Steps for VM2 Techniques

These steps are as they appear in Dr. Mariotti's slides for the VM2 class. These notes are meant to support your own personal study within the context of the BI VM2 class and not to be distributed.

Evaluation / Treatment Protocol (General)

1. GL/IBT standing and / or seated
2. LL/IBT in the area of GL attraction in order to identify contributions to the GL pattern. Use IBT to localize most important organ / tissue
3. LL/IBT at the organ itself to gather precise information. Are you drawn into the organ? What layer; peritoneum, parenchyma, vasculature? Does the organ draw you to an associated organ/structure?
4. Motility evaluation
5. Choose body position (sitting, sidelying, supine)
6. Choose what ever lines up tension best
7. Make certain contacts are secure and precise
8. Choose: induction, direct, or begin with induction and add direct technique, long lever as needed (interchange)
9. Motility treatment if needed
10. Re-evaluate: GL, LL, motility evaluation

Sigmoid Steps

Sigmoid / Portal Vein Technique (pg. 69):

1. Place right hand over sigmoid.
2. Place left hand over liver.
3. Sink to level of each organ individually - visualize what you are feeling.
4. Establish communication between your hands.
5. Fascial load each hand... then drift slightly to allow space for tissue response.
6. Options - stack each hand individually into ease or tension

Liver Steps

Right and Left Triangular Ligament (pg. 20):

1. Right:
    a. Subcostal and quite lateral
    b. Flex forward... slight right side-bend.
    c. Fascial load posterior, superior and lateral...
    d. Mobility induction (use direct technique if needed)
2. Left:
    a. Start medial to mid-clavicular line...
    b. Subcostal... flex forward
    c. Fascial load posterior, superior and lateral...
    d. Mobility induction (use direct technique if needed)

Recoil of Right Triangular Ligament (pg. 20):

1. L hand: Ulnar surface on top of Ribs 9 & 10 - anchors liver medial / inferior.
2. R hand: Pisiform above liver on R triangular lig. (bottom of 8th Rib - inserts into diaphragm) sink towards table through ribs to ligament
3. Mobility test with R Hand: 11:00, 12:00, 1:00 positions.
4. Recoil suddenly on in-breath - supinate at wrists.
5. Re- Evaluate...

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Other Options (pg. 20):

- Stack + Recoil:
    - "Energizes" the area.
    - Use to provide access (~15 minute window).
    - Perform after mobility tech. then do motility to balance.
- Stack + Oscillation/Stretch:
    - Affects nerve endings - + result for nervous system.
    - Pumps fluids into the area.
    - Keep it rhythmic, stay within elastic range (don't come off - too disruptive).

Liver / Diaphragm / Pleura (pg. 22):

1. R hand: Contact liver through ribs and anchor medial, inferior, and slightly anterior.
2. L hand: Lift person's right arm until you feel beginning of communication in "liver hand".
3. Stack arm into ease or tension... to induce "listening"
4. Listen and Follow... tissue pattern until release is perceived.
5. Re- Evaluate...

Anterior Coronary Ligament (pg. 18):

1. Landmarks same as liver lift
2. Significant flexion...
3. Direct finger pads as far posterior as possible (posterior aspect of liver)
4. Fascial load superior - roll liver anterior (engages anterior coronary ligament).
5. Use torso as long lever... listen and follow

Posterior Coronary Ligament (pg. 19):

1. Landmarks same as liver lift
2. Start off with neutral position...
3. SLIGHT extension (not too much as this will push you out of tissues).
4. Fascial load liver superior (liver rolls posterior).
5. Use torso as long lever... listen and follow

Global release of liver in sitting position (pg. 21):

1. Gravity brings in functional forces.
2. Functional positions: eg., people who say "I'm tired at my desk after lunch" - liver working hard! OR, arm pain while sitting.
3. Hands clasped posterior of mid-axillary line....
4. Stack into 3 dimensions of ease...

