Callidae Manus

Practical Manual

IMMEDIATE TREATMENTS

Vertebral Manipulations, Peripheral Manipulations And Therapeutic Exercises

RECOMMENDED PRODUCT

Dr. Marco Aruffo

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Manual

IMMEDIATE TREATMENTS With Vertebral Manipulations, Peripheral Manipulations and Therapeutic Exercises

Dr. Marco Aruffo

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Introduction

This video course is born from the request to learn, in an increasingly advanced way, what is the manipulative approach that allows me to be extraordinarily effective in treating most musculoskeletal conditions.

Now that you know how to identify and correct reversible painful dysfunctions and peripheral joint dysfunctions, it's time to see how to put them into practice step by step, specifically for each painful condition I'm going to explain.

I will teach you exactly how to use the **manipulations** you have already learned in the other 2 video courses, depending on the diagnosis with which your patient presents to you. I will also teach you the **therapeutic exercises** that I prescribe to my patients and that, in most cases, make the difference in solving a lot of musculoskeletal problems.

If you also purchased this video course, it means that you trusted me again, and you know that what I propose is a set of techniques and clinical reasoning often supported by scientific studies, but which are basically the result of my direct experience and continuous reworking.

For this reason, my advice is to try what you will learn in this video course with your patients, even if some reasoning may seem different from what you have learned in physiotherapy and rehabilitation.

Fields of application

Cervicalgia and Cervicobrachialgia

Painful shoulder:

- **Calcific or non-calcific periarthritis**
- **Conflict syndrome or impingement**
- Subacromial bursitis
- Adhesive capsulitis or frozen shoulder
- **Rotator cuff injury**
- **Calcific tendonitis or tendinopathy of the tendons of the rotated cuff.**
- Grade 2 glenohumeral arthrosis

Lombalgia and Dorsalgia

Sciatalgia and Lombosciatalgia

Cruralgia and Lombocruralgia

Epicondilitis and Epitroclitis

Carpal tunnel syndrome and wrist tendonitis

Gonalgia, Meniscosis, Patella tendinopathy

Groin pain or rectal-adductory syndrome

Metatarsalgie, Plantar Fasciitis

Trochanteritis and Coxalgia

Paramorphism correction: Scoliosis, Hyperlordosis and Hyperkyphosis

Contraindications

Although this is an advanced course and you are supposed to already know the contraindications to vertebral and peripheral manipulations. However, I wanted to bring you back a list, summarizing the contraindications also for the immediate treatments that I teach you in this course.
For more information about the contraindications to vertebral manipulations read the manual of the course vertebral manipulations.
It is necessary to distinguish between absolute and relative contraindications.

Absolute contraindications

- All tumor diseases
- Infectious diseases
- Fractures
- Osteoporosis
- Prosthetics
- Pott's disease (tubercular spondylitis)
- Malformations of the cervical-occipital hinge
- Signs of vertebro-basilar insufficiency

Relative contraindications

- The patient is afraid of manipulation
- The operator does not have perfect mastery of the techniques
- Depression and/or severe psychiatric problems

CERVICALGIA AND CERVICOBRACHIALGIA

I am a bit attached to the meaning of words but, in my opinion, even this fixation has led me to effectively rework many treatments of various painful conditions.

My clinical reasoning is based on the fundamental principle of manual therapy, that is, self-healing, and, in the case of cervicalgia and cervicobrachialgia, therefore, we will also correct the reversible painful dysfunctions with the cervical and peripheral manipulations that may result from this painful condition.

As you have already seen in my course on Vertebral Manipulations, not even here I wanted to insert the pre-manipulative test to test for a possible presence of risk of insufficiency vertebro-basilar, and this is because now many studies report that it is not certain that the validity of these tests, given the presence of many false negatives. Moreover, the same studies say that if there is a pre-existing arterial dysfunction and the bloodstained step the pre-manipulative scan is blocked, the same can be dangerous.

Below I leave you an excerpt of an article in English to understand where these studies come from.

