

THOMPSON TECHNIQUE PATIENT WORKUP

The Thompson Technique is to be done on a segmental drop table only, with the cervical, dorsal, lumbar, and pelvic pieces having a drop mechanism. This is done for protection of the patient and doctor and to follow established Protocol.

NOTE: This is a supplement to be used in conjunction with the 12 hour "Basic" Segmental Drop Adjusting featuring the Thompson Technique as demonstrated by Dr. Zemelka on the DVD's or Video tape series – Vol. I and Vol. II.

The first thing you need to do as a doctor is to have the proper patient placement on the segmental drop table. The patient should be on the table prone with the chin at the bottom of the head piece. Once the table has been lowered, raise the foot-relaxer bar up 1-2" to reduce muscular tension in the legs and lumbo-pelvic region. This also aids in comfort of the patient. If you have a patient that is short in stature, have the patient slide up until the chin is at the bottom of the head - piece. Once the patient is in proper placement, inform the patient that you are going to lift up the pelvis to neutralize the pelvic area. Gently place the fingers of each hand underneath the ASIS of each ilium and lift up and down while the patient is relaxed.

***Note: Inform the patient what you are going to do before you neutralize the pelvis.**

Now that the patient is in the proper placement, it is time for you to have the proper stance to perform the Derifield-Thompson Leg Check Analysis. Your feet should be shoulder width apart, with a slight knee bend, and an arch in the back. If your table has the capability to elevate, raise the table up to a level that is comfortable for you to perform the leg check properly.

While you have the patient in this position, inspect the shoes for any uneven wearing and make a note of it. Also, look at how the feet are resting on the relaxer bar. Make a note of any inversion/eversion or internal/external foot flare (aka Foot Abduction/Adduction).

***Note: If the patient is wearing sandals, have them leave the sandals on and remind them to wear regular shoes next time. Do not use the medial malleoli as reference points, since there are anatomical differences in all bones. Adapt the analysis as best as you can. Remind the patient to wear regular shoes next time.**

Leg Check Analysis

You are now ready to perform the Derifield-Thompson Leg Check Analysis. Grasp the patient's feet by placing your thumbs behind or underneath the heel of the shoe and wrap your fingers around the front or top of the feet. Take out any inversion or eversion of the feet and raise the legs up off of the relaxer bar $\frac{1}{4}$ - $\frac{1}{2}$ ". This takes out the friction on the legs touching the relaxer bar when performing the analysis. Grasp the shoes firmly applying slight pressure Inferior to Superior against the bottom of the shoes so that the shoes are pressed against the bottom of the feet. **Don't push the legs up into the acetabular cavity or shake the legs around. This will create neuromuscular changes in the area to be analyzed, and give you an inaccurate result.**

The Thompson Technique utilizes 3-4 thrusts in each level adjusted unless you feel the segment go or in the cervicals and occiput where you thrust only once. Multiple thrusts are used in order to overcome the body's "Fight or Flight" mechanism.

Contraindications/Considerations: Hip/Knee surgeries and/or replacements, spondylolisthesis, and poorly mended broken bones (in legs) alter normal biomechanics. You may have to rely on motion/static palpation, muscle testing, x-rays, etc when dealing with these patients.

Basic 5 Categories

The next thing to do is determine which leg is short. This will be your **Involved Leg**. (Note: An anatomical short leg has been ruled out during physical examination, and ask the patient if there are any heel lifts.) After determining the short (Involved) leg in extension, bring the legs into flexion (no further than 90 degrees) and observe if the short leg changes. **The legs are not brought up past 90 degrees because it creates neuromuscular changes and biomechanical changes that alter the results of the leg check analysis.**

Example: Short leg in extension becomes even or crosses over to become longer in flexion is indicative of a Positive Derifield (+D).

Example: Short leg in extension that stays short in flexion is indicative of a Negative Derifield (-D).

Example: Legs even in extension and even in flexion is a possible Bilateral Cervical Syndrome (BCS). Must perform Cervical Syndrome check in order to confirm.

Example: Legs even in extension and one leg goes short in flexion is indicative of an X-Derifield.

You must then determine if you have a Cervical Syndrome. This is done by having the

patient turn the head (face) to the right (laying the head down) and observe if there is any change in the leg length. Next have the patient turn the head back to the middle (face down) resting for 2-3 seconds, and then turn the head (face) to the left observing any leg length changes. You have a Cervical Syndrome if the involved leg becomes even with or becomes longer than the uninvolved leg.

