TECHNIQUES OF THE MASTERS

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Lift the head cephalad (upward) and rotate the occiput back at the same time.

Sidebend left then right - freeing the sub-occipital musculature.
TUCKER TECHNIQUE FOR THE POSTERIOR OA

- Carry the head from side to side, focusing motion at the atlas, gapping open first one side and then the other side, until the atlas moves back to its normal position.
Place the left index and long fingers parallel along the articular pillar of the atlas with slight pressure while placing your left thumb in front of the ear. The fingers should be up under the occiput so you feel the OA joint.

Reinforce your left ring and long fingers with your right index and long finger so the fingers of the right hand are under the occiput and the right thumb is in front of the right ear. You have the joint between the occiput and the atlas so fixed that it alone moves.
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Sidebend left then right - freeing the sub-occipital musculature.
“The operator can feel definite movement directly between the occiput and atlas. You are turning the occiput back. If the occiput slides forward it also extends a little and laterally flexes to the other side. This technique will accomplish three motions - pushes the occiput back, laterally flexes to the same side and flexes the head anteriorly by the lift on the occiput.”

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EXAMPLE: C3 posterior R

OPERATOR: standing at head of table

PATIENT: Supine

Place the proximal joint of the right index finger behind and below the prominent portion of C3 with the other fingers supporting the neck; the patient’s face being in the median line.
- Hold the articular pillars of C4 with the left hand.
- Sidebend the neck to the right without raising the head and without rotation until all of the tissues of the left side are on tension.
Turn the face to a forty-five degree angle at the same time drawing back slightly, and pressing with the finger across the C3 in the direction of the patient’s nose—parallel to the plane of the articulation. In the average patient a very slight pressure is sufficient to reduce the lesion.
TUCKER POSTERIOR CERVICALS

- Turn the face to a forty five degree angle at the same time drawing back slightly, and pressing with the finger across the C3 in the direction of the patient’s nose—parallel to the plane of the articulation. In the average patient a very slight pressure is sufficient to reduce the lesion.
At the moment of reduction the arch is drawn by the pressure of the finger into two straight columns; the bones below are drawn taut and straight, holding the C4.

The complete extension of the left side makes it serve as a fulcrum.
EXAMPLE: Left scalenes in spasm

OPERATOR: Standing facing patient

PATIENT: Seated

Reach under the right arm and place your right hand upon the tubercle of the left first rib, close to the neck with the fingers directed upwards.
With the left hand on top of the head stretch the head back upon the knuckle: rotating the head forward working it slowly.
WILLIAM WEST’S ANTERIOR CERVICAL TECHNIQUE

- EXAMPLE: C3 dysfunction
- OPERATOR: Standing
- PATIENT: Seated
- Place your right thenar eminence on the occipital protuberance and your long finger on the articular pillar of C3.
WILLIAM WEST’S ANTERIOR CERVICAL TECHNIQUE

- Place your left fingers under the chin and left thumb on the opposite articular pillar.
- Lift the head and add gentle pressure to the articular pillars.
- Have the patient take a deep breath in and hold it until the cervical vertebrae releases.
HAZZARD’S CERVICAL TECHNIQUE

- **OPERATOR:** Standing in front of the patient
- **PATIENT:** Seated
- Place your arm around the patient’s neck so your elbow is just below the occipital protuberance with the hand beneath the chin.
- The head is raised slightly.
- Palpate the cervical spine to find the area that is dysfunctional then move the head to free the dysfunction.
OPERATOR: Standing
PATIENT: Prone

Have the patient rise up on their elbows, so that the upper arms are vertical, with the forearms lying along the table.

Stand at the side of the table, place a thumb on the articular process of the lower of the two dysfunctional vertebrae, pressing down (tending to directly release). Alternately, on the upper of two bones, pressing down and out on the spinous process, thus making a fulcrum of the lower vertebrae.

