed by the Office of the Vice President of Certifying Board Services to present Category 1-A or 2-A CME. For a lecturer to become appropriately credentialed, the CME sponsor must submit an application form demonstrating the applicant presenter’s competence, including a CV. The credential will be good for the remainder of the 3-year CME cycle.

Questions about qualifying criteria can be directed to the Vice President of Certifying Board Services”

Though it is my understanding that the Certifying Board Services is still working out the details on their “application form demonstrating” competence to present 1A or 2A CME, this is a big change that directly results from your advocacy. Thank you all for all you do to support osteopathy and congratulations on this apparent success. We will keep you informed as we learn more.
The Cortex – Exploring the CNS
April 5-7, 2019
Course Director: Maurice Bensoussan, MD FCA
Assistant Director: Maria Coffman DO
Hilton Garden Inn at SeaWorld, Orlando, Florida
20.5 Hours Category 1-A AOA CME (anticipated)

Maurice Bensoussan, MD DO FCA with the able assistance of his French and Belgian colleagues as table trainers well present an original course in treating the Cortex and exploring the CNS.

Osteopathy has been fermenting in France for 50 + years and has produced a fine distillation of osteopathic methods and a unique advancement in palpatory approaches to diagnosis and treatment.

Prerequisite for Enrollment:
Successful completion of two (2) approved Introductory Courses in Osteopathy in the Cranial Field and at least three (3) years clinical experience with OCF.

Registration Form
Name (Print) ____________________________ AOA # _______________________
Address ____________________________________________
City, State, Zip __________________________________
Phone: ____________________________ Osteopathic College __________ Year of Graduation __________
Date and place of first cranial course taken ____________________________
Date and place of second cranial course taken ____________________________
Date and place of intermediate cranial course taken ____________________________

Liability Release: Participation in this program will involve physical activity, including contact by and with instructors and other participants. This, and particularly activity involving physical diagnostics and manual therapeutics, could possibly entail risks for participants of new injury or aggravation of pre-existing conditions.

By applying to participate, the applicant acknowledges and assumes the risk associated with participating in the laboratory sessions and agrees to hold The Osteopathic Cranial Academy and fellow participants harmless indemnify, defend and free of liability from and against any damage or personal injury that might occur during or as a result of participation in this program. Furthermore, the applicant covenants to hold harmless, indemnify, and defend The Osteopathic Cranial Academy from and against any use or misuse that applicant may make at any time of any knowledge or information that applicant derives from participation in this program. The applicant should carry adequate liability insurance which would be activated in the instance of the use or misuse of this knowledge or information. Participants in the course are examined and treated by instructors following the course in case any problems arise from treatment by fellow students.

I acknowledge that I have read the Liability Release and agree to the statement.
Signature (Required) ____________________________

Registration fee includes CME and lunches. Circle appropriate fees.
OCA Member (On or before March 1, 2019) ................................................................. $995.00
OCA Member (Postmarked after March 1, 2019) ............................................................... $1,050.00
Qualified Nonmember ................................................................................................... $1,100.00
Total .............................................................................................................................................. $__________

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

SSN: __________________ Signature: __________________

Cancellation policy: 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 March 1, 2019. Refunds will not be made for cancellations received after March 1, 2019, 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. It is the responsibility of ALL participants to use the information provided within the scope of their professional license.

Accommodations: The Course will be at the Hilton Garden Inn at SeaWorld, Orlando, Florida. Reservations can be made on our website using the hotel link. The room rate is $159.00. Rooms will be available until March 15, 2019, or until the block is sold whichever occurs first.

Register online at www.cranialacademy.org
“Changing Lives: Cranial Osteopathy’s Gift to Children”
February 22-24, 2019
Course Director: Margaret A. Sorrel DO FCA
Associate Director: Mary Anne Morelli Haskell DO
Crowne Plaza Astor, New Orleans, Louisiana

The OCA has requested that the AOA Council on Continuing Medical Education approve this program for 20 hours of AOA Category 1-A CME credits. Approval is currently pending. Specialty Board hours to be determined.

The potential applications of OCF to pediatric care are myriad, from obvious structural problems such as torticollis, plagiocephaly and nursemaid’s elbow, to systemic issues such as recurrent otitis media and gastro-esophageal reflux, to more challenging problems such as cerebral palsy and autism spectrum. The aim of this course is to excite physicians in the opportunities inherent in treating children and to offer them tools to assist in expanding their own practices in the osteopathic treatment of children. It will include a brief review of embryology, pediatric anatomy and normal developmental tasks of newborns and children, a discussion of normal and troubled pregnancies, labor and deliveries, and the risks associated to the developing human. We will discuss the general support of the well child and the chronically ill child, the unique needs of the pediatric patient and the opportunities that treatment offers to change lives permanently, to allow the individual to reach his/her full potential. There will be an in-depth review of the structure and function of the three body systems most prone to clinical issues in the child - the respiratory system, the gastrointestinal system and the neurological system, as well as discussion of normal structural development and the clinical significance of injuries.

Prerequisite for Enrollment: Prerequisite: Successful completion of an approved 40-hour Introductory Course in Osteopathy in the Cranial Field

Name (Print) ___________________________ AOA # _____________
Address ________________________________
City, State, Zip ____________________________
Phone: ____________________________Osteopathic College ____________ Year of Graduation ____________
E-mail: ________________________________
Date and place of cranial course ________________________________

Liability Release: Participation in this program will involve physical activity, including contact by and with instructors and other participants. This, and particularly activity involving physical diagnostics and manual therapeutics, could possibly entail risks for participants of new injury or aggravation of pre-existing conditions. By applying to participate, the applicant acknowledges and assumes the risk associated with participating in the laboratory sessions and agrees to hold The Osteopathic Cranial Academy and fellow participants harmless indemnify, defend and free of liability from and against any damage or personal injury that might occur during or as a result of participation in this program. Furthermore, the applicant covenants to hold harmless, indemnify, and defend The Osteopathic Cranial Academy from and against any use or misuse that applicant may make at any time of any knowledge or information that applicant derives from participation in this program. The applicant should carry adequate liability insurance which would be activated in the instance of the use or misuse of this knowledge or information. Participants in the course are examined and treated by instructors following the course in case any problems arise from treatment by fellow students.

I acknowledge that I have read the Liability Release and agree to the statement.

Signature (Required) ____________________________

Registration fee includes CME and lunches. Circle appropriate fees.

OCA Member (On or before January 10, 2019) ................................................................. $850.00
OCA Member (Postmarked after January 11, 2019) ........................................................ $925.00
Qualified Nonmember ...................................................................................................... $995.00

Total ........................................................................................................................................ $_____

Paid by: Check ______ MasterCard/VISA#/American Express ____________________________ Exp. Date ____________
SSN: ____________________________ Signature: ________________________________

Cancellation policy: 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 January 11, 2019. Refunds will not be made for cancellations received after January 11, 2019, 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. It is the responsibility of ALL participants to use the information provided within the scope of their professional license.

