

Understanding Structural Collapse and the Potential for Maximum Rehabilitation

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Ginny was referred for treatment by a close friend who wanted her pain free and able to resume her active lifestyle. At the time of referral Ginny was 59 and had undergone two low back spinal/disc surgeries, one neck spinal/disc surgery, a left knee cartilage operation, a right shoulder rotator cuff surgery, had migraine headaches that were increasing in frequency and intensity, and was medicated for severe acid reflux. Ginny was still having severe back and neck pain, left knee issues where she could hardly walk, and a partially frozen right shoulder for which she was taking significant pain killers from a pain management center. In addition she was seeing a rheumatologist who suggested that she go on methotrexate even though her arthritis was osteoarthritis due to the injuries and surgeries. Her migraines involved going to the hospital and receiving IV pain killers followed by two days being bed-ridden.

Ginny had led an active life competing in marathons, triathlons, and tennis. At the time of referral she was having trouble walking and was very sedentary due to the pain and medication. It was obvious that these painful conditions did not occur overnight so examining her history that led to the problems and surgeries was necessary and revealing.

The basic component involved in Ginny's structural collapse was actually present when she was born. Like all normal babies she was born with the core distortion. The core distortion is a spiral twist that is present in newborns evident in the structure from the head to the feet. A major component of the core distortion is in the cranium - a torsion at the Sphenobasilar Synchondrosis (SBS) joint that creates an imbalance in the basic cranial motion of the cranium. This imbalance is also reflected in the relationship of all the vault and facial bones. The torsion present in the cranium is repeated in the pelvis with the left ilium rotating anteriorly and the right ilium rotating posteriorly. This results in a tipping and rotation of the top of the sacrum to the left and the tail bone going posterior and laterally to the right. This creates a tipped base for the spine which results in exaggerated curvatures of the spine. These spinal curvatures result in imbalances throughout the thoracic area with the right rib line lower putting uneven pressures on the diaphragm. The imbalanced thorax results in shoulder rotations along with uneven elevations. From this shoulder imbalance we see the arms also imbalanced with one further into internal rotation.

From the imbalanced rotation of the iliums we get a long leg/short leg imbalance. On the long leg side (left) the body has to absorb the extra leg length from the ilium to the feet to maintain balance. This is most commonly seen with a medially rotated and hyperextended knee and a laterally rotated foot. On the short leg side (right) we see additional distortions with more weight on the heel to compensate for the imbalance.

The imbalances of the core distortion result in significant weakening of about 50% of the muscular function and strength in a body. This is verified using both functional and applied kinesiology. Thus, by the time Ginny began walking her body was structurally imbalanced and weakened significantly.

Ginny reported that she had been a dancer, gymnast, and tennis player as a little girl, but discovered she loved to run and swim and play tennis at age 12. That's when Ginny experienced

her first injury which involved her left knee and was diagnosed with strained ligaments. At this point Ginny was given a brace and told to limit her activity for three months. After three months Ginny was allowed to resume her full activities but continued to wear a knee support. About this time Ginny had her first migraine which was attributed to the onset of her menstrual cycle.

Ginny's next injury occurred when she was a passenger in a car that was rear ended at the age of 17. She was diagnosed with a whiplash and low back strain and had chiropractic treatments for 10 weeks. She started having more frequent migraines which were related to her neck.

As a college student Ginny played on the tennis team and ran for the cross country team. She developed chronic soreness in her low back and right shoulder during this time and received physical therapy and strength training along with cortisone injections to allow her to continue training and competing.

At 26 Ginny delivered her first child and had significant low back pain during and after the pregnancy. While picking up her six month old baby she felt something give in her back and was in immediate severe low back pain. She underwent chiropractic treatment with massage for 10 weeks. An MRI showed a herniated disc in her low back for which she had her first low back surgery. The surgery was successful but Ginny felt some discomfort and weakness as a result of the surgery.