The patient is directed to let their head hang down.
TUCKER’S PRONE THORACIC TECHNIQUE (1917)

- With the other hand rotate the head (with the face slightly turned to the side), from side to side to the limit of motion in each direction.
- If extra leverage with the head is necessary, the operator may brace the patient’s shoulder on either side against his abdomen to prevent pulling patient so that the upper arms are not vertical. It is an important point to keep the arms non vertical.
SUTHERLAND’S THORACIC FLEXION DYSFUNCTIONS

- OPERATOR: Standing (if patient seated) Seated (If patient supine)
- PATIENT – Supine OR Seated
- Hold the processes of the upper of the two vertebrae pushing anteriorly and superiorly with the thumb and index finger if seated and the other hand on a shoulder.
SUTHERLAND’S THORACIC FLEXION DYSFUNCTIONS

- If the patient is supine use your finger tips on each of the upper of the two vertebrae pushing anteriorly and superiorly
- Have the patient elevate both shoulders to balance the ligamentous tension. This position is held while the patient inhales and holds the breath in.
TUCKER’S SEATED THORACIC TECHNIQUE (1917)

- OPERATOR: Standing
- PATIENT: Seated
- The patient places their hands on operator’s shoulders, and their head against operator’s manubrium.
- (Alternately have the patient cross their arms and lay their crossed arms on the manubrium then have the patient lay their head against their crossed arms.)
TUCKER’S SEATED THORACIC TECHNIQUE (1917)

- Operator reaches their hands around the patient and places fingers on either side of the spines of the upper thoracic vertebrae.
TUCKER’S SEATED THORACIC TECHNIQUE (1917)

- Lean back carrying the spine in full extension; at the same time lifting the patient’s arms elevating the ribs.
EXAMPLE: Left first rib

OPERATOR: Standing beside the patient

PATIENT: Seated

Reach under the right arm and place your right hand upon the tubercle of the left first rib, close to the neck fingers facing up.
WILLIAM WEST’S FIRST RIB TREATMENT #1

Place your left hand under the left elbow. Raise the elbow and the shoulder strongly, straight up in the mid-axillary line;
Bring the elbow back up and swing the upper arm in a backward rotation of the shoulder while maintaining strong pressure on the rib at the tubercle.
ERNEST TUCKER’S FIRST RIB TECHNIQUE #2

- OPERATOR: Standing
- PATIENT: Supine
- Draw the patient’s right arm across their chest, arm high up and bent at the elbow.
Place their elbow against your sternum.

Place your left hand under first rib, knuckles against table, fingers bearing up against the rib;
With your right hand carry the head to the left side, then to the right. Gentle exaggeration of all of these tensions will tend to bring the rib to normal.
EXAMPLE: Rib - T3
Right stuck in inspiration

OPERATOR: Seated on the left side of the patient

PATIENT: Seated.

Pass the right arm under the left axilla and placing your fingers on the upper aspect of the third rib.
Place your left hand on the patient's head.

First the patient's head is drawn toward you while their body is pushed slightly away.
HAZZARD RIB TECHNIQUE (1905)

- This ‘swerves’ the spinal column and throws the luxated rib up higher, exaggerating the lesion.
- Now the head is pushed well away from you, while the body is drawn to you. Accompany this movement with strong pressure of the right hand downward upon the shaft of the rib.
EXAMPLE: 8th rib elevated on the right

OPERATOR: standing behind

PATIENT: seated

Have the patient place right hand on top of head (highest point)

Pass your right arm under the patient’s axilla (supporting it) and placing your hand on top of the patient’s hand on their head.
ERNEST TUCKER’S RIB TECHNIQUE #2

- Place your left thumb on the rib as near transverse process as possible. Press to the right and forward with your thumb while carrying the vertex to the left and slightly backwards.
Lift the axilla to the full limit of side bending - convex to the far right end of the extension of the segment in dysfunction.

“CAUTION: The neck should not be turned sharply nor bent sharply, as is the natural tendency. It should be bent as little as possible. The focus of the motion should be on the lifting of the ribs and the bowing of the spine. The head should be slightly turned to the right to increase the separation between the transverse processes.
WILLIAM WEST’S 6th through 10th Seated RIB TECHNIQUE

- With their axilla the operator rotates the right side backwards while maintaining pressure on posterior portion of the rib.
- The operator moves the anterior portion of the rib up or down as needed.
- The operator asks the patient to forcibly exhale.
EXAMPLE: T10 Right
OPERATOR: Standing behind the patient
PATIENT: Lying on their left side
Patient place their left arm under the operator’s right axilla and grasps the operator’s right shoulder.
The operator takes their left hand and places their fingers and/or thumb on the 10th rib between the head of the rib and the posterior angle.
WILLIAM WEST’S 6th through 10th RIB TECHNIQUE PATIENT ON THEIR SIDE

- Their right hand (fingers/thumb) on the sternal end of the 10th rib.
- The operator stands up and stretches the arm upwards.
- With your hands press the anterior and posterior aspect of the ribs together.
- Have the patient release the operator’s shoulder.
- With the right hand grasp the patient’s left elbow and then press down and make a sweeping motion backward with the shoulder.
**OPERATOR:** stands behind the patient.