Accommodations: The Course will be at the Crowne Plaza Astor Hotel, New Orleans, Louisiana. Reservations can be made on our website using the hotel link. The room rate is $139.00. Rooms will be available until January 25, 2019, or until the block is sold whichever occurs first.

Register online at www.cranialacademy.org
# 2019 Osteopathic Cranial Academy Annual Conference
## The Second Brain: An Exploration of the Gut-Brain Axis
### June 13-16, 2019
#### Conference Directors: Michael Kurisu DO
#### Associate Director: Ali Carine DO
### Schedule

#### Thursday, June 13

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>2:00 p.m.</td>
<td>Registration</td>
</tr>
<tr>
<td>2:45 p.m.</td>
<td>Welcome</td>
</tr>
<tr>
<td>James W. Binkerd DO</td>
<td></td>
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<tr>
<td>3:00 p.m.</td>
<td>Overview of the Conference (Lecture)</td>
</tr>
<tr>
<td>Michael Kurisu DO</td>
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<tr>
<td>3:45 p.m.</td>
<td>Quantifying Your Gut and Brain – A Personal Journey (Lecture)</td>
</tr>
<tr>
<td>Larry Smarr PhD</td>
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<tr>
<td>4:45 p.m.</td>
<td>Finding the Health Within/Student Lab (Lab)</td>
</tr>
<tr>
<td>Eric J. Dolgin DO FCA</td>
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<tr>
<td>5:45 p.m.</td>
<td>Discussion in Small Group</td>
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<tr>
<td>6:00 p.m.</td>
<td>Grow With Your Gut Instinct (Lecture)</td>
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<tr>
<td>Mimi Guarneri MD</td>
<td></td>
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<tr>
<td>7:00 p.m.</td>
<td>Adjourn</td>
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<tr>
<td>7:00 p.m.</td>
<td>Book Signing/Reception</td>
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#### Friday, June 14

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>9:00 a.m.</td>
<td>Gut-Brain Axis: Functional Medicine Approaches (Lecture)</td>
</tr>
<tr>
<td>Emeran A. Mayer MD PhD</td>
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</tr>
<tr>
<td>10:00 a.m.</td>
<td>Mindfulness for Brain-Gut Axis: What to Teach Your Patients (Lecture)</td>
</tr>
<tr>
<td>Jake Fleming DO</td>
<td></td>
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<tr>
<td>10:30 a.m.</td>
<td>Discussion in Small Groups</td>
</tr>
<tr>
<td>10:45 a.m.</td>
<td>Embryological and Anatomical Review of the GI Tract and its Attachments (Lecture)</td>
</tr>
<tr>
<td>Daniel A. Shadoan DO</td>
<td></td>
</tr>
<tr>
<td>11:00 a.m.</td>
<td>Treatment of the GI Tract and its Attachments (Lab)</td>
</tr>
<tr>
<td>Daniel A. Shadoan DO</td>
<td></td>
</tr>
<tr>
<td>12:00 p.m.</td>
<td>Lunch/Committee Meetings</td>
</tr>
<tr>
<td>1:30 p.m.</td>
<td>Vagus Nerve Physiology: Latest Research (Lecture)</td>
</tr>
<tr>
<td>Ramesh Rao PhD</td>
<td></td>
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<tr>
<td>2:00 p.m.</td>
<td>Autonomic Pistol (Lab)</td>
</tr>
<tr>
<td>R. Paul Lee DO FAAO FCA</td>
<td></td>
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<tr>
<td>3:00 p.m.</td>
<td>Discussion in Small Groups</td>
</tr>
<tr>
<td>3:15 p.m.</td>
<td>Pain Along The Gut Brain Axis (Lecture)</td>
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<tr>
<td>Robert Bonakdar MD</td>
<td></td>
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<tr>
<td>3:45 p.m.</td>
<td>Neuro-Gastroenterology Research Wearable Monitor: Electro-Gut-Gram (Lecture)</td>
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<tr>
<td>Armen Garhibans PhD</td>
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<tr>
<td>4:15 p.m.</td>
<td>Treatment of the Enteric Nervous System and Vagus (Lab)</td>
</tr>
<tr>
<td>Thomas A. Moorcroft DO</td>
<td></td>
</tr>
<tr>
<td>5:30 p.m.</td>
<td>Adjourn</td>
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<tr>
<td>5:45 p.m.</td>
<td>Annual Membership Meeting</td>
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#### Saturday, June 15

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>9:00 a.m.</td>
<td>Nutrition for the Brain-Gut Connections (Lecture)</td>
</tr>
<tr>
<td>Kelli Gray-Meisner RD</td>
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<tr>
<td>9:45 a.m.</td>
<td>Treatment of Abdominal Visceral Ganglia (Lab)</td>
</tr>
<tr>
<td>Richard Schuster DO</td>
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<tr>
<td>10:45 a.m.</td>
<td>Discussions in Small Groups</td>
</tr>
<tr>
<td>11:00 a.m.</td>
<td>Connection of the Microbiome and Ecology to Brain-Gut Axis (Lecture)</td>
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<tr>
<td>Rob Knight PhD</td>
<td></td>
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<tr>
<td>12:00 p.m.</td>
<td>Lunch/Committee Meetings</td>
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<tr>
<td>1:30 p.m.</td>
<td>Sutherland Memorial Lecture (Lecture)</td>
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<tr>
<td>Eric J. Dolgin DO FCA</td>
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<tr>
<td>2:30 p.m.</td>
<td>Treatment of Thoracic Inlet (Lab)</td>
</tr>
<tr>
<td>Daniel Moore DO</td>
<td></td>
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<tr>
<td>3:30 p.m.</td>
<td>Discussion in Small Groups</td>
</tr>
<tr>
<td>3:45 p.m.</td>
<td>CNS Oversight of the Autonomic Nervous System (Lab)</td>
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<tr>
<td>Elliott S. Blackman DO FCA</td>
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<tr>
<td>4:45 p.m.</td>
<td>Gut-Brain Patient Workup - Panel (Lecture)</td>
</tr>
<tr>
<td>Moderated by Michael Kurisu DO and Joshua Alexander DO (Neuro) and Mary Krinsky DO (GI)</td>
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<tr>
<td>5:30 p.m.</td>
<td>Adjourn</td>
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<tr>
<td>6:30 p.m.</td>
<td>President's Reception</td>
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<tr>
<td>7:00 p.m.</td>
<td>Recognition Banquet</td>
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#### Sunday, June 16