Viscoelasticity of liver (pg. 21):

1. Stand to the right of the supine patient
2. Place right or left hand in contact with lateral ribs and rest your elbow against your hip as a support
3. Start contact with your hand more posteriorly and load anterior to take up slack in tissues
4. Place other hand over anterior ribs a few cm right of midline on right to be over the hepatoduodenal ligament and contents at about the 6th rib
5. Load into lateral ribs to engage to level of liver parenchyma by loading with your hip in order to avoid forcing the tissues
6. Load into anterior ribs to engage to level of liver parenchyma
7. Load with each hand alternately until you feel you have reached a level inside the liver with both hands
8. **Treat:**
    - Once at this level engage with both hands even further into this location in order to stimulate an induction
    - When you have reached the end of the listening overtake the listening in order to stimulate the mechanoreceptors
    - As you allow the tissues to expand you are encouraging a sort of "suction" of the tissues to encourage the opening and expansion in the liver
    - Slowly lighten the load with both hands until you feel that you may loose contact inside the liver

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- Repeat loading and drifting numerous times until you feel the quality of the liver parenchyma has softened between your hands

Gallbladder Steps

Gallbladder listening (pg. 38):

1. Listen at fundus: Use pisiform, thenar, or hypothenar eminence.
2. When listening comes to a stop, "extend" your listening.
3. Example: If listening extends as a "fine line" to C-spine - mobility test (C3, C4, C5, C6, C7) anterior glide, rotation, lateral glide.
4. Can be fixed as a response to feedback along phrenic nerve from visceral peritoneum surrounding gallbladder.

Fundus / Cystic Duct (pg. 41):

1. Seated...
2. Right hand - contact gallbladder just below tip of 9th rib Primary load inferior / lateral to initiate listening.
3. Left hand - cystic duct (2 cm inferior and to right of xiphoid. Primary load superior/ left to initiate listening.
4. If needed line up torso in 3 dimensions (sidebend, rotate, flex/ext)
5. If needed line up neck (phrenic nerve component) - "sidebend, rotate left & right".
6. Result: Increased inferior glide at cystic duct.
7. Re- Evaluate with gallbladder drain (should be softer)

Fundus / CBD (pg. 41):

1. Seated...
2. Right hand finger pads on fundus of gallbladder
3. Left hand finger pads along CBD....fascial load together to "feel the connection" and create induction
4. Drift slightly to give room for response.
5. If needed bring in torso or bring in neck

Stomach Steps

Optional Techniques (pg. 34-35):

1. Line up stomach with pylorus... listen and follow
2. Bring in long levers:
    a. Legs straight - more superficial restriction (peritoneum, omentum, transverse colon)
    b. Legs bent - deeper eg: posterior stomach & left kidney.

Engage Lesser Omentum with Lower Extremities Techniques (pg. 34):

1. Stand on left- finger pads on lesser curve.
2. Put their legs on your knee to line up tension
3. First, find AGR in lesser curve - then bring in lower extremities to enhance line of tension.

Stomach / Global (sitting) Techniques (pg. 35):

1. Stand on person's right side: Stomach is anterior to mid-axillary line. Contact through ribs.
2. Stack stomach in 3-Dimensions of ease.
3. Stack torso in 3-Dimensions of ease based on stomach stacking.

Duodenum Steps

Posterior / lateral restrictions (pg. 47):

1. Knees flexed...
2. Hands on lateral aspect of D2: Between Iliac crest and 12th rib (do not go inferior to navel)
3. Sink to viscosity: Pass over tube of AC into trough. Mobilize D2 Medial & Anterior. Scoop OFF back body wall! Follow the listening.
4. Spread tube longitudinally: Separate your fingers at the listening location.

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D1/D2 Interchange (pg. 48):

1. Seated: Line up tensions at D1 & D2 bring in torso as long lever.
2. Supine: Stack D1 & D2
3. Indirect or direct: 3-dimensions
4. Transverse shear: Pyloric vestibule & D1.