At 33 Ginny again delivered her second child. This pregnancy was even more challenging with back pain and migraines and her old left knee injury became inflamed and sore. Ginny's left knee pain got worse caring for two children and she eventually had it scoped for bone chips and cartilage repair.

As her children became older Ginny resumed running, swimming and competing in marathons and triathlons. Then at age 45 she reinjured her left knee and right shoulder while playing tennis. At this point the surgeons felt it best to remove the cartilage from her left knee and surgically repair her right rotator cuff. Afterwards Ginny's right shoulder was always painful after playing tennis so she started playing less. She had to give up the swimming because of the shoulder issue, so running became her primary exercise.

By 52 Ginny experienced significant low back pain and discovered that the disc immediately above the previous herniated disc was now herniated and needed to be surgically removed. Ginny was told not to run for six months and then resume a light exercise program. During the time of inactivity Ginny's neck pain became worse so she had surgery to repair two bulging discs and a herniated disc. Ginny's migraines then increased in intensity and frequency to the point of once a week.

Ginny started a regimen with a pain clinic which reduced her physical activity to no significant exercise. At 59 she was referred to my office with a significant structural collapse and the symptoms listed above.

When looking at Ginny's case it is obvious that if she had correct therapeutic interventions things would have been much different. First, if the Cranial/Structural Core Distortion Release (CSCDR) had been applied when Ginny was a child the core distortion would have been minimized and the patterns of collapse balanced. This would not only have given her structural support but the weakened muscles would have been much stronger and functional and allowed

her physical potential to be much greater. She would have had more success as a dancer, gymnast and tennis player and would probably not have experienced her first knee injury at age 12 because the left leg would have been strong and balanced.

Again at 12 if the CSCDR and soft tissue protocols were applied after the injury she may not have developed migraines. The imbalance of the pelvis is dramatically affected by the swelling of the menstrual cycle which affects the whole structure which consequently can trigger migraines.

At the age of 17 when Ginny was injured in the car wreck if the CSCDR and soft tissue protocols had been applied at that time her whiplash and low back could have been fully rehabilitated by being brought into balance with greater strength than before the injury. Instead because the core distortion still existed there was weakness and damage from the whiplash that made her conditions worse.

As a college student on the tennis team if Ginny had received the CSCDR and soft tissue protocols her low back and shoulder would have been stronger and would not have continued to fall further into the core distortion.

At 26 when Ginny went through pregnancy and delivery she wouldn't have had so much difficulty and wouldn't have developed severe low back pain if she had had the CSCDR prior being pregnant. If the CSCDR and soft tissue protocols had been applied before she went to the chiropractor after delivery, the balance and support in her low back could have allowed the disc to heal without surgery, thus avoiding the discomfort and weakness from the surgery.

At the age of 33 when Ginny delivered her second child the whole pregnancy and delivery would have been easier had she received the CSCDR previously, and if it had been applied immediately after the delivery it probably would have alleviated her migraines and taken the pressure off her left knee so she might have avoided having cartilage repair at that time.

When Ginny resumed running and swimming again if she had had the CSCDR and soft tissue protocols she would not have continued to damage herself running or playing tennis and could have been able to avoid the surgeries. Even if the CSCDR and soft tissue protocols had been applied after the surgeries she could have avoided the future back, neck and shoulder surgeries.

Even more important Ginny would not have been in pain, wouldn't have needed pain clinic treatments, and could have avoided the migraine problem.

Even at 59, using the CSCDR and soft tissue protocols, Ginny would be able to improve dramatically and probably resume some normal life activities pain free. If the core distortion is not addressed her structure will continue to collapse putting more stress on her joints and bone structure, further weakening her musculature - a downward spiral with dysfunction and pain.

Understanding how the core distortion leads to degeneration over the years, and how releasing it can lead to rehabilitation even after years of collapse, opens the door for significant rehabilitation. The integration of the CSCDR and soft tissue protocols allows the body to rehabilitate and heal, and even severe conditions like disc degeneration can be effectively addressed.