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>8:00 a.m.</td>
<td>Ayurveda and Yoga for the Brain/Gut: What to Teach Your Patients (Optional Lab)</td>
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<tr>
<td>Melanie Fiorella MD</td>
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</tr>
<tr>
<td>9:00 a.m.</td>
<td>Common Gut/Brain Axis Conditions in Children and How to Approach Them (Lecture)</td>
</tr>
<tr>
<td>Ali Carine DO</td>
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</tr>
<tr>
<td>9:30 a.m.</td>
<td>Treatments for Children with the Gut/Brain Axis (Lab)</td>
</tr>
<tr>
<td>Ali Carine DO</td>
<td></td>
</tr>
<tr>
<td>10:30 a.m.</td>
<td>Discussion in Small Groups</td>
</tr>
<tr>
<td>10:45 a.m.</td>
<td>Gut-Brain Axis (Lab)</td>
</tr>
<tr>
<td>Elliott S. Blackman DO FCA</td>
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</tr>
<tr>
<td>11:45 a.m.</td>
<td>2020 Conference Introduction (Lecture)</td>
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<tr>
<td>Hollis H. King DO PhD FAAO FCA</td>
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<tr>
<td>12:00 p.m.</td>
<td>Adjourn</td>
</tr>
</tbody>
</table>

### Conference Location
Marriott La Jolla Hotel
4240 La Jolla Village Drive
La Jolla, California 92037
(858) 587-1414

$165.00/plus tax per night

Rooms will be available until May 15, 2019 or until the block is sold whichever occurs first. After May 15, 2019, reservation requests will be confirmed on a space available basis.

The Cranial Letter, February 2019, Volume 72, Number 1
2019 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.

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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, 2019) ............................................................................................................... $850.00
- OCA Member (Postmarked after June 1, 2019) .......................................................................................................................... $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, 2019) .................................................................................... $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, 2019) ................................................................................................. $45.00
EXTRA Saturday luncheon ticket for guest (Before June 1, 2019) ............................................................................................... $45.00
EXTRA luncheon tickets for guests (After June 1, 2019) ................................................................................................................ $50.00
EXTRA Saturday Recognition Banquet ticket for guest (Before June 1, 2019) ......................................................................... $75.00
EXTRA Saturday Recognition Banquet ticket for guest (After June 1, 2019) ........................................................................... $80.00

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

Total........................................................................................................................................................................................................ $_____.00

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

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

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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, 2019. Refunds will not be made for cancellations received after June 1, 2019, 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
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You may also register online at www.cranialacademy.org
The Gut Brain Connection
Charles Beck, DO, FAAO

In the late 1800’s, when Andrew Taylor Still was solidifying and bringing to the world his concepts and ideas about osteopathy, little was known about the immune system, gut bacteria and roles they play in our overall health. The food system as the world knew it was stable, unadulterated, and everything we ate was organic - long before the term came into being. Still focused on what he could study and change to help his patients return to health - anatomy, anatomy, anatomy.

But we live in an ever more rapidly changing world and changing in more areas, with each passing day. Those changes require that we look with new eyes at what may (or may not) be driving the anatomical and health changes in our patient’s bodies that we learned about in school. Are we still correct in assuming that the physical changes that we see and feel are anatomy, or might there be another...smaller, cause of some of the dysfunction we treat? And, might the new knowledge we gain lead us to better care for ourselves and our patients?

If we just look at the numbers, our body has roughly 37.2 trillion cells.\(^1\) Compare that with the 100 trillion bacterial, viral and fungal cells that are also a part of us and the “us” is outnumbered 3 to 1.\(^2\) If these organisms are in balance in our body and interacting well with their neighbors and with us, then the cornucopia of health is bestowed upon everything under our “roof”. If, however, things are out of balance, everything within us, and our bodies, suffer - anatomically and physiologically. New research is suggesting that it is not hard (at all) to do things to mess it all up.

Our gut microbiome, the name for all of the organisms that live within us, is comprised of bacteria, viruses and fungi. Each of these organisms has a mission to survive. In their mission, they may do things to control our body to help themselves maintain their environment - making us a marionette to them in the process. Understanding who or what is at the helm of our body when it is not optimal can help the practitioner choose better treatments for the condition.

The communication between the gut and brain seems to be linked to the neural, humoral, endocrine and immune systems.\(^3\) The enteric and central nervous systems (ENS and CNS) have bidirectional communication between the brain and intestines,\(^3\) which, as a simple example, can be anatomically linked to the afferent and efferent communication within the vagus nerve. If we stay with this example for the content of this article, then how do we distinguish whether a rib dysfunction is somatic, visceral or microbiome in origin?

“We are beginning to find that people who have less microbial diversity — a reduced overall population and fewer types of bacteria — are more prone to inflammatory conditions, including inflammatory bowel disease and certain types of chronic pain,” Dr. [Robert] Bonakdar [MD] says.

“There is even preliminary research linking the microbiome to neurological conditions, including migraines, Parkinson’s and dementia. There is really no condition that has not been linked in some way to our microbial community, although the evidence is stronger in some areas.”\(^2\)

This article goes on to confirm what Dr. Westin Price first published in his book “Nutrition and Physical Degeneration” in 1939:

“We know that the standard, highly processed American diet typically depletes important micronutrients and fiber,” Dr. Bonakdar says. “A number of studies have demonstrated that the transition to a Western diet in traditional countries begins to increase the occurrence of certain conditions, including inflammatory bowel disease, which is highly linked to both a reduced number of microbes and a loss of microbial diversity.”\(^2\)

Mimi Guarneri, MD adds in one of her online articles:

“Unfortunately, dietary diversity has been lost during the past 50 years because of economic pressures for greater food production to support a growing world population. This decreased agrobiodiversity, or the decline in rearing varied edible plant varieties and animal breeds, is occurring at an incredible rate. According to the Food and Agricultural Organization of the United Nations, 75 percent of plant genetic diversity has been lost, as farmers worldwide have left their multiple local varieties for genetically uniform, high-yielding varieties. Of the 250,000 to 300,000 known edible plant species, humans use only 150 to 200. Six livestock breeds are lost each month in favor of high production practices. Today, 75 percent of the world’s food is generated from only 12 plants and five animal species.”\(^4\)

It is not only our diet and its shrinking lack of diversity that is changing our gut, and potentially making us much...
Impact of the Tent

R. Paul Lee, DO, FAAO, FCA

What is the relationship between Parkinson’s disease and trauma? Why do some patients with concussions experience sound and light sensitivity? These questions might be answered by examining the anatomical relationship between the midbrain and the free border of the tentorium cerebri.

Osteopathic practitioners, using osteopathy in the cranial field (OCF), can capably treat specific effects of mild traumatic brain injury (mTBI): both Parkinson’s disease (caused by TBI) and concussion-associated light and sound sensitivity, with the understanding that the edge of the free border of the tentorium can damage the midbrain.