Sphincter Steps

Sphincter dysfunction due to (pg. 55):

- Stress (the MIND uses sphincters as an outlet when it is overloaded)
- Mechanical injury (D.J. Flexure)
- Chemical irritants...
- 5 sphincters function as a TEAM.
- GOAL IS ALWAYS THE SAME: Initiate an induction of the tissues!

Evaluating / Treating (pg. 55):

1. Evaluate - fascial load...SLOWLY drift out. Take FIRST rotational movement indicates function or dysfunction.
2. Inhibit ... determine order of influence.
3. Treat dysfunctional with induction:
    a. Encourage CCW
    b. After corrected follow a few cycles
    c. Recoil of frozen (no movement)

Hiatal Zone Steps

Localizing restriction with LL:

1. LL at the level of the cardiac sphincter:
2. From cardiac sphincter does your listening attract you superior into the esophagus or inferior into stomach?
3. If superior inhibit at cricoid...

Vertical Stretch at Esophageal Hiatus (pg. 29):

1. Seated...
2. Left thumb - lesser curve of stomach
3. Anchor toward left ilium ...
4. Extension and right rotation...
5. Option:
    a. Right hand over sternum
    b. Communication between two points of contact (could be cricoid, could be at sternal angle)

Phreno-Esophageal Release (pg. 30):

1. Seated...
2. 2cm inferior of xiphoid, slightly left (3cm of abdominal esophagus)
3. Flexion...
4. Sink posterior and superior - as high as you can go. Sink, don't push!
5. Evaluate rotation of esophagus (MOBILITY) to right and left - direction of ease until release (softening).

Balancing Tensions between cardiac sphincter and diaphragm around sphincter (pg. 31):

1. Anterior hand at cardiac sphincter
2. Posterior hand:

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a. First position - T10-T11
b. Second Position - L1, L2, L3, L4
3. Slight compression to create communication between hands.
4. Stack each dimension into ease or tension.

Kidney Steps

General Steps:

1. GL...
2. LL from midline - which kidney attracts you?
3. LL superficially at restricted kidney:
    a. Ptosis? .... What degree?
    b. Drawn into the kidney? Go to next step.
4. LL at level of kidneys to validate (deeper "presence" deeper intention, only slightly deeper contact). Attracted to parenchyma, vasculature, associated organ / structure? One kidney can be attracted towards other if both are involved in restriction pattern.
5. Motility evaluation:
    a. Frozen kidney?
    b. Ptosis? What degree?
6. Palpate...
7. Choose treatment plan...
8. Motility re-evaluation and balancing

LL superficially (Over Anterior Projection of Kidney) (pg. 100-101):

1. LL at midline. Which kidney has an attraction?
2. Place hand over kidney
3. Do you feel pattern of ptosis? (validate with motility evaluation)
4. Are you drawn deep, to level of kidney? If yes, then LL at level of kidney.
5. Is kidney attracted to another organ? If yes, inhibit to confirm.

Ptosis (pg. 100):

1. 1st degree - inferior pull
    a. Listening - Inferior
    b. Motility - Exaggeration of inferior
    c. Possibly a frozen kidney...
2. 2nd degree - inferior pull, external rotation.
    a. Listening - Inferior / external rotation.
    b. Motility - exaggeration of inferior & lateral
3. 3rd degree - inferior pull and internal rotation.
    a. Listening - Inferior / medial rotation
    b. Motility - exaggeration of inferior and medial
    c. Decrease in expir with ptosis.

LL at level of kidney (pg. 100-101):

1. With intention follow through layers to level of kidney:
    a. Visualize each layer... (viscosity of abdomen & density of retroperitoneal space)
2. LL:
    a. Passive listening or fascial load... slightly drift (to wake up)
    b. Where does kidney attract? (Inhibit to confirm).
3. Option: LL kidneys blt. Due to renal fascia healthy kidney may pull toward restricted kidney.