> *From several studies evaluating arterial blood flow with Doppler studies it has become apparent that the postulated changes in blood flow thought to occur during the pre-manipulative screening do not always occur in the rotation/extension position, and therefore the validity of the these screening tests is questioned. Firstly, if the test does not fully evaluate the integrity of blood flow, then false negatives will occur, meaning that the safety of performing cervical manipulation has not been determined. Secondly, if there is a pre-existing defect in the vertebral artery and blood flow occlusion does occur, the tests themselves may be dangerous (Thiel & Rix., 2005).*

Other studies have shown that the stretching of cervical arterial vessels was not significant, except to a lesser extent than the normal actions generally performed in the quoti- dianity, such as the rotation of the head and neck to do reverse.

I wanted to make this preamble to you because I know how controversial this topic is and it arouses fears both for the health care professional and for the patients. So it is good that you have the certainty of treating patients with a medical diagnosis, but once you have excluded all the absolute contraindications to vertebral manipulations and evaluated those related, feel confident to be able to help your patients as never before with these manipulative techniques and with the clinical reasoning that I am going to teach you.

Cervicalgia

The word **cervicalgia** literally means cervical pain, because the suffix "*algia*"
Means pain.

The first symptom of cervicalgia is the pain, and is usually localized on the neck laterally and posteriorly, almost never anteriorly. If you suffer from acute cervicalgia you can also get to have dizziness and, usually, these symptoms can be caused by what is commonly referred to as the tuberculosis technique.

Musculoskeletal causes are generally muscle tension, protrusions or hernias of the cervical disc and arthritic degeneration.

Cervicobrachialgia

The term **cervicobrachialgia**, on the other hand, indicates precisely cervical and brachial pain, that is, along the arm, because in medicine the suffix "*algia*" means pain as we have said.

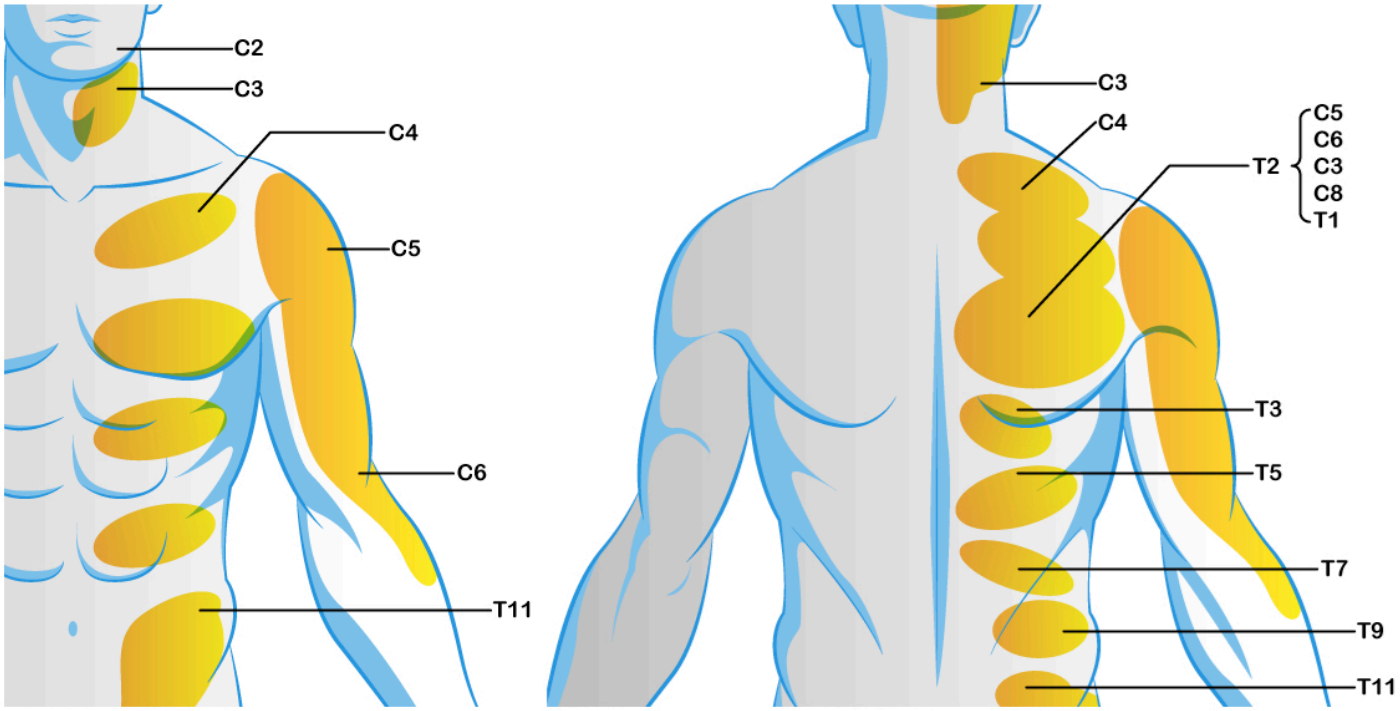
The first symptom is the pain and is usually located on the neck laterally and posteriorly and along the arm. If you suffer from cervicobrachialgia you can, therefore, have pain both cervical and along the arm to the hand and fingers. The musculoskeletal causes of this pain are therefore generally muscle tension, cervical disc hernias or cervical arthritic degeneration.