Using OCF, I have successfully treated these dysfunctions caused by mTBI: symptoms of Parkinsonism (tremor, gait freeze, and unsteadiness) as well as sound and light sensitivity, by respectively treating the substantia nigra and the superior and inferior colliculi (corpora quadrigemina) of the midbrain.

We can easily envisage the mechanism of injury. Traumatic forces can whip the cerebrum, cerebellum, and brainstem, which have the consistency of custard, causing them to strike adjacent structures that are harder and less mobile, such as the tent. Some effects of mTBI appear on MRI as hyperintensities of meninges and punctate vascular injuries where, for example, the temporal lobes impacted the wall created by the lesser wings and greater wings of the sphenoid (anterior to the temporal poles) or the frontal lobes impacted the frontal bone.

Anatomically, one discovers that the incisura, the posterior portion of the free border of the tent, is positioned adjacent to the pontomesencephalic sulcus of the brainstem, the indentation at the superior aspect of the pons where the mesencephalon (midbrain) begins. The incisura is the curve made by the free border of the tent anterior to the point where the two leaves of the tent meet each other and the falx cerebri. This is also where the straight sinus receives the inferior sagittal sinus and the Great Vein of Galen (great cerebral vein). The incisura marks the transition between the posterior and middle cranial fossae and serves as well as a marker for the transition between the pons and the midbrain, just as the foramen magnum marks the transition between the spinal cord and the medulla.

Caudal to the tent we find the pons, ventrally (residing posterior to the clivus) and the tectum, dorsally (the roof over the aqueduct of Silvius). The two pairs (superior and inferior) of colliculi are situated dorsal to the aqueduct as part of the tectum. Caudal to the colliculi, the tectum is
continuous with the thin superior medullary velum forming the roof of the fourth ventricle and connecting to the cerebellum. The cerebellum nestles beneath the tent, mostly posterior to the incisura.

The neurological tissue at the pontomesencephalic sulcus in the midbrain, adjacent to the incisura includes the superior and inferior colliculi (collectively known as the corpora quadrigemina) on the posterior aspect of the brainstem, and the tracts of the cerebral peduncles bilaterally on the anterolateral aspect, with the substantia nigra located immediately internal to these tracts. The substantia nigra and the corpora quadrigemina find themselves in precarious positions relative to the tense, sharp edge of the free border of the tent.

The performance of the substantia nigra and corpora quadrigemina carries great importance for our wellbeing. The substantia nigra along with four other nuclei (caudate, putamen, globus pallidus, and subthalamus) compose the basal ganglia. The substantia nigra, a pair of melanin-colored, relatively flat, thin, and semi-transverse nuclei are critical for reward and movement functions. Each of these bilateral nuclei is composed of two parts. More medially, the pars compacta sends the excitatory neurotransmitter (dopamine) to the striatum (caudate and putamen). When deficient (i.e., cell death), Parkinson’s disease results. More laterally is the pars reticulata; it is an important processing center for the basal ganglia. The pars reticulata conveys the final processed signal of the basal ganglia through inhibitory GABAergic neurons to the thalamus and the superior colliculus.7 8

The superior and inferior colliculi are reflex centers involving vision and hearing. The superior colliculus orients the head towards something seen and heard. It receives auditory information from the inferior colliculus. Superior and inferior colliculi connect through two pairs of brachia that serve to exchange information with the thalamus. The superior colliculi communicate with the lateral geniculate bodies and the inferior colliculi with the medial geniculate bodies, located on the posterior and inferior limit of the thalamus, just anterior and superior to the colliculi. The geniculate bodies receive primary visual (lateral) and auditory (medial) information from the optic radiations and auditory pathways respectively. The colliculi integrate these sensory inputs to coordinate muscular responses.9 10 11

The inferior colliculus is the largest nucleus in the auditory pathway and processes multiple audio signals to integrate them and filter out the sound of vocalizing, breathing, and chewing. It also localizes the source of sound, known as binaural hearing. It is the central processing center for not only audio but also many other sensory inputs. It responds to loud sounds with the startle reflex, for example. The superior colliculus is responsible for stereoscopic vision. Because of colliculi, one can hold a gaze, follow a home run, or visually investigate to discern fine detail.12 13

One can appreciate how damage to the colliculi makes for sensitivity to sound and light making difficult such activities as driving at night, watching television or computer screens, and listening to music or noise. A sense of compression or congestion often distinguishes what one feels when tissue has been injured and is not functioning well. Often the tissue feels deflated, compressed, and lacking motility and vitality. In the case of a mechanical injury from the free border of the tent, the injured tissue in the midbrain is quite obvious. Injured tissue, like a soldier out of step, draws one’s attention.

One patient displayed an obvious injury to only the left substantia nigra on the lateral side of the midbrain. The right side felt vital, full, and breathed well with primary respiration. He had tremors only in his right hand and foot. He had been in an auto accident 18 months earlier and had never been “right” since then, but experienced progressive tremor, unsteadiness, and gait freezes over the six months prior to his first visit with me. As I worked to balance the left and right sides of his midbrain, his symptoms responded remarkably. I had never before seen a Parkinson’s patient respond to osteopathic manipulative treatment with improved symptoms. His symptoms have nearly resolved with one month of weekly treatments.

I have many more patients with concussion who experience sensitivity to noise and light than I have patients with Parkinson’s disease. Concussion patients likewise recover well from light and sound sensitivity with attention to the colliculi. Improving fullness, fluidity, and vitality of motility seems to be the key, as it does anywhere we apply OCF.

To find these structures, orient yourself to the tent as an extension of the petrous temporal bones, more familiar and easily visualized through bony contacts. Now visualize the sweep of the leaves of the tent superiorly and posteriorly towards the straight sinus that points from inion to bregma at the coronal suture in the midline. Follow the line from the inion towards bregma (the initial segment of this imaginary line being the straight sinus) and visualize the intersection of this line with the two lines of the edges of the petrous temporals that come to mind best with a bilateral temporal contact. Fill in this picture of normal anatomy (from which Dr. Still instructs us to always operate) with the free borders of the tent (incisura). Feel Sutherland’s fulcrum oscillating up and down the suspended fulcrum represented by the straight sinus. Look inside the curve of the incisura to the lateral and posterior aspects of the midbrain for the nuclei in question. See if your attention is attracted by a sense of heaviness and compression from any injured tissue. Once you find this injured tissue, your memory for such a sense of congestion will direct you more easily to other injured tissue the next time.
Treatment requires the injured tissue to be identified. Once the operator recognizes the congested and devitalized tissue, he or she simply watches the primary respiratory mechanism work to foster healing activity. Sometimes it takes many minutes, but the time is a small price to pay for the valuable benefits. The healing function becomes evident in your perception as the injured tissue begins to blend in with its surroundings, becoming homogeneous with the whole. Wait for the formerly injured tissue to breathe with the neighboring tissue. This is integration. Once a stillpoint occurs and normal motion resumes at a quieter pace we know that the job is finished.