***Note: Face turned Rt – Right Cervical Syndrome.
Face turned Lt – Left Cervical Syndrome.**

Palpate on the opposite side to which the face is turned and locate the lowest palpable nodular mass (taut and tender fibers) and adjust that level. **Always adjust the Cervical Syndrome/Bilateral Cervical Syndrome first. These two cervical conditions could be “Masking” what is occurring in the pelvis. On occasion, the patient will demonstrate an apparent Cervical Syndrome in both directions. This does not mean to adjust both sides. Adjust the lowest level first, then do a post-check and adjust according to your findings, as the Protocol dictates.

**Remember to perform the Cervical Syndrome check for an X-Derifield with the legs in the flexed position.

Once the Cervical Syndrome or Bilateral Cervical Syndrome is cleared, adjust your pelvic findings according to your leg checks. You may come across what we refer to as “switching” in the pelvis. Your leg check results in a –D or +D, so you adjust that. Next, you perform a post-leg check and you determine to have the opposite of what you just adjusted.

Example: You find a –D and you adjust. Post leg check indicates a +D. This is the “switching” that occurs.

Solution: Have the patient get up off the table and walk down the hall. Place the patient back on the table and adjust according to your results of the leg check.

The patient may also present with “Walking Feet” on occasion. This occurs during the initial leg check. The legs are even in extension and flexion, but you notice that there is a shifting in the length of the legs. This leg length shifting back and forth is very slight, but sometimes you can even feel the legs shifting back and forth. This situation is indicative of a Sacrum – Base Posterior and your thrust is SI – PA. (***Note: Bilateral Cervical Syndrome has been ruled out.**)

Posterior Ischium/Piriformis/Posterior Tibia

After clearing out the –D, +D, BCS, X-D, or Cervical Syndrome, you move on to the next step in the protocol. Gently squeeze the mid belly of the gastrocnemius muscle on

both legs comparing the tonicity and sensitivity. If there is “boardiness” or Taut/Tender fibers, you have 3 possibilities: Posterior Ischium, Piriformis, and Posterior Tibia. *Note: When squeezing the muscles, it is advisable to stand off to one side. Sometimes patients kick due to the tenderness in the muscles, and you don’t want to get kicked. The Posterior Ischium should be addressed first by thrusting PA using the lumbar and pelvic pieces. If a post check reveals Taut/Tender fibers, adjust the Piriformis muscle, and finally, the Posterior Tibia. There may be times when you have to adjust all three levels. **Contraindications/Special Considerations would be: hip/knee surgeries with screws, pins, plates, etc, and advanced osteoporosis.**

IN/EX Ilium

The next step is to evaluate the pelvis for IN or Ex ilii. Adjust according to your evaluation. The indications for adjustment are toe flare in or out, and/or high or low gluteus muscles.

Sacrum Analysis and Adjustment

After the ilia are cleared, move on to analysis of the Sacrum. Sacral Analysis is performed by placing the superior hand over the sacrum remembering to stay off of the spinous of the 5L. Place the flat of the hand at S1 or S2 with the fingers pointing towards the patient’s feet. Ask the patient to raise each leg (with the knee locked in extension) as high as possible, but leaving the hip on the table. The leg that does not raise as high is the involved leg and the sacral apex has deviated away from this leg.

Example: Right leg lower, Sacral Apex-Left.

Left leg lower, Sacral Apex-Right.

*Both legs raised only 1-3 inches each – Sacrum-Base Posterior

Adjust according to your findings. Remember to cross the involved (low) leg over the high leg. Thrust the apex towards the involved (low) leg with the inferior hand and thrust on the PSIS (high leg) medial to lateral. The doctor is standing on the side of apex deviation facing the patient’s feet. Perform a post leg check after adjustment. **This is a thrust in the horizontal plane, not PA.**

If you determine that there is a Sacrum-Base Posterior, your thrust will be SI – PA. The superior hand will be placed on the sacrum with the fingers pointing towards the feet of the patient. Stabilization will be hand over hand. You will be using the pelvic and lumbar pieces. If your table has the capability, have the pelvic piece drop down and back or caudally.

