SUPERFICIAL AND MID-CERVICAL FASCIA

(Notebook – pg. 12-13)

1. ***Superficial fascia***
    a) LL under chin (how far is the attraction), inhibit to confirm end-point
    b) Mobility test:
        i. "Lizard neck" while you palpate under chin
        ii. Active rotation of head (how many fingers from table?)
        iii. Test extensibility of SCF by gliding it over mandible to confirm restricted side (evaluate 3 spots along each side of mandible)
    c) Once on exact spot of restriction find end point of line of tension (sternum, pectoralis, clavicle)
    d) Treat
2. ***Mid-cervical fascia:***
    a) Locate hyoid bone (a "witness" to superior or inferior restrictions) - locate thyroid cartilage and go superior
    b) ID hyoid muscles & vascular sheath contents

Structure	
Sternohyoid	
Sternothyroid	
Omohyoid	
Vascular Sheath	Carotid Artery
	Vagus Nerve
	Internal Jugular Vein

    c) LL with finger pads and thumb with one hand and inhibit end of attraction to confirm.
    d) Inhibit to find end-point of restriction
    e) Mobility test hyoid bone to confirm listening
    f) Treat between hyoid and end-point of restriction
3. ***Use long lever if needed***
4. ***Treat clavipectoral fascia***
    a) Scoop – Pectoralis major over thumbs to allow access to space.
    b) Locate – Line of tension (manubrium, clavicle, ear)
    c) Spread – Thumbs to stimulate mechanoreceptors…induction.
    d) Follow – the listening…have patient move arm slowly – engages brain.
    e) Lift – tissue anterior to open space.
    f) ****NO PAIN…NO NUMBNESS…NO TINGLING!!!!

VISCERAL SHEATH FASCIA

(Notebook - pg. 28-31)

1. ***Identify structures:***
    a) Hyoid bone
    b) Thyroid membrane
    c) Thyroid cartilage
    d) Cricothyroid ligament
    e) Cricoid cartilage
    f) Thyroid gland
    g) Tracheal rings
2. ***LL to structures:***
    a) Thyroid cartilage
    b) Cricoid cartilage
    c) Thyroid gland
    d) Tracheal rings
3. ***Inhibitory balance to find the most important restriction***
4. ***Motility evaluation:***
    a) Thyroid gland
    b) Tracheal rings
5. ***Mobility testing:***
    a) Thyroid cartilage
    b) Thyroid gland
    c) Tracheal rings
6. ***Treat what you find*** but do not leave lab until you feel the motility of the thyroid and trachea.
7. ***Suggestions for successful treatment:***
    a) Identify (with inhibition) where the structure is being pulled.
    b) Ensure you are on the structures / layers. Get the feedback in your hands - when you move one hand-contact you feel it in the other contact.
    c) Fascial load to start mechanical dialogue with structure.
    d) Drift off slightly to allow space for tissues to respond (creates induction).
    e) If no response stack tissue (individually) into ease.
    f) If no response stack tissue (individually) into tension.
8. ***Recap of lab (sequence of steps:***
    a) Identify structures
    b) LL at thyroid cartilage, thyroid gland, trachea
    c) Inhibit between all three to find most important
    d) LL at most important and find end-point of listening
    e) Mobility evaluation of thyroid cartilage, cricoid cartilage, thyroid gland, trachea with a focus on primary structure that was the primary listening
    f) Treat what you find but don't end lab before feeling motility of thyroid and trachea.

FIRST RIB

(Notebook - pg. 32-34)

1. ***A witness to a problem on the same side of the body!***
2. ***Identify:***
    a) Follow the lateral border of the SCM to locate the Anterior Scalene muscle.
    b) Follow the anterior scalene muscle as it dives inferior to go to the first rib (don't push, sink!)
    c) Palpate the insertion on first rib at scalene tubercle
    d) Palpate following structures:
        I. Medial to scalene tubercle - subclavian vein
        II. Go back to scalene tubercle and then lateral to feel the subclavian artery (pulse)
        III. Go lateral to subclavian artery to feel the brachial plexus (flat)
        IV. Do you get a listening into the vein, artery or nerve?