Motility Evaluation (pg. 99):

- Inspir – Inferior, lateral, posterior (inferior pole rocks posterior)
- Expir – Superior, medial, anterior (inferior pole rocks anterior)
- Evaluate both kidneys together
- Evaluate restricted kidney (decreased motility...)
- Pre-evaluation tool (compare before and after treatments)

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Palpating Kidneys (pg. 95-96):

1. Sink slowly & circuitously through viscosity until you reach density of retroperitoneal space (your hand spreads)
2. Pronate hand - palm is on inferior pole of kidney.
3. Use posterior hand to "bump" kidney into anterior hand. (you can also use breath to encourage kidney into your hand).
4. Evaluate elasticity & mobility.

Treatment using Breath (pg. 100-101):

1. Palpate inferior pole with top hand.
2. Posterior hand at Grynfeltt's Triangle.
3. Engage kidney...
4. Inhalation – kidney comes into your hand
5. Exhalation – kidney ("bar-of-soap" feeling) should dissipate.
6. Treatment:
    a. Exhalation - take up slack - "follow with firm presence"
    b. Inhalation - maintain your position...
    c. ~ 4-5 breathes - kidneys and surrounding tissue fibers begin to respond.

Treatment using long lever (leg) (pg. 97):

1. First, engage leg (lift or put on your knee).
2. Palpate inferior pole with top hand.
3. With leg on your knee put posterior hand at Grynfeltt's Triangle.
4. Engage kidney...
5. At leg stack 3-D (flexion/extension, external/internal rotation, abduction/adduction).
6. MAINTAIN communication between leg and kidney.
7. Options: Mobility induction, stack into ease or tension, contract/relax of psoas, recoil.... or ADD BREATH!

Treatment of frozen kidney (pg. 98):

1. Encompass superior pole with ulnar edge of one hand OR approach through ribs (flat hand over liver).
2. Encompass inferior pole with other hand (ulnar edge).
3. Fascial load both hands toward one another.
4. Stack dimensions into ease or tension... listen & follow.
5. Recoil suddenly on inhalation.
6. Follow recoil with motility induction.

Seated Kidney Release (pg. 92):

1. Two hand contact...
2. Slightly below umbilicus....
3. Right kidney - medial to AC
4. Left kidney - lateral to DJ
5. Sit on ischial tuberosities...
6. Apex of flexion at finger contact
7. Sidebend to same side...
8. Rotate away from treatment side - brings kidney anterior

Posterior Kidney Release (pg. 100-101):

1. Sidelying...treatment side up
2. Contact kidney through Grynfeltt's Triangle - with thumb or ulnar edge of hand (engage to level of kidney) bring kidney anterior/superior.
3. Approximate diaphragm and kidney by mobilizing shoulder in 3-D.
4. Have them extend their upper leg just to point where you feel engagement at kidney.
5. Return to neutral set up
6. Repeat motion with kidney, shoulder and leg
7. Follow kidney as it shears / glides on its way to regaining its mobility via the psoas.

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Spleen Steps

General Steps:

1. GL - anterior, to left
2. LL - lateral of stomach
3. Motility evaluation
4. Mobility evaluation
5. LL at spleen / inhibit to find associated structure (organ)
6. Treatment plan - choose body position
7. Contact both organs - be confident you are on the structures
8. Mobility induction (or stack 3-dimensions of ease or tension)
9. Re-eval: mobility, motility, LL, GL

Draw & Locate (pg. 130):

1. Behind the axillary line on the left
2. Between ribs 9 and 11 (follow the outline of the ribs to get just under the scapular apex; i.e., near the rib angles)
3. Lateral to the erector spinae muscles.

LL at Level of Spleen & Inhibit to Confirm (pg. 128):

1. Superior or lateral - diaphragm
2. Anterior - Medial - stomach
3. Inferior - splenic flexure
4. Posterior - spleen / left kidney
5. Medial - spleen / tail of pancreas

Motility Evaluation (pg. 126):

1. Person is supine, stand on right side
2. Palm posterior to mid-axillary line at ribs 9-11
3. Motility follows stomach (some subtle differences). Keep it simple - think of it as similar to stomach and then feel for subtle differences.
4. Where do you feel a drag on motility?
    a. Inspir (superior, posterior, lateral)
    b. Expir (inferior, anterior, medial).