Coccyx/Sacral Tuberos Ligament

You will need to examine the coccyx or the sacro-tuberos ligament on occasion in the pelvic area. After adjusting the sacrum, the legs may remain sluggish or appear to be

heavy when raising them on the Sacral Leg Check. Palpate along the right and left side of the coccyx along the course of the sacro-tuberous ligament. This is a very sensitive area so palpate lightly. *Remember to inform your patient what you are going to do prior to the procedure. The tender side will be the side you adjust. In some instances, you may have to adjust both sides. Place the thumb of your superior hand along the inferior portion of the ligament (the tender one) using an IS tissue pull. Raising the pelvic piece 2-3 inches will allow you to get a better line of correction. Place the pisiform of your inferior hand over the thumb and thrust IS 3-4 times.

Sacrum – Posterior Laterally

There will be times when the Sacrum rotates posterior laterally on one side. This can be found on the AP lumbopelvic x-ray and upon palpation. You address this only after adjusting the Sacral Apex. The doctor stands on the side opposite the posteriority. Use the side (knife edge) of the superior hand contacting on the sacrum medial to the PSIS. Stabilization will be hand over hand or over the wrist, whichever is more comfortable for you. Thrust in a PA and MEDIAL-TO-LATERAL direction, or along the angle of the joint space of the sacrum and ilium. Thrust 3-4 times unless you can feel a release.

Psoas

When you have a patient with an acute low back condition or a chronic low back that does not improve, check the Psoas muscles. This is done after adjusting the spine. Place the patient on the table supine and perform a muscle test bilaterally, comparing strength. Stabilize over the crest of the left ilium and have the patient raise the right leg and turn the toes out. As you push down and out, have the patient push against you. Test the left psoas muscle next. You may have to adjust both muscles. ***Before you adjust the psoas muscle, make sure the sacrum is on a flat surface. An SOT board is recommended when performing this adjustment.** Stand straight away on the involved side contacting the belly of the psoas muscle with the side of the superior hand. Stabilize hand over hand or over the wrist and thrust AP 3-4 times. Perform a post check on the muscles to note improvement.

Contraindications/Special Considerations:

1. Abdominal surgeries when screws, pins, staples, etc are left in.
2. Aortic Aneurysm
3. 2nd –3rd Trimester Pregnancy

Lumbar Adjusting

Now that you have cleared out the pelvis, the next step is to evaluate and adjust the lumbar region. Utilize palpation and your lumbopelvic x-rays. If you don't x-ray your patients, you are doing a disservice to them. There are too many congenital anomalies out there that you cannot discover with palpation. The most common anomalies are the spina bifida, spondylolisthesis, and either sacralization/lumbarization.

Many of the adjusting procedures taught in the colleges can be adapted for use on the segmental drop table. You can use a single-hand contact (on the mamillary process/body rotation), double thumb (on side of body rotation), or a cross-over with the pisaforms of both hands.

Lumbar Facet Syndrome

The Lumbar Facet Syndrome adjustment is a procedure that you should utilize in your patient management. Not only do you get a traction on the facets in the lumbar, but you also affect the muscles in this region. The primary muscles affected with this procedure are the psoas, multifidus, erector spinae, etc. This can affect the entire muscle complex of the back. The doctor stands straight away (either side) placing the superior hand on the sacrum as you would when adjusting the base posterior. The inferior hand is placed over the lowest vertebra you can contact. Cup the inferior hand so you aren't directly contacting the spinous. Your thrust will be SI-PA (hand on sacrum) and IS-PA (hand over vertebrae). You will thrust 3-4 times. With each thrust, move the inferior hand (hand over vertebrae) up 1-2 levels. **Caution should be used when performing this procedure on a patient that has had a spinal fusion of any kind. Do not adjust the fused segments if they are located in the lumbar region.**

Spondylolisthesis

The Spondylolisthesis is also easily managed on the segmental drop table. The patient is supine with the sacrum on the flat of the pelvic piece. The use of an SOT board is recommended. Remove any belts or thick clothing that the patient may be wearing, and bend the patient's knees to relax the abdominal muscles. Depending upon the level of the spondylolisthesis, place the thenars on the umbilical area about 1-2 inches apart about the level of the crest of the ilium. The thrust will be AP 3-4 times. Have the patient empty the bladder prior to this adjustment to avoid any discomfort or embarrassment.

Special Considerations/Contraindications:

1. Grades 3 and 4 spondylolisthesis.
2. Abdominal Aneurysm.
3. Abdominal surgeries where there are any staples, wires, or wire mesh left inside the patient.
4. Special considerations should be taken when adjusting pregnant or obese patients.

Thoracic/Dorsal Region

The next area of the spine to address is the thoracic area. This is another area where various procedures can be adapted to the segmental drop table. You can use the double thenar, the double knife-edge, and the double pisaform (cross-over). Remember to thrust according to the angle of the facets.