Location	Feel	Structure
Anterior / medial to scalene tendon	**Collapsible**	Subclavian vein
Posterior / lateral to scalene tendon	**Pulsing, pushes back at you**	Subclavian artery
Posterior / lateral to artery	**Cord-like feel**	Brachial plexus

2. ***Continue medial or lateral to find pleural dome of lung.***
3. ***Compression / decompression test of first rib.***
    a) Thumb against posterior, superior part of 1st rib
    b) Finger pads on anterior part of 1st rib
    c) Passively side bend head toward side you are palpating
    d) Rotate head to find line of tension
    e) Rib should move easily inferio-medially
    f) If restricted - line up tension and do indirect, direct stretch, or recoil
    g) Can do supine, side lying, or seated

STERNOCLAVICULAR / INTERCLAVICULAR LIGAMENTS

(Notebook - pg. 46-53)

1. ***LL at Jugular Notch:***

Direction	Feel	Structure
Superior, superficial	**Spongy, soft-feel**	Thyroid
Slightly posterior	**Round, tube-feel**	Trachea
Superior	**Flat, planar-feel**	Cervical fascia

   a) Inhibit to confirm

2. ***LL at Manubrium:***

Direction	Feel	Structure
Posterior and deep	**Elastic, round tube-feel**	Esophagus
Superior, superficial	**Spongy, soft-feel**	Thyroid
Lateral, short distance	**Hard end-feel**	Sternoclavicular joint
Inferior	**Hard end-feel**	Sternum

3. ***Test SC ligaments in seated:***
   a) Shoulder moves anterior / medial for posterior ligament
   b) Shoulder moves posterior / lateral for anterior ligament.
4. ***Test Interclavicular ligament*** – Shoulder moves posterior, lateral and inferior (slightly)
5. ***Treat restricted ligaments***
6. ***Finish with bilateral treatment of interclavicular ligament***

Thyroid

1. LL at thyroid gland
   a. Does it take you to one lobe vs. the other?
   b. Are you drawn into the parenchyma of the gland?
2. Do a compression / decompression test of the gland.
   a. Decompression +:
      i. If the LL took you to one lobe vs. the other:
         1. Find the isthmus below the cricoid cartilage and with palpation locate the edge of lobe.
         2. Tune into the motility of that lobe and work with the motility.
      ii. If the LL took you to the whole gland:

1. Using the isthmus as your starting point, with palpation find the edge of both lobes.
2. Place your contact over the whole gland.
3. Tune into the motility and balance.

b. Compression +:
   i. If the LL took you to one lobe:
      1. Locate that lobe the same as above and do an induction of this lobe.
   ii. If the LL took you to the whole gland:
      1. Locate the edge of both lobes as above and do induction of whole gland.

Thyroid

(Notebook - pg. ?)

1. LL at thyroid:
   a. Does it take you to one lobe or the other?
   b. Are you drawn into the organ itself?
2. Compression / Decompression Test:
   a. Decompression +?
      1) Find isthmus and edge of lobe
      2) With fingers on isthmus and lateral edge of lobe tune into motility
   b. Compression +?
      1) Find isthmus and edge of lobe
      2) Follow induction of this lobe

CORACOID PROCESS

(Notebook - pg. 55-59)

1. ***Listening at manubrium*** will attract your hand lateral along clavicle. If no listening imagine what it would feel like if you got a listening into lateral clavicle.
2. ***Listen at lateral 1/3 of clavicle***

Direction of Listening	Feel	Structure
Slightly superior	**Flat, planar-feel**	Cervical fascia
Into bone of clavicle	**Hard feel**	Clavicle
Inferior, short distance	**Hard feel**	Coracoid process

3. ***Listen at CP*** (if CP inhibits clavicle listening) and use inhibition to find what corrects the listening.