References
6 D. Shlosberg, M. Benifla, D. Kafer, and A. Friedman, Blood–brain barrier breakdown as a therapeutic target in traumatic brain injury Nat Rev Neurol. 2010 Jul; 6(7): 393–403. Published online 2010 Jun 15. doi: [10.1038/nrneurol.2010.74]
8 Deniu M1, Mailly P, Maurice N, Charpier S, The pars reticulata of the substantia nigra: a window to basal ganglia output. Prog Brain Res. 2007;160:151-72.
Because of the prevalence of severe compressive, tensile or shearing force trauma in the craniosacral mechanism, oft secondary to the traumatic forces of labor, delivery or acquired thereafter, it will not be uncommon to be prompted to administer much needed preparatory work before the neuroanatomy of the eye, and its relevant structures, per se, are directly manually addressed via the sequence. As in any surgical procedure, the methodical and repeated application of the sequence, and OMT in general, could help the clinician determine at what point in a session or series of sessions the sequence, or part(s) thereof might best benefit progress in the overall case. It can not be overstated that strategy as to its usage in a given visit will be better indicated and integrated as experience fosters proficiency in completing the sequence, in the time frame of a typical visit, from its frequent application. That being said, because of the proximity of structures, the eye might respond to any of these techniques regardless of whether the sequence is completed or not. If the aim is for improvement or cure of specific eye disorders and it is methodically applied, and reapplied, in the context of the whole body, this clinically time-tested approach, worthy of one’s best efforts, becomes a vital addition to one’s armory. At which point to apply the sequence, or defer to regional or global OMT, and for how many visits, will also become apparent as the tempo of improvement is revealed or a plateau is reached. The sequence would ideally seem to follow OMT for the remainder of the body. However, irrespective of the application of eye techniques locally, there were visits and even entire cases where this was bypassed due to time constraints and non-eye OMT still yielded brilliant results.

Because there are so many small, vital structures in such a small space, especially when eye disorders are bilateral, strategy is often needed, because of time constraints, even where time is allotted for OMT procedures in the setting of a traditional osteopathic practice. If the pathology is severe, the complete sequence for the more affected eye is preferred. When pathology is not severe, OMT for both eyes, applying either the extraoral (Table I), or OMT for the intraoral visually - relevant structures (Table II), can be considered. Beginning with the external eye portion of the OMT sequence might be desirable in the case of mild to moderate severity, since the documenting and follow up for treatment progress from this less - subtle aspect is easier. Also, beginning externally might tend to address root causes of facial trauma, usually inflicted from without. It is advisable to default to the direct approach, the restrictive barrier being loaded, for all techniques presented in this series, for reasons discussed early on in the article series. Simply put, after finding the direction(s) the structures want to go, with a passive range of motion testing, or into the direction of ease towards unloading the restrictive barrier (Indirect approach), proceed next in opposite fashion, stacking all vectors in the direction of engaging the restrictive barrier, for Direct release.

The decision to begin with the sequence was made for Patient Number 65, a 46-year-old pharmacy assistant. He presented with bilateral glaucoma, with intraocular pressures (IOP) in the right (OD) 31 and the left (OS) eye, 14. This prevailed despite three OD medications, in addition to three laser procedures (and two for the OS). In an attempt to release the most fascia in the least time, periorbital, regional cranial percussion and homeopathy (Syphilinum 50M) was applied in lieu of the abbreviated VST and the occipital CV4 (Table III), for this, and one more visit. Lacking this resource, these last two procedures could just as well have been employed, also with excellent outcomes, historically. (An interim ophthalmologist exam showed the OD IOP was now 13.) Patient Number 66, a 60 -year - old obsessive-compulsive woman with multiple issues including multiple chemical sensitivities, presented once more with a vague complaint of eye sensations in both eyes (OU) that were deemed abnormal. No signs of overt eye disease such as photophobia, redness, ocular tenderness, periorbital swelling, discharge or blepharospasm were noted. The extraoral part of the sequence (Table I) for the OD and OS, which revealed un-physiologic strain patterns, was applied without the intraoral OMT. As in the past, for varying numbers of weeks or months, this offered immediate relief of her symptoms.

If time is very limited, and the pathology will not lead to loss of sight or eye function, and does not reflect an acute cerebrovascular incident, an invaluable OMT alternative would be the Radio Dial Technique. To review, with the patient supine, sitting or reclining (hospitalized), the osteopath very gently contacts the involved globe, eye closed, determined by the patients history or palpation (utilizing the bilateral palpatory scanning technique as presented in The Cranial Letter, Part 3, November 2016, page 9). This essentially entails forming a cup with all finger pads of one hand. With a light, very gentle contact, motion testing for rotation, translation, compression and traction to ascertain the restrictive barriers, is undertaken. Stacking all traumatic vectors, for a direct release of the globe/orbit complex, follows this. If time is exceedingly restricted, this can be limited to the rotational vector aspect of the strain pattern with excellent results. This simple and very effective eye technique, from the toddler to the elderly, can be administered, often yielding profound relief, with or without the regional Venous Sinus Technique (VST), or global/regional occipital Compression of the Fourth Ventricle (CV4) techniques (Table III). After all, the operator is in contact with the eye, the forward extension of the brain, which is also the only out - and - out manually accessible portal to the Central Nervous System (CNS) itself. It remains that in any given visit, it is better to apply any part of the sequence, or even one such technique such as the Radio Dial, than nothing at all. Also not included in the sequence summary (Tables I, II and III), for the sake of brevity so as not to overwhelm, are other potent eye techniques, discussed throughout the series, well worth knowing. An example is the direct
fibrous scleral technique. This is achieved via a fifth fingertip between the iridal rim and the globe perimeter, for ocular fascial release. For example, this can be a consideration in the approach for episcleritis, associated with many diseases such as Rheumatoid Arthritis, Sjogren’s syndrome and Herpes Zoster (conventional cause unknown). It should also be stated that age variations must be factored in applying the sequence. For a five-year-old child, for instance, one would substitute a unilateral intraoral and extraoral contacting for release of the Maxilla (hand 1) while the other operator hand (2) contacts the Greater Wings, bilaterally, in lieu of the Palatine and Palatomaxillary suture releases (due to the unavoidable stimulation of the gag reflex in a still small oral cavity), while leaving out the occipital CV4. Also, as discussed, an excellent substitute for the newborn/infant involves one vinyl-gloved finger pad contacting the hard palate while the other operator hand contacts the baby’s Greater Wings for direct release of the visually relevant intraoral structures. It is not entirely uncommon to detect a lateral fluctuation between and encompassing both globes during the subtle, expanded sensing Bilateral Eye Palpatory Scanning (see Table I). If this is sensed, it is advised to stay in contact with the Potency in flux, following it until a treatment cycle is completed; a palliative lateral fluctuation technique of the eyes.