We also utilize or perform the Specific Dorsal adjustment. Stand on the side of body rotation and place the thumb of your superior hand on the transverse process. Place the pisaform of the inferior hand over the thumb and thrust 3-4 times unless you feel a release. This is used most often on children or smaller adults, when you want to be more specific.

Contraindications/Special Considerations:

1. Compression fractures (old or new).
2. Surgeries in the thoracic spine.

Lateral Facet Syndrome

There will be occasions (rare) where you see a condition in the thoracics we refer to as a Lateral Facet Syndrome. You find the pain presents on one side of the involved level, but not over the rib head. The patient has not responded well to adjusting in the area. There is no posteriority or rotation of the segment and no rib involvement. The doctor stands straight away on the side of pain. Reach across (over) the spine to the opposite side of the spinous process of the involved vertebra and tissue pull into the spinous (lateral to medial). Superior hand contact is with the pisaform against the lateral portion of the spinous. Your stabilization hand will be the inferior hand interlocking the fingers of the superior hand clasping the hands together. Drop your arms parallel with the patient's body. Thrust 3-4 times by pulling towards you using the dorsal and lumbar pieces.

Anterior Dorsal

Yet another condition you will find in the thoracic region is the "anterior" dorsal. We all know there is no such thing as an anterior dorsal. What occurs is a loss of the kyphotic curve where the spine flattens out. Sometimes a dishing (Pottinger's Saucer) takes place with 3-4 vertebrae and the spinouses are tender. Typically, this is due to either a cervical and/or lumbar problem. First have the patient sitting up to palpate to the lowest tender spinous. This is where the top of the dorsal blocker will be placed. Cross the patient's arms over the top of the shoulders. The side the doctor is standing should have that arm crossed over on top. Lay the patient back over the dorsal and lumbar pieces with the dorsal blocker in place. Elevate the head piece for patient comfort. Stand over the patient and place your hands over the upper arm of each of the patient's arms. Thrust in a "scooping" motion (IS-AP) 3-4 times. You can also have the patient tuck the chin towards the chest to aid in correction of this subluxation. ***Refer to the contraindications for the thoracic region.**

T1, T2, and T3 Analysis & Adjustment

The upper dorsal area (T1, T2, and T3) is an area that many conditions arise from on many of our patients. This area is a continuation of the cervical curve and is a very integral component of the shoulder girdle. There are many ways to adjust these vertebrae. You can use the MDP, or Thumb contacts when adjusting these vertebrae. X-

rays and static palpation are the most common methods used when determining what to adjust in this area. There is another method that you can use to analyze the motion of these vertebrae. Place three fingertips on top of the spinouses and have the patient turn the head (face) to the right (letting the head rest on the head piece), and then do the same thing to the left. Observe and feel the fluidity of the rotation of these spinouses in both directions. When the patient turns the head to the right, the spinouses should rotate to the left, and when the head is turned to the left, the spinouses should rotate to the right. Adjust according to your findings. The dorsal and cervical pieces are used when adjusting this area, and deflect the head piece 10-15 degrees down. After you adjust, check the motion of the vertebrae. There are times when the spinouses are restricted in both directions, and you have to adjust both sides.

When adjusting the thoracic region, don't forget to evaluate the rib cage. Your patient's will have a wide range of problems in the ribs and you will be able to address these on a segmental drop table. **Never perform any of these rib adjustments on anything other than a segmental drop table which has a pelvic, lumbar, dorsal and cervical drop pieces.** Adjust the ribs after you have adjusted the thoracic spine.

Rotated Rib Adjustment

One of the problems you will find some of your patient's presenting with is the rotated rib. The rib rotates at the head and rotates in such a way that the inferior margin of the rib rotates superiorly. You can actually palpate along the inferior margin of the rib. The pain syndrome follows a course from the rib head along the rib to the sternum. The pain is predominant upon deep breathing, coughing, or sneezing, and twisting/bending. Adjust the spine prior to this adjustment. Place the patient in a seated position and place the superior hand (thenar) over the rib head with a medial to lateral tissue pull. Lay the patient down over the dorsal and lumbar pieces. Next, place the inferior hand (thenar) over the anterior sternal – costal joint with a lateral to medial tissue pull. **Inform the patient what you are going to do prior to performing this procedure, and make a note of it in the patient's records. You may even want the patient to initial the documentation.** Make sure that the superior arm follows the angle of the rib you are adjusting. When contacting the anterior portion of the rib, have the patient (if female) pull the breast out of the way so you have proper hand placement, and to alleviate any accidental contact with the breast. It is also important to have the female patient wear a gown or shirt, but remove the bra. It is impossible to have proper hand placement and correction when the patient is wearing a bra. Thrust 3-4 times with the superior hand pulling towards you and the inferior hand thrusting away from you. Use very light tension on the drop pieces and thrust with patient breathing.