Direction	Ligament
Superior / medial	Conoid
Superior	Trapazoid
Superior / lateral	Coracoacromial
Lateral, slightly inferior	Coracohumeral

4. ***Mobility test ligaments*** – Conoid, trapazoid, coracoacromial coracohumeral
5. ***Treat restricted ligament*** – induction, stack into ease or tension, or recoil
6. ***General clavicle release*** – anterior / medial lift of clavicle with active external / internal rotation of shoulder.
7. ***Neurovascular bundle technique***
    a. Sit at head of supine patient
    b. Have the patient's hands resting comfortably on their abdomen
    c. Place thumb pad along superior lateral aspect of clavicle (far lateral as you can position your thumb)
    d. Evaluate external rotation of both arms to evaluate side of restriction
    e. Roll your thumb posterior to the clavicle
    f. Engage clavical in a anterior inferior and medial direction
    g. Have the person move their arm into external rotation as you maintain your position with the clavical
    h. At the point you feel tension in your thumb contact along the clavical have the person stop there external rotation
    i. Hold this for a few seconds and follow the listening
    j. Have the person take their arms slowly into internal rotation and take up the slack as the clavical allows
    k. Repeat 3 to 4 times
    a. Reevaluate external rotation of the arms
8. ***Osseous release of clavicle (Treat the listening side).***
    a. Torsions occur in the clavicle with trauma.
    b. Surround medial side of clavicle with thumb and finger pads.
    c. With other hand walk to the later section of the lateral 1/3. Use index and thumb.
    d. Be sure you are on the layer of the bone and not on the soft tissues.
    e. Take up the slack of the tissues until you get to the periostium and then go one more layer until you feel the cancellous (compact) bone tissue.
    f. Stay at the bone level and then engage both hands toward one another and then let the bone cells speak to each other. They

will give you more information about the residual effects of the trauma.

g. Do not stop until the bone tells you it can no longer go any more into compression or you will not be treating it fully. Keep going until you feel the whole bone collected. This will help with the huge compression that occurred during the trauma.
h. This is an excellent, excellent technique!!

INFERIOR CLAVICLE

(Notebook - pg. 53 & 60-61)

1. ***Listening at medial 1/3 of clavicle:***

Direction	Ligament / Structure
Inferior / medial, short distance	Costoclavicular
Inferior, short distance	Subclavius

2. ***Treat costoclavicular ligament supine***
   a) Where sternum ends and cartilage begins place your thumb or pisiform aspect of hand on this spot on the rib and thumb under the medial end of clavicle.
   b) Alternate hand placement:
      i. Anchor on superior surface of medial aspect of first rib by "hooking" with index finger pad of one hand and placing the middle finger of the same hand on top of index finger for support.
      ii. With thumb of other hand scoop under inferior surface of medial clavicle and fascial load clavicle superior and slightly lateral.
   c) If you can't access this space you can do this in side lying/
3. ***Treat subclavius:***
   a) Sidelying (treatment side up)
   b) Mobilize the subclavius and see how much motion you get.
   c) Bring shoulder forward to allow you in.
   d) Move along the clavicle toward distal end. When you meet the coracoid process it is as far as you can go.
   e) Evaluate 3-4 areas to find most restricted fibers.

STERNUM

(Notebook - pg. 64-69)

1. ***LL to sternum***
2. ***Think globally of the possibilities.*** Think of the percentage of the depth you are attracted to.

%	Feel	Structure
5	Hard-feel	Sternum
5-10	Elastic-feel	Endothoracic fascia, transversus thoracis
20-90	Pressure, spongy	Lung
20-90	Spreading	Pleura
80	Buzzing	Sympathetic trunk
90	Hard-feel	Spine

3. ***If LL is attracted to sternum*** do compression/decompression
4. ***If sternum is compression +*** do longitudinal compression / decompression
    a) Similar to osseous technique on the clavicle.
    b) We are giving the bone an opportunity to tell us why it is not able to move or compensate.
    c) Superior palm superior to sternomanubrial joint.
    d) Inferior palm over xiphoid.
    e) Position yourself directly over them to avoid bias.
    f) Migrate through the top soft tissues until you feel you are on the bone structure and bring hands toward one another. Visualize how the bones move as you bring the bone together. You can interlock fingers if your hands are too big.
    g) Gather superiorly and inferiorly until your hands meet. If the inferior hand meets the tissue tension first then wait until the superior hand migrates to it and vise versa. Once you have the tissue at the end-point then FL together and then give a little space for it to respond and then listen and follow. It might come closer together for a bit while it is sorting out the tensions but you stay with it until you get a sense of it wanting to expand and go into decompression.
5. ***Sternal lift***
    a) With finger pads hook gently inferior to and around xiphoid and superior to jugular notch.
    b) Do not push but sink under the bone with intention.
    c) Engage with anterior intention.

d) Allow the sternum to lift anterior as it needs to. Stay with the intention and allow the sternum to sort out the patterns underneath until you feel a sense of the bone lifting away.
e) If it does not lift from the lower 1/3 consider restrictions in the transversus throacis muscle fibers.