Compared to cervicalgia this painful condition is almost always associated with the pre- without one or more protrusions or cervical hernias, which compress the brachial plexus. In addition to pain, this condition is often characterized by the presence of paresthesias and functional impotence.

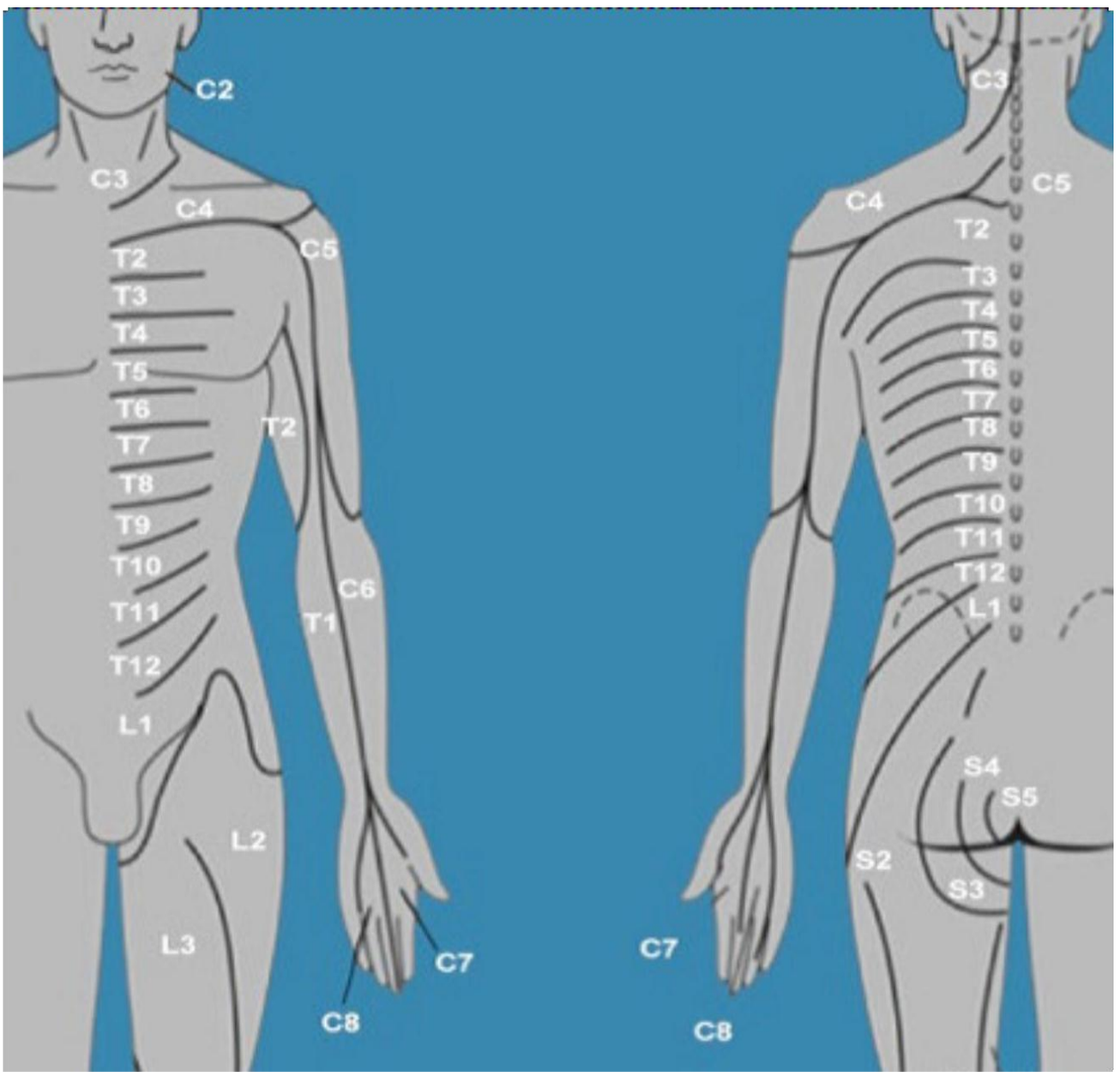
My manipulative approach to treating both these painful conditions is the same, and it is always aimed at reducing symptoms, through the use of manipulations and at achieving a musculoskeletal balance, through the execution of therapeutic exercises, which I prescribe to patients and which I will obviously teach you.