Mobility Evaluation (pg. 127):

1. Right side-lying...
2. Sink to level of spleen
3. Mobility test:
    a. Anterior / posterior (diaphragm)
    b. Superior / inferior (colon / diaphragm)
    c. Medial/lateral roll (kidney / stomach)
    d. Compression /decompression (diaphragm / parenchyma of spleen)

Superior, Anterior or Lateral (Diaphragm) (pg. 131):

1. Right side-lying...
2. One hand on spleen...
3. Move their arm/shoulder with your other hand
4. Add breath to enhance release
5. Mobilize on exhalation (moving diaphragm over spleen)

Anterior / Medial (Stomach) (pg. 131):

1. Right side-lying or seated...

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2. R hand finger pads on lesser curve of stomach - engage posterior and laterally
3. L hand - engage spleen through the ribs
4. Allow spleen and stomach to communicate. "How do these structures want to create a relationship"?
5. Stack in ease or tension

Inferior (Splenic flexure) (pg. 131):

1. Seated, Walk up the DC to rib 10...subcostal
2. Migrate superior, posterior, lateral
3. Use breath to allow you in
4. Shear medial and to right hip (use torso - extension, left rotation)
5. Not at actual level of spleen!!! Goal: provide spleen space
   ** If you feel a hard structure (the spleen)... person has splenomeglia.

Posterior / Medial (Left kidney) (pg. 131):

1. Supine...
2. Right hand thumb lateral to DJ flexure, finger pads in grynfeltt's space - sink to kidney
3. Left hand over spleen through ribs
4. Bring spleen to kidney - create induction
5. Listen & follow...
6. Stack in 3-dimensions of ease or tension

Medial (Tail of pancreas): Will discuss with pancreas

"Spleen Viscoelasticity" (General Spleen Mobilization) (pg. 131):

1. Seated (stand behind person)
2. Left hand on spleen (sink to spleen)
3. Right hand on persons right shoulder
4. Engage Spleen medially to point of tension (follow listening)
5. Engage R shoulder medially & inferiorly toward spleen to point where you feel feedback in spleen hand.
6. Overtake the listening slightly to optimize the induction of the mechanoreceptors.
7. Drift slightly and follow listening.
8. Repeat a few times until softening is perceived.

Motility balance with stomach (pg. 131):

1. Supine (stand on person's left)
   a. Left hand on stomach
   b. Right hand on spleen
2. Motility balance of spleen
3. Motility balance of spleen with stomach...

Pancreas Steps

Free the Environment (associated structures) DO NOT physically manipulate Pancreas!

1. Stomach, liver, duodenum, spleen
2. R or L kidney
3. Transverse mesocolon
4. DJ flexure (supports pancreas)
5. CBD (passes through pancreas)
6. Influenced by pressures at Oddi.
7. Parietal peritoneum
8. L2 spinal segment

General Treatment Guidelines (pg. 105):

1. Evaluate Oddi...
2. Free up surrounding structures...Free the Environment (associated structures). DO NOT physically manipulate Pancreas!

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3. Working between pancreas and associated structure:
    a. Gently stabilize pancreas!
    b. Take up 3-dimensions in associated organ.
    c. Create mechanical dialogue between your hands (listen, follow, encourage at soft end-feel)

General Steps:

1. Motility...
2. LL / inhibition to find associated organ (structure)
    a. (Universal inhibition point for the pancreas is sphincter of Oddi)
3. Check function of sphincter of Oddi
4. Determine treatment plan - choose body position
5. Contact both organs, LL, line up tension with both.
6. Motility induction of pancreas

Superficial LL (pg. 114):

1. Our middle finger drifts to left toward spleen on transverse plane.
2. Inhibition point is always where pancreatic duct goes into Oddi.

Types of Pancreas Listenings (pg. 114):

1. "Exocrine Listening (ducts) - a discrete line anywhere along pancreas
    a. Motility - restriction into expir
2. "Endocrine Listening (cellular) entire pancreas attracts you into it
    a. Motility - restriction into inspire
    b. With "endocrine listening" MOTILITY is the ONLY treatment!