The final technique in the intraoral part of the sequence (Table II) deserves clarification. This technique, taught by Dr. Viola Frymann addresses the prevalent ipsilateral intraosseous strain between the Greater Wing and the Lesser Wing of the addressed side, specifically. It naturally follows the preceding technique, the Frontosphenoidal Suture release, as the Greater Wing/Pterygoid contact is maintained while the lateral frontal contact with the other hand is merely slid medially over the medial brow for a more specific unilateral releasing of the intraosseous strain commonly present between Greater and Lesser wings. This is in contradistinction to the intraosseous Sphenoid release utilizing bilateral Greater Wing contacts for release of the entire sphenoidal matrix, as taught by Dr. James Jealous, an excellent technique in and of itself, a consideration based on the clinical presentation. The interosseous sphenoidal strains are traditionally taught as being addressed through sphenobasilar synchondrosis (SBS) OMT, although interosseous strains can potentially be resolved via intraosseous OMT, and vice versa. Recall, the strategic importance of the posterior wall of the orbit, the site of many nerve and vessel transmitting foramina and fissures, the prime mover of the face, the Sphenoid. It truly is the troublemaker of the eye, influenced and influencing no less than 11 articulations, other bones, and their spheres of influence.

A concise, methodical, traditionally osteopathic approach to visual disease has been presented. It is offered in the hopes of providing cure or significant improvement, for a myriad of eye-related illnesses, many disconcerting and disabling, to patients young and old. In addition to benefitting the whole person, the approach herein has consistently identified the cause of and proven its depth and worth in many cases where conventional neurophthalmology, ophthalmology and optometry have proven limited or failed.

Even as you desire good treatment, so render it. – Seneca saying

<table>
<thead>
<tr>
<th>STRUCTURES</th>
<th>CONTACTS</th>
<th>NOTES</th>
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<tbody>
<tr>
<td>Bilateral Eye Palpatory Scanning</td>
<td>Frontal (hand 1)</td>
<td>Primarily diagnostic (Dx)</td>
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<tr>
<td></td>
<td>Globe (hand 1)</td>
<td>Can be applied to assess sequence results,</td>
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<tr>
<td></td>
<td>Maxilla (hand 1)</td>
<td>immediate or delayed</td>
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<td></td>
<td>Frontal (hand 2)</td>
<td>Becomes therapeutic (Tx) if treatment cycle</td>
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<td></td>
<td>Globe (hand 2)</td>
<td>follows (E.g. palliative lateral fluctuation</td>
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<td></td>
<td>Maxilla (hand 2)</td>
<td>involving one or both eyes)</td>
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<tr>
<td>Globe and Orbit</td>
<td>Frontal (hand 1)</td>
<td>Eye possibly decided by above simultaneous</td>
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<tr>
<td></td>
<td>Maxilla (hand 1)</td>
<td>Globe and Orbit Dx then Tx</td>
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<td></td>
<td>Zygoma (hand 1)</td>
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<tr>
<td></td>
<td>Globe (hand 2)</td>
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<td>Lacrimal (hand 1)</td>
<td>Lid Fascia/Ligaments (Not the Suspensory</td>
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<tr>
<td></td>
<td>Zygoma (hand 2)</td>
<td>Ligament)</td>
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<td>Orbital Projection</td>
<td>Orbit (as above via hand 1)</td>
<td>Contacts bridge opposite diagonal, engage</td>
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<tr>
<td></td>
<td>Opposite inferior</td>
<td>restrictive barrier even if vector(s)</td>
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<td></td>
<td>Occiput (hand 2)</td>
<td>not towards opposite diagonal occiput</td>
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<tr>
<td>Periorbital</td>
<td>Fascia between Globe and Orbit</td>
<td>Bulbar fascia</td>
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<td></td>
<td>(hands 1 and/or 2)</td>
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<tr>
<td>Ethmoid</td>
<td>Frontal(s), Gr. Wings</td>
<td>Strain virtually always includes transverse</td>
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<td></td>
<td>(hand 1)</td>
<td>plane vector</td>
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<td></td>
<td>Nasals, Maxillae</td>
<td>Ethmoid is treated by proxy</td>
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<tr>
<td></td>
<td>(hand 2)</td>
<td>via surrounding bones accessed</td>
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Table I. Extraoral Techniques of the Visual System Sequence
Dental Corner

Pain after Routine Dental Treatment

Craig A. Zunka DDS

**Patient:** D.B.

Patient presented to the office on 10/31/18 with a chief complaint of significant pain across his forehead and between his eyes with tightness down into the TMJ, bilaterally.

He states that he had been treated for a TMJ disorder some 30 years ago and had been completely symptom free until earlier this month when his general dentist placed a filling in a lower left molar. He states after the filling was placed his bite felt off and his head began hurting. He returned to his dentist on three separate occasions where his dentist adjusted the bite. He states that the pain in his head changed slightly after each adjustment of his bite but that the pain was still present.

**Examination:**

Using wax, we checked the bite and found that it was normal. He had normal range of opening at 47 mm; 11 mm left and 10 mm right movement of the mandible, which was slightly restricted. Palpation of the lateral and posterior temporomandibular joint was asymptomatic.

Cranial evaluation showed that he had a right basiocciput, posterior AO, external rotation of the left temporal, internal rotation of the right temporal, superior strain of the sphenobasilar symphysis, external rotation and torsion of the
left maxilla and a longitudinal strain from the head down to the left hip.

**Treatment:**
Decompression of the longitudinal strain, adjustment of the basiocciput and posterior AO. SBS, right and left temporals and maxilla, he stated that the pain between his eyes was 50% better at the end of the treatment.

**Discussion:**
I think with a significantly high tooth filling that it forced the left maxilla into external rotation and torsion of the whole maxilla, which then effected the left temporal, sphenoid and then the sphenobasilar symphosis creating a longitudinal strain.

Patient was educated on the length of time for the treatment to work. Dr. Herb Miller and Dr. Jim Jealous said it takes 72 hours for a treatment to finish. This has also been my experience. Quit often, the next day the patient can be sore; second day after treatment they are improved and by the third day post treatment, they are much better. This was the case with this patient.

Follow-up on 11/6/2018, patient states that he is 100% better. The pain had been gone for at least three days. He is completely back to normal.

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**C-Pap Patients Need Help!**
Douglas G. Vrona DMD

Last year I became the proud owner of a C-Pap machine for sleep apnea. I’ve never missed a night as it has been very successful.

The problem was that each morning I would find that my cranial vault was distorted and my CRI had decreased. Overtime, much of this was reversed by self-treatment and adjusting the necessary headgear straps.