6. ***Transversus thoracis technique***
   a) Compare ribs 3, 4, 5, 6, always feeling for the extensibility and elasticity.
   b) Find the muscle fibers that have the most tension, the most important

RIB CAGE

(Notebook - pg. 71-78)

1. ***LL at sternum*** attracts you to sternochondral joint (SC) on one side…Inhibit to confirm
2. ***Evaluate affected side***:
   a) Anterior / posterior ligaments of SC joints from ribs 1-7
   b) Glide across restricted SC joint to feel for possible subluxation
3. ***Treat SC joint that is most restricted (seated or supine):***
   a) Index finger of testing hand superior to lateral clavicle
   b) Second finger of testing hand inferior to lateral clavicle
4. ***When treating subluxation treat in supine:***
   a) Gap that which is posterior
   b) Fascial load that which is anterior in posterior direction
5. ***If Listening is attracted to posterior aspect of rib:***
   a) Have person prone
   b) Listen at spinous process (SP):

Direction of Listening	Feel	Structure
Rolls anterior short distance	Hard end-feel	Costotransverse
Rolls anterior slightly longer distance	Hard end-feel	Costovertebral

6. Treat with gaping and induction:
   a) With one hand anchor at TP
   b) With other hand at posterior rib angle gap, fascial load, listen & follow
   c) Costotransverse – gap lateral
   d) Costovertebral – load anterior then gap lateral

MUSCLES OF RESPIRATION

(Notebook - pg. 79-83)

1. ***LL at sternum***, which attracts you lateral along rib/s.
    a) Inhibit to find rib/s that bring listening back to neutral.
    b) Inhibit between affected ribs to find most primary.

2. ***LL at primary rib to find listening:***

%	Feel	Structure
5-10	Hard-feel	Bone
15	Spreads hand	Pleura
20-90	Pressure, spongy	Lung

Direction of Listening	Feel	Structure
Inferior, very short distance	Buzzing, energetic	Intercostal nerve
Inferior, short distance	Elastic-feel	Intercostal muscle
Superior, short distance	Elastic-feel	Intercostal muscle

Intercostal Nerves	Tissue innervated
1-6	Breast tissue
7-10	Abdomen

3. ***Evaluate intercostals:***
    a) External – "hands in front pockets"
        i. Anchor rib above, traction rib below (medial / inferior)
    b) Internal – "hands in back pockets"
        i. Anchor rib below, traction rib above (medial / superior)
4. ***Treat intercostals:***
    a) Traction on ***E***xhale for ***E***xternal, ***I***nhale for ***I***nternal
    b) Global release for group of ribs
    c) Lower ribs – use side lying or ilium
    d) Posterior ribs – prone
5. ***Treat levator costorum:***
    a) Load on exhale
6. ***Global Diaphragm Release:***
    a) One hand on anterior projection – costal margin
    b) One hand on posterior projection – T12 to L1-L2
    c) Load hands toward one another until you feel the connection.
    d) Follow induction until you feel a softening.

PLEURA

(Notebook - pg. 91-114)

1. ***General Pleura Technique:***
    a) Supine
    b) Find easiest access to pleural dome
        i. Put head on slack
        ii. Feel both sides for the experience but you would work on the side of their GL attraction.
    c) Listen to both sides… which side has the strongest listening?
    d) Listen until the line of attraction stops. Be open to if it is anterior, posterior, or lateral.
    e) Inhibit to confirm end-point of listening.
    f) For treatment sink to level of pleura at both ends. Get feedback between your hands.
    g) Fascial load, listen and follow.
2. ***Mediastinal Pleural Technique:***

Hand Placement for Mediastinal Pleura		
Right Side	Lateral Edge of Sternum	***Left Side***
3rd / 4th IC space		5th / 6th IC space
4th / 5th IC space		

    a) With ulnar edge of your hand sink to level of pleura at lateral edge of sternum
    b) With finger pads of other hand sink to level of pleura in IC space.
    c) Get feedback between your hands.
    d) Fascial load, listen and follow.
    e) For direct stretch take up slack at IC-space contact.
    f) On exhale fascial load posterior / inferior / lateral.
3. ***You can also connect the mediastinal recess with the diaphragmatic recess.*** Do this in seated if this was their functional issue.