LL at Level of Pancreas (pg. 114):

- HEAD - where is it attracted?
    - Anterior .. pylorus.
    - To right ... duodenum.
- TAIL - where is it attracted?
    - Deep posterior ... left kidney.
    - To left ... spleen.
- BODY - where is it attracted?
    - Inferior ... short distance - transverse colon.
    - Superior ... short distance - splenic artery
    - Anterior ... stomach.

Motility (pg. 113):

- Inspir:
    - HEAD moves posterior
    - BODY migrates to right towards duodenum
    - TAIL lifts anterior
- Expir:
    - HEAD moves anterior
    - BODY migrates to join spleen (dives deeper)
    - TAIL moves posterior in the body toward spleen (note how posterior the Spleen is).

Pancreas / Stomach (No page):

1. Seated or supine...
2. R-hand thumb / thenar eminence along lesser curve.
3. Finger pads of L-hand over pancreas - stabilize only!
4. Fascial load stomach to create induction, listen & follow.
5. Encourage shear / glide between stomach & pancreas.
6. Options: Stack into 3-dimensions of ease or tension.

Pancreas / Duodenum (No page):

1. Supine

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2. L (or R)-hand finger pads on anterior / medial surface of duodenum.
3. R (or L)-hand thenar eminence / hand on pancreas - STABILIZE!
4. Add slight superior / inferior shear (vertical) at duodenum to induce a "listening"
5. Listen & follow at duodenum.

Tail of Pancreas / Spleen (pg. 127):

1. Right side lying... stand at person's back.
2. Finger pads / hand (L-hand) over pancreas - STABILIZE!
3. R-hand palm over spleen (ribs)
4. Encourage spleen towards tail of pancreas.
5. Appreciate the barrier... feel barrier dissolve & feel spleen glide in relationship to pancreas.
6. *Option - Have them extend L-leg, repeat in rhythmic fashion.

Pancreas / Transverse Colon (No page):

1. Supine...
2. Sit at person's right side...Their knees should be up
3. Contact L1/L2 posteriorly...
4. Contact transverse colon between thumb/thenar eminence and fingers - focus is on the transverse mesocolon, ENGAGE INFERIOR.
5. Feel communication between your hands.
6. Create induction or stack in 3-dimensions of ease or tension.

Pancreas / Kidney (No page):

1. Right side lying or supine...
2. Finger pads of posterior hand (L-hand) on left kidney (envelop area from L2 up to11th rib)
3. Anterior palm (R-hand) on pancreas (GENTLY STABILIZE)
4. Bring posterior hand toward anterior hand
5. Listen & follow...

Spleen / Pancreas / Duodenum - "Visco-Elasticity Technique of the Pancreas" (No page):

1. Left side-lying, 3/4 roll posterior leaning against your left thigh (or supine)
2. R-hand palm contacts lateral border of D2.
3. L-hand palm / finger pads contacts spleen...migrate through ribcage.
4. Hook left thumb around costal margin to prevent spleen from sliding inferior.
5. Encourage spleen across body until you feel "communication" into duodenum.
6. When corrective activity begins encourage induction. Feels like an accordion closing and opening (visualize the "wavy" course of the splenic artery and vein). Work in correlation with CS rhythm. Do not expand so far that you lose your contact with the organ.
7. Roll the person forward as you go into compression as this will ensure you move the pancreas around the spine and not push the head of the pancreas against the vertebral body. When you come to end of the motion "overtake" the motion slightly to help with stimulating the mechanoreceptors.
8. When you allow the expansion and opening of the tissue take the person into a slight roll posterior to encourage opening of the tissue / spaces. You are working with a "suction" as you allow expansion of this tissue.
9. Focus on pancreas ability to move freely in its space.
10. You are not finished until you feel the pancreas could expand, expand, expand.