I then turned to my patient population and found that many of my most difficult cases also used a C-Pap - a question I did not ask while taking a history.

Obviously, the device compresses the SBS & Maxillary Ethmoid complex. Straps also inhibits cranial expansion at the SSS & T/P sutures, as well as compress the OAA articulation. Finally, the TMJ’s are directly affected by pressure on the zygomas.

Fortunately, with cranial osteopathy & appropriate strap adjustments, patients can routinely gain relief from chronic head, ear, TMJ, upper cervical and back pain.

Full-face masks seem to cause the least problems. Due to expansion, nasal hoods need to be changed every 4-6 weeks or else leakage causes patients to tighten head gear straps which should actually fit quite passively (personal experience).

Medicare supplies 4 nasal hoods quarterly i.e., S, M, L, XL but only one actually fits the patient and 3 are discarded! However, if a request is made to the supplier, FOUR of the proper size will be sent eliminating the need to tighten the vault straps.

The latest fad is a nasal cushion used just below the nasal passages. It is the biggest offender in that although it allows more bodily movement in bed, it requires the tightest headgear.

C-Pap patients, once treated are able to

1) Get off headache & sinus meds
2) Eliminate weekly chiropractic visits (OAA ++ L4L5 S/I)
3) Reduce glaucoma pressure drops
4) In one case, eliminated scheduled major eye surgery.

It should be noted that this concept is not something new.

In 1949 H. Brooks Walker, D.O. (Nantucket, MA) wrote *Anesthesia and Cranial Technique*:
"All of us have noticed the relaxation with the shift to abdominal breathing induced by any physiological manipulation of the skull. This works also with the unconscious patient, and is especially useful in the individual who is very apprehensive in spite of preliminary medication. I have used only the gas-oxygen-ether method with closed rebreathing. The patient is first given nitrous oxide, and then ether is gradually added while the gas is cut down. As the patient approaches the third stage of anesthesia - or as soon as the anesthetist can spare the time –the parietal bone or the mastoid process on one side is put gently and slowly through external and internal rotation. I dislike using the tight band necessary for holding the mask to the patient’s face. It does free both hands for the anesthetist, but tends to prevent normal cranial motion. Therefore I hold the mask with one hand and apply motion with the other hand, alternating sides." (Collected papers by J.J. Henderson)

In conclusion, I would urge a coordinated effort between the osteopathic & sleep medicine professions to research and address these iatrogenic issues.

James Kennedy, DDS
1190 Bookcliff Ave #101
Grand Junction, CO 81501
Email: drkennedy@dentocranial.net
(970) 242-1900

The Cranial Dental Proficiency Examinations are scheduled. Please check the website for upcoming events or for further information contact the Dento-Cranial Competency Board at 540-635-3610. Website: http://dentalcranial.org/home
From the Archives . . .

Anesthesia and Cranial Technique
H. Brooks Walker DO

This monograph lays no claim to being based on a sufficient number of case histories, but simply presents an idea which it is hoped others with more adequate facilities may follow up and find useful.

During a particularly troublesome anesthesia last summer, the patient stopped breathing. After he had resumed with the help of artificial respiration, oxygen and carbon dioxide, it occurred to me that Dr. Sutherland had once successfully used cranial technique on a man who had been pulled out of the water with breathing stopped. With my free hand I began rotating first one temporal bone then the other externally and internally by means of the mastoid process. Soon the patient's respirations smoothed out and deepened, and I could enjoy life once more! Reflection later brought home the fact that if the cranial concept had been useful in this case, why shouldn't it be of value in every anesthesia? Since then I have tried some form of cranial technique in a total of fifteen cases and have found it well worth while.

All of us have noticed the relaxation with the shift to abdominal breathing induced by any physiological manipulation of the skull. This works also with the unconscious patient, and is especially useful in the individual who is very apprehensive in spite of preliminary medication. I have used only the gas-oxygen-ether method with closed rebreathing. The patient is first given nitrous oxide, and then ether is gradually added while the gas is cut down. As the patient approaches the third stage of anesthesia - or as soon as the anesthetist can spare the time - the parietal bone or the mastoid process on one side is put gently and slowly through external and internal rotation. I dislike using the tight band necessary for holding the mask to the patient's face. It does free both hands for the anesthetist, but tends to prevent normal cranial motion. Therefore I hold the mask with one hand, and apply motion with the other hand, alternating sides.

Cranial technique is also useful with short, thick-necked patients who seem to have the most breathing trouble. These individuals commonly have heads of the flexion type. Better relaxation obtainable with this technique helps the surgeon and means less ether for the patient. This of course speeds recovery.

This application of the cranial concept, like all others offers great possibilities and should be adequately investigated by an anesthesiologist with knowledge of Dr. Sutherland's methods.

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International Proficiency Exam

International Exam of Proficiency was created seven years ago by a friendly collaboration between the French AMOC and the SCTF Belgium. If you are interested in taking the examination at the OCA Annual Conference in La Jolla, California, please contact the OCA office (info@cranialacademy.org) or Daniel Ronsmans DO (daniel.ronsmans.do@skynet.be). There is no charge for this exam. The written exam will be Thursday, June 13 at 6:30 p.m. and the oral and practical will be at 6:00 p.m. on Friday, June 14. We will send 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
Eight scholarships were awarded by The Osteopathic Cranial Academy Foundation for the Midwinter Introductory Course in Osteopathy in the Cranial Field offered by The Osteopathic Cranial Academy. The recipients, selected by random drawing at the time of the American Osteopathic Association Convention include Stephanie E. Czajkowski UNE/COM; Kelly Fuchs DO; Victoria Gerthe LUCOM; Breanna M. Glynn UNE/COM; Holly Laird DO; Jillian Smith CCOM; Tabinda Syed TUCOM Middletown; and Alex Tobar MSU/COM. Fifteen additional scholarships were awarded. Sophia T. Adams DO; Karen D. Farris DO; Tasha N. Loader DO and Caitlin K. Stauder DO received the scholarships from the Barkley Fund; Bethany Blum DO received the scholarship by David Coffey DO FAAO FCA; Kelli N. Chaviano DO received the scholarship by Eric J. Dolgin DO FCA; Elizabeth Cipparrone LMU/DCOM received the scholarship by Melvin R. Friedman DO FCA; Natalie L. Gould RVU/COM received the scholarship by Maria Gentile DO; Shannon Garrison KYCOM received the scholarship by Viola M. Frymann DO FAAO FCA; Ander M. Wojtanowski RVU/COM received the scholarship by R. Paul Lee DO FAAO FCA; Jacob R. Gallagher DO received the scholarship by Paul S. Miller DO FCA; Monika D. Janikowicz BCOM received the scholarship by Michael J. Porvaznik DO FCA; Xiawei Zhong TUCOM-Middletown received the scholarship by Mark E. Rosen DO FCA; Paula Archer PNWU received the scholarship by Melanie Tetrambel DO FAAO; and Jordan Delgadillo DO received the scholarship by Quoc Vo DO.