In the videos you will understand well how to adapt the various manipulations, depending on the pain and symptoms your patient has, and I recommend that you always consult the two maps below, which I have cut out specially, and which you already know from the previous course Vertebral Manipulations.

Pain mapping



Dermatome mapping



Cervicalgia and Cervicobrachialgia Treatment

- ✓ Cervical Manipulations
- ✓ Cervico-Thoracic Manipulations
- ✓ Double Chin Exercise
- ✓ Cervical Stretching Exercise
- ✓ Shoulder blades squeezed exercise (2 variants)
- ✓ Brachial Plexus Decompression Exercise
- ✓ Pyramidal Progressions

Painful shoulder

I am very happy to teach you in detail my approach to the **painful shoulder**, which I had already mentioned in previous courses, but this time I will follow you step by step to teach you what I call a truly effective method (unconventional) to treat the diagnoses that I list below:

- Calcific periarthritis
- Conflict syndrome or impingement
- Subacromial bursitis
- Adhesive capsulitis or frozen shoulder
- Rotator cuff injury
- Tendonitis or calcific tendinopathy of the rotator cuff tendons
- Grade 2 glenohumeral arthrosis
- Tendonitis/Injury of the supraspinatus or of the long head of the biceps.

I also added adhesive capsulite because, in many cases, my method was win- This diagnosis is also important; however, you should know that in some cases, and when special- Metabolic diseases such as diabetes, hypertension or hypothyroidism, even in the case of my method may not be effective, unfortunately.

I have developed a valid and effective method for all the painful conditions that I have given you above. These are clinical techniques and reasoning that I have learned together with my own personal experience and experimentation.

My approach to the painful shoulder considers and treats this set of joints as a single functional unit, so the manipulations I will teach you will realign this functional unit, so as to facilitate the healing of all the soft parts that compose it.

I assure you that, in the vast majority of cases, what I am about to teach you is a method that will make you succeed where most of your colleagues fail, and I am very happy to teach you.

Why does it work?