Parietal Peritoneum (PP) Steps

Listening to the PP

1. Sink through layers into a place of increased tone and slippery quality - P.P.
2. One layer deeper - greater slippery quality - G.O.
3. Induce a listening - put in a slight fascial load (generous contact) - wake up tissue and create a dialogue.
4. "Where is the attraction?"

Local Listening at level of PP (pg. 137):

1. Be at correct layer with both hands...

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a. Fascial load PP and drift slightly
b. With attraction anterior focus on thumbs and 1st & 2nd fingers and fascial load midline
2. With attraction posterior focus on 4th & 5th fingers and fascial load anterior.
3. Use inhibition to confirm location
4. To inhibit deep, THINK deep!!!

Testing Peritoneal Tensions (pg. 137)

1. Same hand placement as with previous slide...
2. Be at correct layer!!
3. Mobilize PP medial and anterior to locate restricted area.

Motility – Pattern (pg. 136)

1. "Be generous with your hands"!
2. Think "global sphere"... Think of a water balloon filling and emptying.
    - Inspir - lateral, superior (slight), posterior (slight)
        - (supination)
    - Expir - medial, slight inferior, slight anterior
        - (pronation)

Treating Anterior Restrictions (pg. 138):

1. Superior restriction anchor at costo-chondral border with finger pads curved around ribs - "intend" to diaphragm.
2. Inferior restrictions anchor at iliac crest (stay within abdominal compartment - not to far lateral)
    a. With knees bent move pelvis in relation to P.P. restriction.
    b. Remember, strong attachment to ilium & iliolumbar fascia.
3. With thumb of other hand traction along "spokes of wheel" to locate connections.
4. Use mobility induction or direct stretch to enhance line of tension.
5. Use pelvic tilt, breath or torso to engage long lever.
6. Main challenge - staying at P.P. layer.

Treating Posterior Restrictions (pg. 139):

1. Palms at lateral edge of rectus abdominius
2. Sink to level of PP...
3. Fascial load palms toward one another "on your way" to clasping fingers together (if you can)
4. Engage anterior to access posterior PP
5. Line up dimensions: Superior/inferior? Side bend right or left? Rotate right or left?
6. Mobility induction, direct stretch, or recoil

Lesser omentum Steps

Lesser omentum (pg. 152):

Organ	***Listening attraction***	***Treatment***	***Ligament Treated***
Liver	Slightly posterior and inferior	Liver / duodenum	Hepatoduodenal
Stomach	To lesser omentum	Liver / stomach (VM1)	Lesser omentum
Duodenum	Superior to D1/D2 interchange	D1 Stretch (VM1) or D1/D2 interchange (VM2)	Hepatoduodenal
Stomach	Deep to stomach	Medial / lateral glide (VM1)	Omental bursa

Greater Omentum (GO) Steps

Hand Placement (pg. 150):

1. Hands are medial to colon.
2. R-hand palm towards pelvic cavity.
    a. Trace out lateral border of Stomach.

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    b. Contact G.O. below Stomach.
    c. Finger pads at splenic flexure.
3. L-hand palm towards pelvic cavity.
    a. Lateral border of Duodenum.
    b. Fingers at hepatic flexure.

LL to G.O. (pg. 150):

1. Sink to level of G.O. (slippery layer deep to PP)
2. Fascial load G.O. and drift off slightly to allow tissues to respond.
3. When listening comes to a stop inhibit to confirm

Motility Steps (pg. 150):

1. Sink to the tone-layer of the stomach and then feel for GO (migrate anterior one "micro-layer"...
    a. More springiness
    b. More adipose tissue
    c. Very slippery
2. Tune into motility:
3. Strongest phase will follow inspir motility pattern of stomach.

Treatment (other than VM1 techniques) (pg. 151):

1. Palms on G.O. near colon - medial edge of Cecum and Sigmoid.
2. Interlace fingers (more narrow than PP) - keep quadrants in mind when listening to G.O.
3. Be at correct tissue depth - not as deep as with PP, more fluid at this level.
4. "Suction" G.O. into your palms in order to create induction of the entire organ.

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