All of us encounter patients with various respiratory conditions. No matter what the condition may be, these patients will be suffering from "Oxygen Deficiency Syndrome". In other words, they are not getting enough oxygen for their body's to function properly. There are two methods of adjusting the rib cage that will greatly enhance your patients' outcome. One of the procedures addresses the posterior rib cage, while the other

addresses the anterior rib cage.

***Caution should be used when adjusting the rib cage of elderly patients or patients who have advanced Osteoporosis.**

Posterior Rib Mobilization

The Posterior Rib Mobilization will affect the musculature of the spine, and rib cage. After adjusting the spine, place your thenars just lateral to the rib heads. Begin at the inferior portion of the rib cage. Your thrust will be lateral to medial and inferior to superior (torque in towards the spine). Each time you thrust, move up a couple of levels. This can be done up to about 3-4 dorsal depending upon doctor and patient size. Perform this procedure 2-3 times up the posterior aspect of the rib cage.

***Other areas to consider when adjusting the rib cage are the clavicles, scapula, and the first rib.**

Scapula

The scapula is the next area to address on the patient. This is generally adjusted prior to adjusting the rib cage. Many of our patients are very active and present with various complaints of shoulder pain, and other patients may have fallen and injured their shoulders. The scapula can be analyzed in many different ways. You can have the patient perform Apley's test to determine the particular scapula problem. There is a method that can be used while the patient is in the prone position on the table. Have the patient bring the arms behind the back and let the hands rest on the lower back and make sure they are relaxed. Next, locate the angles of the scapula and place your thumbs below this. Note the levels of the thumbs. The procedure for adjusting the scapula is to have the patient place the arm of the involved scapula along side the body. The doctor should be standing with the superior hand over the involved scapula. The stabilization hand is placed over the opposite scapula with the arm on the patient's back. Your thrust is IS and Lateral – to – Medial, 3-4 times. The post check is easy. Have the patient place the arms back onto the hand rest, then bring the arms back behind the back. Note the level of the scapula.

***You should consider checking and adjusting the first rib and clavicle when a patient presents with a shoulder complaint.**

First Rib Adjustment

Whenever you have a patient that presents with shoulder problems, radiating pain from the neck along the top of the shoulder, or any respiratory problems, you should check the First Rib. Static palpation at the base of the neck under the trapezius muscle will elicit pain. The doctor should stand straight away on the side to be adjusted. The superior hand will take a tissue pull from AP and SI into the base of the neck at about T1. The contact point will be #8. The stabilization hand is placed on the opposite side of the

patient's head and lightly flexes the head towards you. This reduces the tension of the muscles and aids in correction. The thrust is SI and Lateral – to – Medial with the superior hand. **Note: The first rib is addressed after the spine, ribs, and scapula are corrected.**

Cervicals

The next step in the protocol is to address the cervicals. Even if you didn't find a Cervical Syndrome on the Leg Check, always analyze this area to be adjusted after the rest of the spine. There are many ways to adjust the cervicals: Classical Method, Single Thumb, Double Thumb, and the Christmas Tree (X-mas Tree).

Contraindications/Special Considerations:

1. **Advanced DJD/DDD**
2. **Advanced Osteoporosis**
3. **Arteriosclerosis/Atherosclerosis**
4. **Surgeries: pins, screws, plates, fusions, etc.**

Rotated(Overcompensated) Cervical Syndrome

The Rotated Cervical Syndrome presents a complicated challenge to the average Doctor. Doctor Thompson, however, had a unique approach to this condition. He used a "soft-tissue" approach when addressing this problem. Since the muscles of the neck run primarily vertical, with a few exceptions, Doctor Thompson thrust SI on the side opposite the spinous rotation. The energy applied into the muscles pulled the spinouses back into a more neutral position. The adjusting procedure is similar to that used when adjusting the first rib. The doctor stands straight away on the side of BODY rotation. Contact point #8 is placed at the base of the neck at the first rib, and the stabilization hand (finger pads) on the zygomatic arch. Have the patient turn the head towards the side of spinous rotation and lay the head down on the head - piece (deflected down 10-15 degrees). Thrust SI with slight PA 3-4 times.