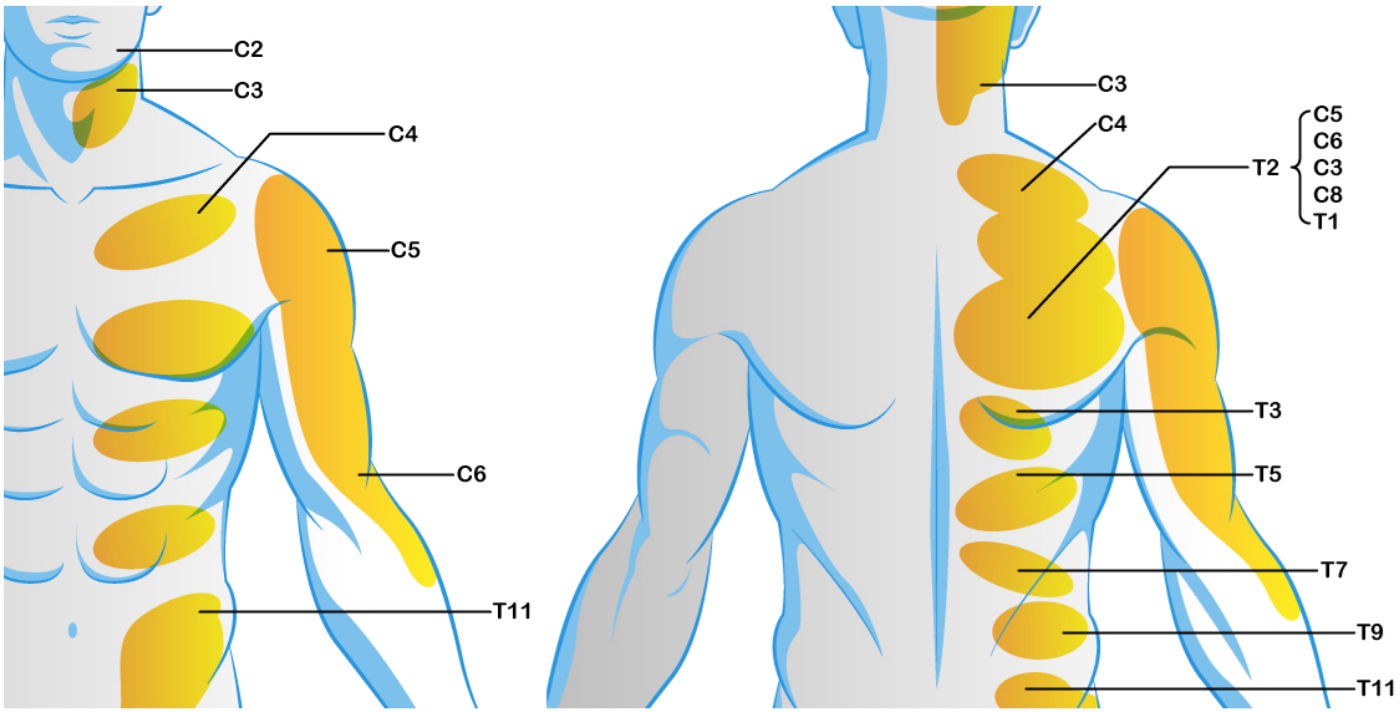
You should know that the shoulder has an extraordinary ability to compensate for any injury and / or anatomical degeneration, so many research studies show that often the rotator cuff lesions are only occasional findings and therefore not related to the symptoms of the patient.
The same is almost always true for the hook acromion, which is rightly blamed for generating the conflict syndrome, when instead it is not at all so, also because many things do not return, including the fact that the painful shoulder is almost always one and the hook acromion instead is alwaysquasisre bilateral

Not to mention the shoulder calcifications that are often bombarded with shock waves and quiet if you do so too :) Not many people know that the overwhelming majority of calcifications are extrarticular and have little to do with shoulder pain and functional impotence.