Gifts to the Foundation are used to support the scholarship program, to purchase teaching materials and to underwrite research programs. Donations are tax deductible as charitable contributions for federal income purposes to the extent permitted by law. Donations received since October 16, 2018 include:

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Wanted:

Memories of Viola M. Frymann, DO, FAAO, FCA for a publication describing and honoring her contribution to Osteopathy over her near 60-year career. This includes her international travels and all the courses she did. We would like to receive 1 to 2 page stories and memories and a picture or two of Viola with you or your group. This will be published by Osteopathy's Promise to Children. Please send inquiries and contributions to Co-Editors Hollis King (hhking@ucsd.edu) or Lorane Dick (drldick@gmail.com) or to OPC (director@the-promise.org)
Osteopath and the Dental Occlusion

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The Cranial Letter, February 2019, Volume 72, Number 1
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Osteopathy’s Promise to Children is accredited by the American Osteopathic Association to provide osteopathic continuing medical education for physicians. Courses are held at: Osteopathic Center San Diego, 3706 Ruffin Rd. San Diego, CA 92123

February 21-24, 2019
ADVANCED COURSE
PED UniCOURSE
Advanced Explorations in Pediatric Osteopathy:
Innovative Healing Approaches to Support Rapid Change in the Child
Course Director:
Shawn K. Centers, DO, FACP
No CME’s Provided | $1320

March 1-2, 2019
INTERMEDIATE COURSE
DENTAL COURSE
Integrated Osteopathic Dental Team: Practical Resolution of Complex Sleep Disturbances (Part I)
Course Directors:
Julie Mai, DO and Darick Nordstrom, DDS
16 Hrs AOA Category 1-A
Dental CME anticipated | $750

May 3-5, 2019
INTERMEDIATE COURSE
CRANIAL DISORDERS COURSE
Expanding the Osteopathic Concept Beyond the Basics
Course Directors:
Ray Huoby, DO, FAAO, MS; and
R. Mitchell Hiserote, DO
Faculty:
Julie Mai, DO and Darick Nordstrom, DDS
24 Hrs AOA Category 1-A
Dental CME anticipated | $1050

July 17-21, 2019
INTRODUCTORY COURSE
40-HR CRANIAL COURSE
Foundations of Osteopathic Cranial Manipulative Medicine
Course Director:
R. Mitchell Hiserote, DO
Faculty:
Rebecca E. Giusti, DO; Ray Huoby, DO, FAAO, MS; Hollis H. King, DO, PhD, FAAO; Mary Ann Magoun, DO; Veronica Vukotics, DO
40 Hrs AOA Category 1-A CME anticipated | $1795

September 7, 2019
INTRODUCTORY COURSE
SYSTEMIC DISORDERS COURSE
OMT for Systemic Disorders and Physiological Functions: Cardiopulmonary & Immune Systems
Course Director:
Hollis H. King, DO, PhD, FAAO
8 Hrs AOA Category 1-A
CME anticipated | $330

October 5, 2019
INTRODUCTORY COURSE
SYSTEMIC DISORDERS COURSE
OMT for Systemic Disorders and Physiological Functions: Gastrointestinal & Nervous Systems
Course Director:
Hollis H. King, DO, PhD, FAAO
8 Hrs AOA Category 1-A
CME anticipated | $330

Osteopathy’s Promise to Children (OPC) is accredited by the American Osteopathic Association to provide osteopathic continuing medical education for physicians. OPC designates this program for the maximum AOA Category 1-A CME credits allowed and will report CME and specialty credits commensurate with the extent of the physician’s participation in this activity. Approval is currently pending.

Online registration available at Registration. The-Promise.org
UPCOMING CME

Feb. 22-24, 2019

**Viscerosomatic Release: A Systemic Model for NMM**
John P. Tortu, DO, course director
University of North Texas Health Science Center
Texas College of Osteopathic Medicine in Fort Worth
20 credits of AOA Category 1-A CME anticipated

March 10-12, 2019 • Pre-Convocation course

**Brain Therapy for Neonatal Reflexes & Lifelong Reflexes in Adults and Children**
Bruno Chikly, MD, DO (France), course director
Rosen Shingle Creek in Orlando, Florida
24 credits of AOA Category 1-A CME anticipated
Registrants must have taken Dr. Chikly’s “Brain 1” course or at least two cranial courses.

March 10-12, 2019 • Pre-Convocation course

**Fascial Distortion Model—Beyond the Basics: Osteopathy and FDM moving forward together!**
Todd A. Capistrant, DO, MHA
Rosen Shingle Creek in Orlando, Florida
24 credits of AOA Category 1-A CME anticipated

March 10-12, 2019 • Pre-Convocation course

**Visceral Lymphatics**
Kenneth J. Lossing, DO
Rosen Shingle Creek in Orlando, Florida
22 credits of AOA Category 1-A CME anticipated

Learn more at www.academyofosteopathy.org/CME.

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March 13-17 • Rosen Shingle Creek in Orlando

Rebecca E. Giusti, DO, program chair
# Osteopathic Cranial Academy

## Coming Events

**February 16-20, 2019 Midwinter Introductory Course in Osteopathy in the Cranial Field**  
Course Director: Zina Pelkey DO FCA  
Crowne Plaza Astor, New Orleans, Louisiana

**February 22-24, 2019 Pediatric Course**  
Course Director: Margaret A. Sorrel DO FCA  
Associate Director: Mary Anne Morelli Haskell DO  
Crowne Plaza Astor, New Orleans, Louisiana

**April 5-7, 2019 The Cortex – Exploring the CNS**  
Course Directors: Maurice Bensoussan MD DO FCA  
Orlando, Florida

**June 8-12, 2019 June Introductory Course in Osteopathy in the Cranial Field**  
Course Director: Richard F. Smith DO  
Marriott La Jolla Hotel, La Jolla, California

**June 13-16, 2019 Annual Conference**  
“The Second Brain: An Exploration of The Gut-Brain Axis”  
Conference Director: Michael Kurisu DO  
Assistant Director: Ali Carine DO  
Marriott La Jolla Hotel, La Jolla, California

**June 14, 2019 Annual Membership Meeting**  
Marriott La Jolla Hotel, La Jolla, California

Website: cranialacademy.org/product-category/events/

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**Introductory Course Osteopathy in the Cranial Field**

**June 9-13, 2018**  
Hilton Norfolk The Main, Norfolk, Virginia

**Course Director:**  
Richard F. Smith DO

**Scholarship deadline**  
**March 1, 2017**

Register online at www.cranialacademy.org

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