Student Still Technique Workshop
AAO Convocation 2020

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Learning Topics

• Learn Still Technique treatments for:
  • Lumbar Spine
  • Pelvic Muscles
    • Psoas
    • Iliacus
    • Piriformis
  • Pelvis
    • Anterior/Posterior innominate
    • Superior or inferior innominate sheer (AKA upslip)
    • Pubes
  • Sacrum-introduction to new diagnosis
    • Diagonal
    • Unilateral
  • Sacral treatment
86 year old Dr. A.T. Still lecturing & demonstrating osteopathic treatment to students
Richard VanBuskirk, DO, PhD, FAAO

- PhD earned from Duke University
- Was a physiology & neuroscience professor at WVSOM
- Quit his faculty position to become a DO
- Attended WVSOM and graduated in 1987
- Dual board certified in FM, NMM/OMM
- History in his own words:
  - Dr. VanBuskirk interview 7.4.2013 at AIOT Italy
Still Technique: Key Concepts

• Introduction of a force vector resulting in a smooth arc carried toward the position of tissue compliance
• The position is altered while maintaining this force vector
• Carrying the somatic dysfunction toward and through the restricted position to its position of motion

“indirect and then direct”  Herb Yates, D.O., F.A.A.O.
Still Technique compared to FPR

FPR shares quite a bit of technical similarity to a different technique described in 1996 by Richard Van Buskirk, DO, PhD, FAAO, which he titled “Still Technique”, but there are a few differences:

- Still technique’s position of ease is usually more exaggerated than FPR’s.
- Still technique requires the practitioner to move from the position of ease through neutral and into the barriers – FPR does not, although many FPR practitioners do so as well.
Still Technique
Indications/contraindications

**Indications**
- Articular somatic dysfunction
- Intersegmental motion restriction
- Muscle hypertonicity
- Myofascial dysfunction

**Contraindications**
- Loss of intersegmental motion
  - Spondylosis
  - Osteoarthritis
  - Rheumatoid arthritis
- Joint instability
  - Ligamentous tear
  - Hypermobility syndromes
- Acute strain or sprain
Steps of Still Technique

• 1. Diagnose Somatic Dysfunction
• 2. Position of Ease
• 3. Apply Force Vector
• 4. Articulatory Movement
• 5. Release Force Vector
• 6. Return to Neutral
• 7. Recheck the segment

• Note that the patient is passive for all treatments
Diagnose the Lumbar Spine- 5 minutes

• Necessary before diagnosing and treating the sacrum
• Diagnose per Fryettes principles
Vectors & Levers
Practice localization

• Cervical traction
• Cervical compression
• Thoracic compression through shoulders
• Elbow compression to thorax
Still Technique seated neutral lumbar
L5 NSrRI example

- Operating hand over shoulders
- Sensing hand on transverse processes
- Place segment in ease (NSrRI)
- Apply compression vector to segment
- Move in smooth arc from ease/neutral/NSlRr
- Release force vector
- Return to neutral
- Recheck
Still Technique seated non-neutral lumbar

- Sensing hand over transverse process on side of ease
- Operating arm over patient’s shoulders
- Place patient in three planes of ease: flexion/extension, sidebending, rotation
- Apply compression vector (about 5 lbs.)
- Patient is moved from ease (L2 ERSleft)/neutral/to, per example, FRSright
- Release force vector
- Return to neutral
- Recheck

L2 ESRleft
Diagnose: Piriformis, Iliacus & Psoas (10 mins)
Find tenderpoints, trigger points or hypertonicity

Iliacus: leg/hip restrictor
Psoas major/minor: thoracolumbar stabilizer

Piriformis: assists in femur stabilization in the acetabulum

Travell figure 5.1 page 90
Still Technique: Iliacus

- Find Iliacus SCS tenderpoint
- Physician flexes knee and hip into strong adduction, bringing the hip in full flexion off the table
- Physician’s other hand is placed under the PSIS
- Introduce compression through the knee toward the origin of the iliacyus dysfunction
- Patient’s knee is abducted and extended
- Release compression and retest
Still Technique: Psoas

- Diagnose tight psoas
- Patient lateral recumbent with affected side up
- Fully flex knee and hip on affected side
- Physician’s sensing finger on transverse process L2
- Physician’s operating hand places compression on patient’s knee towards sensing hand
- Physician brings the knee inferiorly & posteriorly with mild abduction until hip is in full extension
- Release compression and return leg to neutral
- Retest tenderpoint and ROM
Still Technique: Piriformis