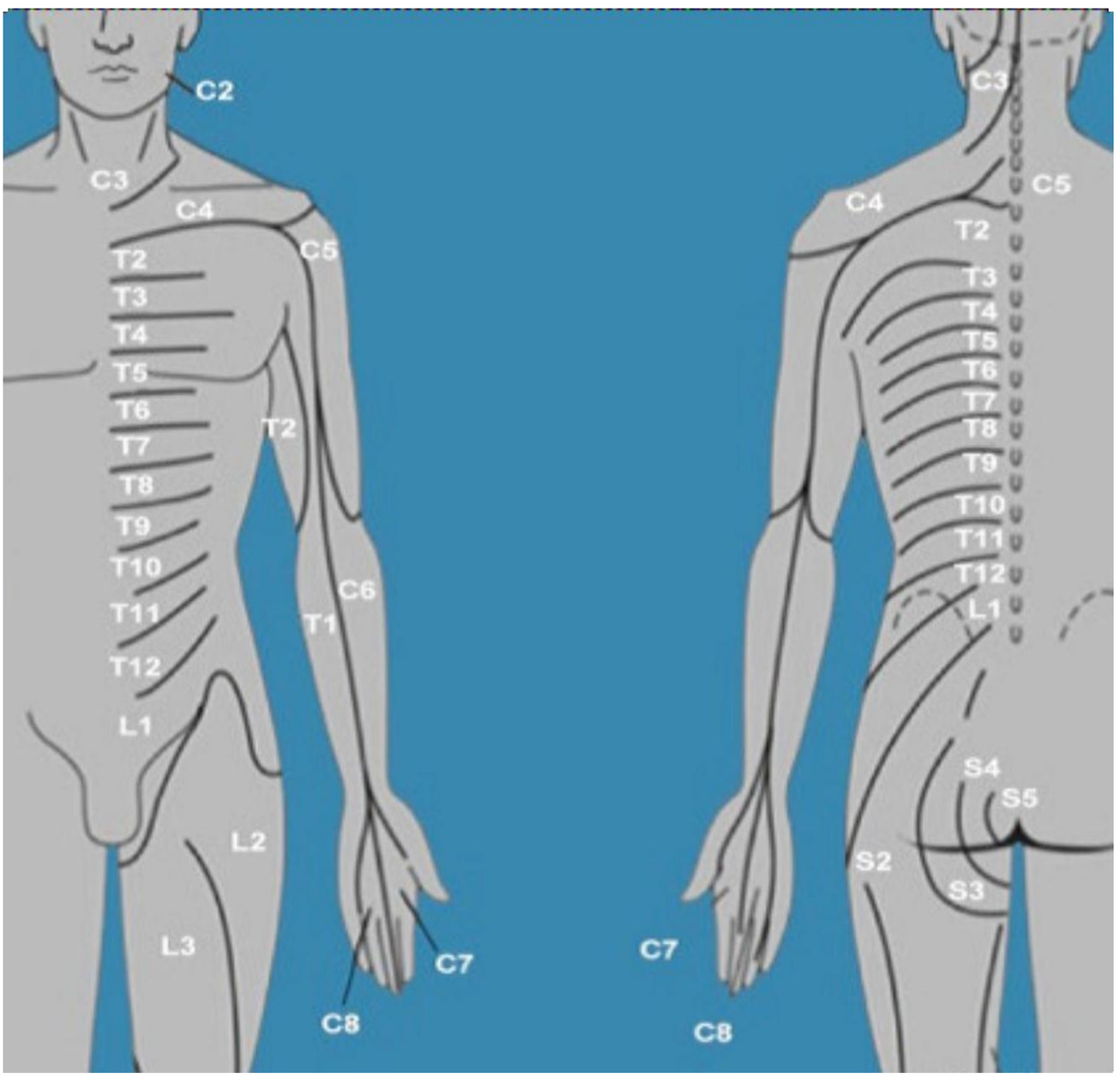
When you put your shoulder in the best condition, thus making it "work at the top", the recovery is almost always total and from experience I tell you that it is often, even in pre- without major muscle-tendon injuries.

In the event that your patient presents with numerous recurrent dislocations, ligament laxity or SLAP, unfortunately my method, in that case, is almost never successful, but we talk about rare conditions, compared to the cases that will arise, where instead you can almost always avoid a shoulder surgery to your patients and be effective where many of your colleagues are not losers.

Pain mapping



Dermatome mapping



Painful Shoulder Treatment

- ✓ Cervical Manipulations
- ✓ Cervico-Thoracic Manipulations
- ✓ Scapulo-Thoracic Manipulations
- ✓ Elbow flexion variant (see video)
- ✓ Scapulo-Omeral Manipulation
- ✓ Standing variant (only in certain cases)
- ✓ Sterno-Clavicular Manipulation
- ✓ Shoulder blades squeezed exercise (2 variants)
- ✓ Global reinforcement ½-litre bottle

My advice as I told you is to consider the shoulder, and then treat it as a **single functional unit**, without reasoning clinically on each muscle and separate function, as I was wrongly doing.

Lumbago, Dorsalgia

Obviously, these are both very common painful conditions and concern patients who can present themselves with back and lumbar pain every day in your practice.

I remind you that diagnosis and magnetic resonance imaging always allow you to manipulate safely and I therefore always invite you to exclude all contraindications before injecting the treatment.

We will treat both of these common painful conditions with a global approach and you will see that your patients will be amazed by the immediate results, but, I recommend, always emphasize to your patients the importance of the exercises I teach you,

Because they really make the difference in the long and short term, so by doing so you will be able to very often prevent a relapse of your patient.