4. ***Diaphragmatic Pleura Technqiue (pg. 111):***
    a) One hand at mastoid process, dome of lung, or mediastinal recess
    b) Other hand is at/or below the 7th rib
    c) Sink to level of pleura
    d) Line up pleural tensions
    e) Line up body with head turned to contralateral side and knees up and used to enhance line of tension.

f) Induce, stretch at the end of exhalation or recoil at appropriate place in respiration

PLEURA LIGAMENTS

(Notebook - pg. 97-104)

1. ***Identify / evaluate / treat the 3 ligaments of pleural dome:***
   a) Person is seated in front of you
   b) Web of hand on dome – globally
   c) Other hand on opposite side of head
   d) Side bend toward side you are evaluating to access dome
   e) Evaluation of ligaments:

Pleural Dome Ligament	Evaluation / Treatment Direction
Transverse pleural	Side bend away
Costopleural	Side bend away, rotate towards
Pleurovertebral	Side bend away, rotate away

2. ***Treat most restricted ligament on side of listening***
3. ***Lateral decubitus technique for pleural dome – pg. 103***
   a) Person is sidelying treatment side up
   b) Lean onto patient's thorax and role shoulder over your soft finger pads.
   c) Locate maximum line of tension
   d) Fascial load, drift and follow the listening

LUNG / Fissures

(Notebook - pg. 113-117)

1. ***LL down midline:***

Tissue / Structure	% Depth	Feeling
Parietal pleura	10-20	Sliding and gliding
Lung	20-80	Perception is beyond pleura and is something more soft, light and spongy
Fissure	20-50	Feels like you are being drawn into an abyss?
Mediastinum	20-80	Attracted more medial
Bronchi	50-60	Tube, direction (oblique), firm

2. ***If no listening evaluate motility***
3. ***If nothing shows up define the lobes and fissures*** and perform a mobility test of the lobes and fissures

Landmarks		
Right Lung		**Left Lung**
Oblique Fissure		
Posterior	~ T3/T4 (not always symmetrical)	
Lateral	~ 4th / 5th rib	
Anterior	Ends at ~ 6 costochondral joint	
Horizontal Fissure		
Lateral	Start at oblique fissure at ~ mid-axillary line	
Anterior	~ 3rd / 4th intercostal space	

a) ***<u>To find fissures</u>*** start at 6th costochondral joint and proceed one step-at-a-time.
b) <u>Find with palpation</u>
c) ***<u>Find location between lobes</u>*** that have decreased mobility.

4. <u>Treatment:</u>
a) Compression / decompression
b) Fascial load one lobe while anchoring on other
c) Use induction, direct stretch, recoil.
d) Line up tensions in neck, legs or arms if indicated.
e) Consider supine, side lying, or prone.
f) End with motility induction for balance on each side.

HEART / PERICARDIUM

(Notebook - pg. 127-139)

1. Place finger pads of listening hand at 2nd / 3rd IC space with palm biased to left of sternum.
2. Listen to Pericardium – 15-20% depth

Direction of Listening	% of Depth	Ligament
Superior, short distance	15-20	Superior sternopericardial
Inferior, short distance	15-20	Inferior sternopericardial
Posterior to heart and then superior, long distance	40-50	Vertebropericardial
Inferior to diaphragm and then slightly deeper	40	Phrenopericardial

3. ***<u>If no listening still do technique</u>*** – VERY POWERFUL!
4. <u>Validate listening with sternum compression/decompression</u>
5. ***<u>Treat sternopericardial ligament</u>*** – fascial load to depth, listen follow, encourage.
6. <u>Treat vertebropericardial ligament:</u>

a) Posterior palm at C5/C6 with two middle fingers straddle spinous processes down to T4 (like the Spock "Live long and prosper" mudra)
b) Anterior hand over superior or inferior sternopericardial ligament
c) Migrate until you get feedback between hands.
d) When at tissue level fascial load, listen, follow, encourage

