

The Hyperbolic Arc of the Frontal Plane- *corrections to vertical*

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Further Discussion on Static and Dynamic Aspects

The goal of any vector-based procedure is to first calculate the correction vector and then to access the reduction pathway. This is a two-part process. First, is to establish the vector and secondly, is to know where to apply it to access the reduction pathways. The correction vector alone (the static aspect) cannot access the correct reduction pathway autonomously. It needs to be applied at the access point or entrance to the reduction pathway and then routed through the collective vertebrae. This entrance point is conceived by the understanding the relationship of the upper cervical x-ray series and the Anatometer measurements of the pelvis below.

This top to bottom “mapping”, of the closed kinetic chain gives the doctor the entrance placement for the skull and headpiece. It then presets a closed contact path or connection to allow the vector to travel down the appropriate resistant pathway.

The Static Aspect Encompasses:

1. Machine balance, port, and filters
2. Precision and accuracy of analysis
3. Anatometer
4. Leg Check

From the above information the pathway of the vector from the three structures (skull, atlas, and lower section C2- Pelvis) can be measured, mapped, and accessed.

*This is the integral step to access the reduction pathway so the vector can overcome the resistance.
This is the dynamic aspect of the correction process.*

To take this step the Anatometer measurements are recorded (weight differential, pelvic rotation, and fixed point) and the QSM³ algorithm then details this placement. *This is accomplished by aligning the structures into the resistant pathway so the force travels up or down through it.* The atlas (C1) because of its two-cup (coupling) design can be used to direct the vector force through skull, headpiece, and pelvic 3D placement. It is this protocol that establishes a specific placement protocol.

Every misalignment has multiple pathways. Each pathway has a placement that is required to be changed to access and then reduce it. It's like a game of golf... hit the ball re-assess, hit it again, re-assess, and hit it again and etc until you reach maximum available correction. This is a ONE VECTOR MULTIPLE PLACEMENT PROTOCOL. This game of correction is so much more difficult without the tools to identify the pathway and its access or entrance point.

I have found that there is more than one placement that corrects a misalignment correctly unless you use enough force to jam it to a FALSE zero. A false zero will always show a short leg on one side and an Anatometer weight differential on the opposite side.

Here are the questions that initiated this search:

1. Do you understand the breakdown pathway of the misalignment (head to toe) before; during or after you initiate the dynamic correction process?
2. Do you have comprehensive system (algorithm) to correct each pre and subsequent post?
3. Do you know what to do on each post?
4. Do you feel your knowledge base is complete?

The dynamic aspect of the QSM³ algorithm begins to address these questions. Like any successful science, it will hopefully continue to grow. It is apparent that there are many factors involved in spinal breakdown and its correction. D. D said ‘mechanical stress, toxins, and auto-suggestion disrupts our tone.’ But innovation converts to better possibilities in the ‘dynamic aspect’ of spinal corrections.

Though still incomplete, the QSM3 protocol moves the ‘mechanical stress’ aspect forward by systematically accounting for the variable possible resistances (dynamics) caudal to the cervical spine.

The Dynamic Aspect Encompasses:

The Dynamic aspect of the correction first:

1. Measures three dimensional pathways
2. Accesses the pathways through placement, doctor position

Then the doctor through position, use of the wrist lever, and torque can change the direction of the vector to:

1. Change the frontal plane direction
2. Change the rotation direction
3. Access multiple pathways

Understanding all of these above concepts well enough to use them in practice, requires a series of sequential classes that are now offered three times a year (QSM³)

The focus of this article is to discuss the frontal plane aspect of the correction and its access points. The stabilizing factor in a misalignment is the frontal plane. The symptom aspect of the misalignment is the rotation.

This means if you do not get the frontal plane on vertical it will be unstable and if you do not clear the rotation the patient will be unhappy.

Frontal Plane Access Points

The frontal plane is the easiest plane to correct. Yet, at times it can be difficult for four reasons:

1. You are not accessing all the frontal plane access (entry) pathways
 - Resolution- roll the skull (see below)
2. You are on the wrong side of laterality
 - Reanalyze –check skull asymmetry and C1 upper & lower registry points
3. Torque Issue
 - Anterior torque corrects the frontal plane towards vertical (Remember: use only if measured anterior from pelvis)
4. Height to rotation is below 45 degrees
 - When the height is less than rotation the frontal plane pathway has to be accessed through increasing headpiece tilt

1. The weight scales are opposite laterality so the force must be redirected to the right side to travel R to L to correct the pathway to vertical.
2. The rotation of the atlas is left posterior but the pelvis is right posterior. The rotation vector also must be reversed to correct the posterior pelvic pathway.

Vector Issue:

1. Vector needs to be redirected right to left. Based on the weight scales.
2. The vector has more frontal action (height larger than C/A & above rotation (above 45°))

Patient Placement 1st correction

Hdpc: tilt down to re-direct force to go R to L (weight)
 Skull: chin up to direct force P to A on the weighted side
 Pelvis: Left pelvis tractioned A to P to preset the pathway
 Shoulder: Left shoulder A to P or right shoulder P to A

1st Post:

Good reduction on film but patient did not come to vertical on the anatemeter
 Anatemeter - R6lbsP⁻¹

Reposition on post based on the new Anatemeter readings

Goal: to clear 2nd frontal pathway of R6lbs
 Checked chin in Neutral and Flexion
Result: Anatemeter L1.8P1

Case Study#2

Patient: Trey K
 Symptomatic Picture: MS
 QSM³ Simple Frontal
Anatemeter: Wt Right 28.7 Pelvis anterior 1mm

AT: R1	Pl +1
OD: R1	At/OD 0
BC: R1	C/A +1 1/2
SP: R1/2	< -1

Vector: $I^2 \frac{RH^1 A^{2 1/2}}{U}$

Discussion:

This is a large frontal component pathway with no rotational component that may fool you and blow out the pelvis because it is jammed in. Don't panic ... just stay with it and follow the algorithm

Vector Issue:

1. Height is smaller than Rotation (below the 45°). This creates more transverse action than frontal action is what is needed based on the Anatemeter

Placement:

Hdpc: tilt up to direct force to go R to L (weight)

Skull: chin tuck to direct force A to P

Pelvis: right pelvis tractioned A to P and s to I

Shoulder: Right side A to P

Post:

Patient did not come to vertical

Anatometer – R22.2A⁰

Reposition on post Anatometer- because patient did not come to vertical

Goal: to clear 2nd frontal pathway of R22.2lbs

Checked chin in Neutral and Extension- There was a 2nd pathway in extension (S to I)

Result: Anatometer L5P₁

Happy hunting!

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