Occiput

The last area for analysis and adjustment is one that you will find more frequently in today's world. The Occiput, when subluxated, can create a wide range of health conditions. There are two ways to adjust the occiput. In the beginning of the Leg Check Analysis, one of the possibilities was the Bilateral Cervical Syndrome. Remember that the occiput has rocked backward on the condyles. The most effective way to adjust this is with the patient prone. Deflect the head piece 10-15 degrees and have the patient tuck the chin towards their chest, while relaxing the shoulders. The doctor stands on either side with the thenars on either side of the EOP with the fingers splayed towards the ceiling. Your stance is a Scissors stance and inferior to allow for proper line of

correction. Your thrust is IS with your hands coming up towards the ceiling. Remember to do a Post Check on the legs. The other occipital adjustment is the Supine Occiput. The patient is supine with the head-piece elevated slightly for patient comfort. You have already determined the side to be adjusted by examining the area. Perform the occipital glide analysis and note the side of restriction. In some instances, you may have to adjust both sides. Slide your pisaform IS up into the Mastoid Notch behind the ear on the side to be adjusted. The stabilization hand is under the other side of the head. Turn the patient's head away from the side being adjusted slightly, and thrust SI with slight AP. Only one thrust is used in the occipital area.

Atlas

Now, you may have noticed that I didn't refer to adjusting the atlas throughout the protocol. The easiest method is the Toggle Recoil. Place the patient on their side with the side to be adjusted up. Elevate the head-piece to the proper height and bend the patient's knees for stabilization of the patient and comfort. Set the tension control on the head-piece for the patient's weight. Take your tissue-pull onto the atlas, get your proper stance over the patient, and thrust. Remember that you want the thrust to be quick, and it does not have to be a hard thrust. Let the patient lay there for a few minutes and bring up off the table.

Once you have adjusted the spine, you can now move on to the High Shoulder/Elevated Rib Cage, and the Anterior Rib Mobilization, if necessary.

Elevated Rib Cage/High Shoulder

Many times you will observe patients with one shoulder higher than the other prior to adjusting them. Adjust the spine then re-evaluate to see if the shoulder is still high. The doctor stands on the side of the high shoulder taking a thumb – web contact with the superior hand just below the clavicle over the pectoralis muscles. The other hand (inferior hand) is contacting **on top** of the lower rib cage on the opposite (low) side with a thumb – web contact. Drop the arms parallel to the patient and thrust in a horizontal plane. The superior hand thrusts Superior to Inferior, and the inferior hand thrusts Inferior to Superior. If you have an elevation table, you can raise the table to a comfortable level to adjust. The dorsal and lumbar pieces are used, and thrust 3-4 times. Follow up this with the Anterior Rib Mobilization to re-establish normal biomechanical and neuromuscular function to the rib cage.

Anterior Rib Mobilization

The Anterior Rib Mobilization is performed after adjusting the spine, shoulder, and clavicles. This adjustment will affect primarily the intercostals muscles and the biomechanics of the sternal-costal area. **Explain the procedure to the patient prior to performing this adjustment, and note it in the patient records.** Place both hands on

top of the inferior portion of the rib cage with a thumb – web contact. As the patient exhales, thrust IS with slight AP, and move up a couple of levels, and thrust again. On a female patient, inform her that you will be coming up to a point underneath the breasts. To avoid any difficulties, have the patient place her hands over her breasts and pull the breasts up out of the way. The last step to this procedure is to set the sternum in place. Place the flat of the hand on the sternum and stabilize hand over hand. Thrust IS with slight AP 1-2 times when the patient exhales. The patient's will be able to breath with much less difficulty after this adjustment and feel much better. You will not have to perform this adjustment each time the patient comes in, but you will find that the patient's you do this on will come in to have you adjust the ribs when they sense a problem. There may be times where you find ribs that are subluxated at the sternal-costal area, and you can adjust these too. Using the side of the hand (knife edge) contact the rib(s) along the sternum and thrust IS with slight AP.

Here is a review of the Protocol: Leg Check Analysis (Adjust +D, -D, XD, CS, BCS first), Posterior Ischium, Posterior Tibia, Piriformis, IN/EX Ilium, Sacrum, Lumbars, Psoas, Dorsals/Thoracics, Ribs, Scapula, First Rib, Cervicals, Occiput, TMJ, and Extremities.