7. ***Treat phrenopericardial ligament in seated***
   a) Outline lower border of rib cage
   b) Contact costochondral junction - be on each side of xiphoid and find the area of comfort for them.
   c) Take them into flexion. Migrate under the ribs. As you sink in your finger pads migrate and are pointing superior.
   d) Don't push fingers into them just let the body give you slack.
   e) When your finger pads are sliding along the posterior surface of the anterior ribs then slide medial to the point where you feel the beat of the heart. You will feel a thickening up against the ribs.
   f) With finger pads scoop forward (anterior and inferior) and feel for where they don't want to glide.
   g) Go to the side that gives you a listening. Do whatever you need to gain the access - side-bending, rotation, etc..
   h) Treat by taking the tissue anterior and inferior (fascial load and let go) to get it to go into a listening (induction)
   i) Re-evaluate and if still giving you a listening do a more direct technique.
   j) Re-evaluate.

HEART / ASSOCIATED ORGAN & MOTILITY

(Not in notebook)

1. ***Listen at level of heart -*** Is there an attraction (extended listening)?
2. ***Where does it go*** - liver, lung, stomach, spleen, or lower?
3. ***Wait for listening line to stop*** then inhibit.
4. ***Treatment:***
   a) With one hand on heart and one over associated organ sink to tissue levels.
   b) Give slight fascial load, drift slightly, listen and follow.

Heart Motility	
Inspir	***Expir***
Anterior	Posterior
Left rotation (almost like a "twisting)	Small right rotation
Inferior (slight)	Superior (slight)

MEDIASTINUM – Trachea / Bronchi

(Notebook pg. 144-153)

1. ***Listen at trachea*** – if attracted short distance inferior inhibit at sternomanubrial joint to confirm possible bronchi listening
2. ***Listen at sternomanubrial joint*** - inhibit at level of bronchus at bifurcation or at right or left bronchi to confirm

Trachea / Bronchi Listening			
Listening Location	***% Depth***	***Direction of Listening***	***Structure***
Trachea (above manubrium)	~ 5%	Inferior	Trachea
Sternomanubrial Joint (*Angle of Louis*)	~ 50%	Posterior	Bifurcation of Bronchi
		Inferior & ~ 20-30° to right	Right Bronchi
		Inferior & ~ 40-50° to left	Left Bronchi

3. ***Set up for "Test of Tension" and treatment:***
   a) Finger pads and thumb of one hand around trachea (above manubrium)
   b) Palm of other hand at sternomanubrial joint – sink to level of bifurcation of bronchi and get the feedback between hands that you are on the bronchi. Use the trachea as your anchor and when you think you are on the bronchus fascial load the bronchus inferior to get the feedback at your anchor.
   c) Take your anchoring hand off of the trachea without losing your connection with the bronchus with your other hand.
   d) Place the ulnar edge of your free hand along where you think the right or left bronchus is and sink to the level, all the while evaluating the feedback in your contact the bifurcation.
   e) "Test of Tension" and treatment:
      i. Anchoring hand (pisiform) on Angle of Louis (bifurcation)
      ii. Fascial load hand (ulnar edge) or finger pads along bronchus orientation.
      iii. Fascial load, listen & follow (indirect, direct or recoil)
   f) "Test of Tension" and treatment:
      i. Anchoring hand (pisiform) on Angle of Louis (bifurcation)
      ii. Fascial load hand (ulnar edge) or finger pads along bronchus
   g) Viscoelasticity of Right Bronchus:
      i. Place the palm of your most sensitive hand hand over the right superior thorax (feel with this hand)
      ii. Place other hand over the top of this hand (load with this hand)

iii. Evaluate the consistency of the lung tissue and compare this to palpating slightly inferior and midline at the location of the bifurcation and extension of the right bronchus, which should feel more dense once over the location of the right bronchus sink slowly through the hard frame until you reach the level of the right bronchus at about 50% depth
iv. Engage the right bronchus and feel for where the tension is, which is reflected in the listening pattern (anterior to the bronchus, right side of the bronchus, left side of the bronchus)
v. When feeling a listening to the right side of the bronchus you are close to the azygos vein
vi. Load into the tissue of the right bronchus and follow the listening
vii. At the end of the listening overtake the listening slightly in order to optimize the activation of the mechanicoreceptors
viii. Decrease your load on the right bronchus and as it opens up follow it into expansion with a suction like attraction away from the right bronchus
ix. Repeat 3 to 4 times until you feel a softening in the tissues