Lumbago

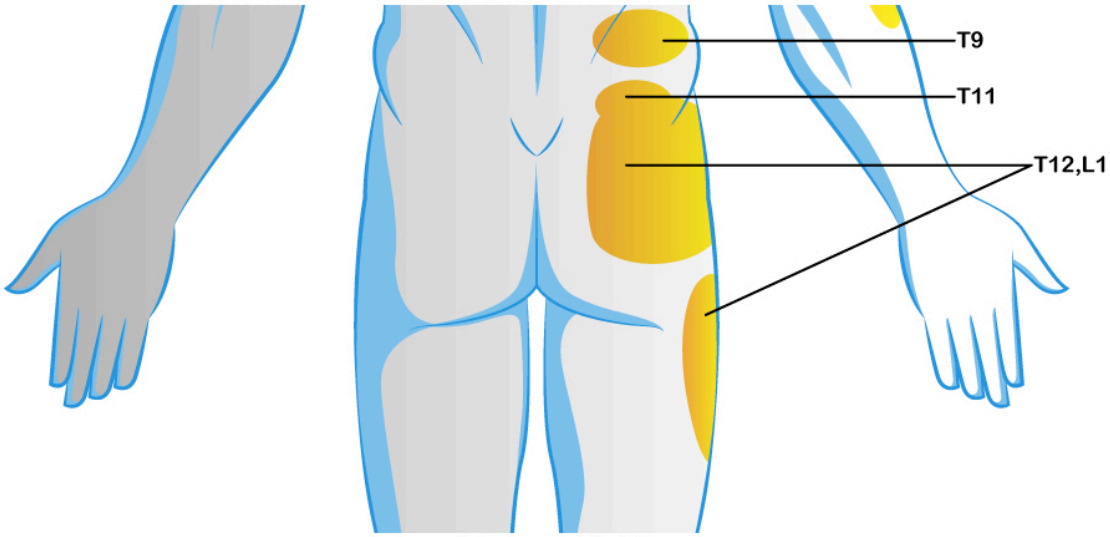
The main causes of **low back pain** are: protrusion or hernia of the lumbar disc, stenosis of the lumbar canal, discopathy, spondylolisthesis (anther and back), and arthritic degeneration with formation of osteophytic beaks and muscle contractures.

Overweight, obesity, sedentary lifestyle, stress, bad posture and incorrect lifting of excessive weights can all be predisposing factors. The initial symptom is obvious pain, then there may also be a lack of strength and alteration of almost all daily movements.

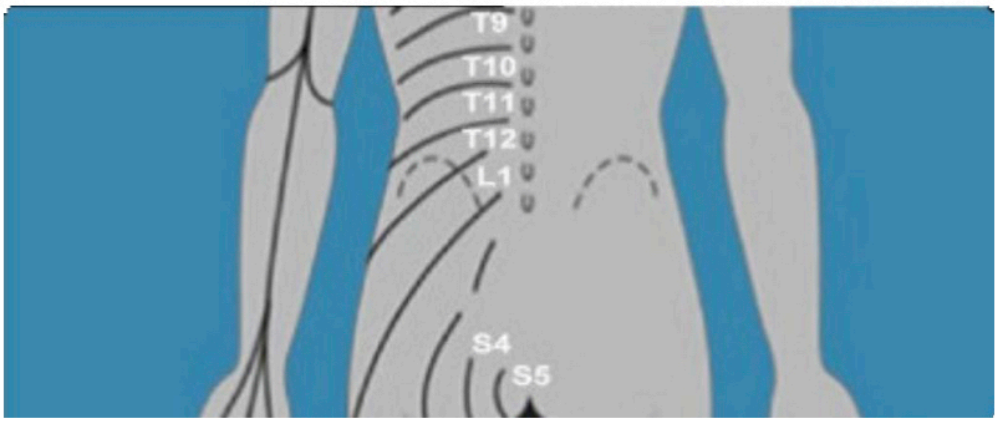
My advice remains to always evaluate your patient well, with the various tests I taught you and, therefore, with the functional, palpatory and spinous processes. Then always take as reference the maps that I enclose here below to be able to be preci- fer and give immediate benefit to your patients.

Even if by following the mappings you can really be a sniper of good :), my advice is to always have a global manipulative approach and, even if your patient feels good after a manipulation, recreate a global balance to the whole column by doing what you define as expressive education.