- Physician stands on side of dysfunction
- Sensing hand palpates piriformis near sciatic foramen
- Patient’s knee and hip are fully flexed & abducted to find ease
- Once piriformis is relaxed, sensing hand is removed & transferred to knee
- Compression towards sciatic foramen
- Bring leg over into strong adduction and internally rotate the thigh
- Bring the ankle back towards physician and extend knee and ankle
- Release compression when knee at 45°
Still Technique: Sacral poles
Superior A, Middle, B Inferior C

• Important palpation points for all innominate treatments
Diagnose

Pelvis

• Innominate
  • Rotation anterior or posterior
  • Superior/Inferior innominate sheer
    • AKA upslip/downslip
• Pubes
  • Sheers superior or inferior
Still Technique: Anterior Innominate
Supine

- Sensing hand over SI joint, C pole
- Partially flex knee 45-60 degrees
- Move knee laterally until SI joint relaxes
- Introduce compression through the knee towards same SI
- Move knee in an arc through full hip flexion, to flexion with adduction
- Release compression when the patients ankles meet (last photo)
- Recheck
Still Technique: Posterior Innominate Supine

- Sensing hand over SI joint, A pole
- Operating hand flexes adducted knee
- Add compression vector through to SI joint
- Move knee into abduction and transfer compression from hand to abdomen
- Maintain compression until the leg is almost fully extended
- Recheck
Still Technique: Innominate Slips

**Downslipped-compression**
- Physician grasps ankle on effected side with both hands
- Externally rotate femur
- Introduce compression to the SI-B pole
- Internally rotate leg, maintaining compression
- Release compression
- Perform both innominate treatments, posterior first (A pole, then anterior (C pole)
- Recheck

**Upslipped-traction**
- Physician grasp ankle on effected side with both hands
- Externally rotate the leg
- Introduce axial traction to SI, B pole
- Internally rotate leg with traction
- Perform posterior innominate treatment first (A pole), then anterior innominate (C pole)
- Recheck
Still Technique: Pubes

• Patient supine
• Flex patient’s hips & knees so that patient’s feet are planted on the table
• Physician places one hand on each knee and stands at foot of the table
• Introduce compression towards pubic ramus bilaterally
• Bring knees laterally, simultaneously. Maintaining compression
• Remove hands from knees and move to ankles. Fully extend legs.
• Recheck
Perform modified seated flexion test

- Patient’s ischial tuberosities bear equal weight
- Feet do not need to touch ground
- Physician palpates at medial border or PSIS at sacral base
- Patient flexes forward
- The side that moves more is the positive side (NOT THE ONE THAT MOVES FIRST)
- Palpate ILA, if it won’t move anterior, or the ILA is more inferior it’s positive
Still Technique: Sacrum diagnosis

- Sacrum Models
  - Mitchell: Every Osteopathic medical school instructs on this model
  - Chicago
  - Still is kind of like Chicago: only 4 diagnoses possible

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Seated flexion</th>
<th>ILA</th>
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</thead>
<tbody>
<tr>
<td>Diagonal Right</td>
<td>+ Right</td>
<td>+ Left (posterior, tight, long)</td>
</tr>
<tr>
<td>Diagonal Left</td>
<td>+ Left</td>
<td>+ Right</td>
</tr>
<tr>
<td>Unilateral Right</td>
<td>+ Right</td>
<td>+ Right</td>
</tr>
<tr>
<td>Unilateral Left</td>
<td>+ Left</td>
<td>+ Left</td>
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</tbody>
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*Table 10-3: Sacral diagnosis and criteria for the Still Technique.*

*Figure 10-1: Sacrum with three axes of motion. A: Superior pole. B: Middle pole. C: Inferior pole.*
Still Technique
Right unilateral sacrum seated

• Left hand sensing just medial to PSIS for relaxation
• Right hand and axilla are operating
• Patient’s left shoulder is brought anterior until SI joint relaxes (top photo)
• Introduce compression using operating arm
• Rotate the left shoulder posterior and the right shoulder anterior until sacral release is felt.
• Release force vector, retest
Still Technique

Right diagonal sacrum supine

- Both patient’s legs are flexed at the knees and hips
- Physician picks up both feet, increasing hip flexion to 90 degrees. Rotate feet to the left (top photo)
- Compression now added towards the sacrum
- Carry the knees toward the right across midline, the feet simultaneously swing right
- Once the knees reach about 45 degrees sidebent left, carry legs into extension.
- Release compression, recheck
References

• ATSU youtube channel
• The Still Technique Manual, 2nd Ed. Van Buskirk