MEDIASTINUM – Esophagus

(Notebook pg. 154-155)

1. ***Listen at stomach***
2. ***Listen at cricoid***

Listening Location	*Direction of Listening*	*Inhibition Point*
Stomach	Superior, long distance	Esophagus (around cricoid)
Cricoid	Inferior, long distance	Stomach

3. ***Treat in seated:***
   a) Migrate from stomach to esophagus (as superior as you can).
   b) Keep person in flexion.
   c) Find superior end of esophagus around cricoid.
   d) Get feedback between hands.
   e) Fascial load toward each other or away to create induction.
4. ***End with General Release:***
   a) Posterior hand – T2-T7 (vertical orientation of hand)
   b) Anterior hand – sternum (vertical orientation of hand)
   c) Fascial load to get feedback between hands.

d) Fascial load, listen and follow

PLEXI

(Notebook pg. 159-169)

1. ***General information:***

a) With allot of issues in one area of the body working with the plexi can do to help balance the tissues.
b) Chronic hiccups, chronic cough, post cardiac and/or lung surgery can all be something that would respond to working on the phrenic nerve.
c) With an emotional response consider working bilaterally with the phrenic nerve.
d) When you work with the plexi it helps people to "live better with their issues and fears".

2. ***Phrenic nerve:***

i. Locating:

i. Find the space in-between the bellies of the sternal and calvicular divisions of the SCM. Feel for a groove, a slight dip.

ii. Use light pressure so the sensation of the nerve will come into your hands.

iii. Do you feel a smooth gliding motion or erratic and ratchety-like motion? It might also be that it feels ratchety in one part of the motion.

j. Evaluation / treatment:

i. Feel for the motion. It feels like a string in a sheath. This is the nerve in its fascial sheath.

ii. Off of the right 10th rib walk toward midline to feel the branches of the right and left phrenic nerves as they come together.

iii. Stay connected to the upper part of the right phrenic nerve at the SCM and you will feel the motion in the lower part at Demussy's point.

iv. Feel for smoothness in the motility of the nerve. Feel for where it might stop. Feel for what direction it moves with greater ease.

v. Work with induction.

vi. Give yourself permission to hang out a bit and encourage the inferior direction. Very soft intention. Notice how their breathing changes.

vii. Work slowly and notice how things change.

viii. Work with re-educating the nerve motion by following the balanced motion or until you feel no motion.

ix. You can also work on the left side SCM space and connect it to Demussy's point.

II. Celiac:

a. Locating:

i. At xiphoid walk finger pads to 7th costal cartilage on right and with the pisiform aspect of your hand feel the motion of the celiac plexus.

b. Evaluation / treatment:

i. With very light hand contact allow the motion that feels more like a pattern to come up into your hands.

ii. The nerves come together and form a bundle and their natural, functional motion is a smooth rotational, back-and-forth motion.

iii. Work with induction until the motion is smooth and even or until you feel no motion.

III. Cardiac plexus:

a. Locating:

i. Between left 2nd / 3rd IC space just lateral to sternum.

b. Evaluation / treatment:

i. Use hypothermal eminence and tune into the motion.

ii. Is the motion erratic? If so feel for the direction of ease and treat with induction.

iii. This is a whole different feeling in your hands from other tissues. It is a deeper, balanced feeling.

iv. As the tissues of the plexi soften feel for the change. Visualize the motion and stay with it until you get the sense of a lightening and the sense that your hands want to drift away or until you feel no motion.

IV. Balancing Plexi:

a. Evaluate and treat the phrenic nerve (right or left) between the two heads of the SCM and Demussy's point that is most "restricted"

b. Evaluate / treat cardiac plexus and/ or celiac plexus

c. Balance cardiac plexus to celiac plexus.

d. Balance left frontal area to cardiac plexus.

e. Balance left frontal area to celiac plexus.