**PATIENT** seated on the table.

The patient places their left hand behind their neck.

Place your left hand under the patient’s left axilla and over the patient’s hand at the back of their neck, with your forearm supporting their axilla.

With your right hand press forward on the eleventh thoracic vertebra until the spine is in full extension.
TUCKER FLOATING RIB TECHNIQUE #2

- With your right thumb on the head of the rib as above, produce a side-bending motion to the right, keeping the patient’s neck as near to the mid-line as possible, and focusing all motion at the twelfth rib.

- To this complete extension and complete lateral flexion, add some rotation until the dysfunction is felt to have released.
Have the patient take a deep breath and hold their breath.

If it hasn’t released, the operator may then press downward on the neck, while carrying the spine suddenly into flexion. Maintain side-bending rotation and constant pressure with your thumb.
Alternate extension and flexion until complete correction is made.

“In all of these forms of technique deep inspiration may be of some assistance. In deep inspiration the intercostal muscles are tensed, drawing up and towards the spine. The diaphragm is also tensed, drawing up and on the tip of the rib and transversely across the body.”
ANNE WALES STERNAL RELEASE

- PATIENT: Supine
- OPERATOR: Seated
- Place your hand only on the manubrium with your fingers pointing towards the head.
- Gently compress the manubrium and find a point of balanced tension.
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Have the patient take in deep breaths - in and out.

Alternate Hand Hold
This will shift all the fascia around this thoracic outlet and all you do is hold the manubrium sublet. When you’re doing it you will have a good opportunity to note that when the patient breathes in the manubrium goes in. When they breathe out, it goes forward and out, which is not the way the body of the sternum moves. The manubrium does move
EXAMPLE: Left Clavicle
OPERATOR: Standing
PATIENT: Seated
The acromioclavicular ligament is going to be the fulcrum around which both ends of the clavicle will move.
Place your Left thumb under the clavicle near the sternal end
Place your other thumb under the clavicle at the acromial end
Ask the patient to bend straight forward from the hips with all their weight onto your thumbs
When that has stabilized the field of operation, ask the patient to carry the opposite shoulder backward. That takes the other clavicle and the manubrium away from the left clavicle.

Have the patient take a deep breath in and hold it. The clavicle will slide back into place.

Have the patient now sit up straight.
Example: Left Clavicle
PATIENT: Seated
OPERATOR: Stand in front of the patient
Place your right thumb on the left clavicular-sternal junction
Place your left thumb at the acromio-clavicular junction
Have the patient lean forward placing their weight on your hands
Have the patient move their left shoulder backward moving the manubrium away
Then have the patient raise both their elbows to about 90 degrees.
EXAMPLE: 8th rib elevated on the right
OPERATOR: standing behind the patient
PATIENT: Seated
Place the right hand on the left shoulder.
Facing right; place your left axilla over patient’s shoulder and your left arm and hand passes around the body and under the patient’s right elbow, placing your fingers on the eighth rib in front of the axillary line.
ERNEST TUCKER’S RIB TECHNIQUE #1

- Place your right thumb on the eighth rib as near the transverse process as possible with the fingers as far along as possible.
- With the right thumb and fingers carry the rib away from the transverse process enough to overcome the catch or wrinkle that is holding it in dysfunction.
ERNEST TUCKER’S RIB
TECHNIQUE #1

- With the left fingers on the front press down, in and centrally, overcoming the resistance of the intercostal muscles and, acting through the curved spring of the rib, still further aid in carrying the rib away from the transverse process.

- (Pressure back and in on the front ends of ribs makes a fulcrum of the thumb in the back. This tends to gap not only the articulation at the transverse process, but also that at the head of the rib). The movements then act to tense all muscles, to gap open the joint at the top, and with the pressure of the thumb carry it back to a normal position.
Exert a slight pressure on the rib in all of these directions.

Then execute a “cork screw movement” a time or two.

Bow the spine convex to the right to complete side-bending of the eighth segment, at the same time rotating to the left to the complete limit of rotation. Alternately bow these ribs.