Pain mapping



Dermatome mapping



Lombalgia Treatment

- ✓ Direct Thoracic Manipulations
- ✓ Pyramidal progressions

Dorsalgia

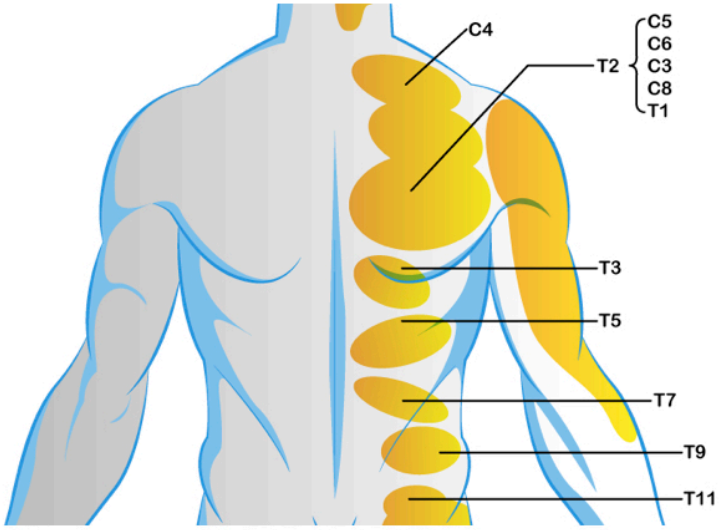
As with lumbago, the main causes of **dorsalgia** are: protrusion or hernia of the dorsal disc, stenosis of the dorsal canal, discopathy, spondylolisthesis (anther and back), arthritic degeneration with formation of osteophytic beaks and muscle contractures.

Predisposing factors can be overweight, obesity, sedentary lifestyle, stress, bad posture and incorrect lifting of excessive weights. The initial symptom is obvious pain, then there may also be a lack of strength and alteration of simple daily movements.

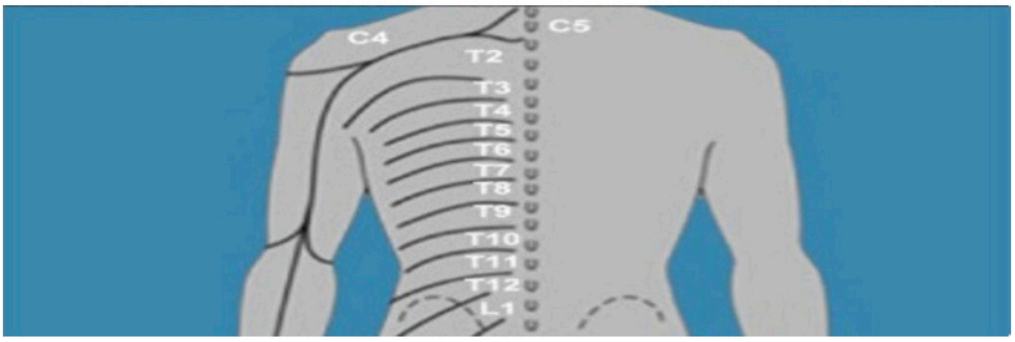
I want to be repetitive in advising you to evaluate your patient well, with the various tests I taught you and, therefore, with the functional, palpatory and spinous processes. Then always take as reference the maps that I enclose here below, to be able to be preci- fer and give immediate benefit to your patients.

Even if by following the maps you can really be a wellbeing sniper, as I told you before, my advice is to always have a global hands-on approach and, even if your patient feels good already after a manipulation, recreate a global balance of the whole column, performing a spinal re-education.

Pain mapping



Dermatome mapping



Dorsalgia Treatment

- ✓ Cervico-Thoracic Manipulations
- ✓ Direct Thoracic Manipulations
- ✓ Seated Dog Technique
- ✓ Dorsalgia Exercise
- ✓ Shoulder blades squeezed exercise (2 variants)
- ✓ Pyramidal progressions

Sciatalgia and Lombosciatalgia

In medicine, sciatalgia is defined as a pain that radiates to the leg from the back to the foot. This pain can also start from the back and radiate posteormente along the whole leg up to the foot and, in that case, we talk about lumbosciatica.

Typically, these symptoms appear only on one side of the body, although in some cases they may be present bilaterally.

Weakness or numbness can occur in various parts of the leg and foot. About 90% of cases of sciatalgia are due to a herniated disc that, by pressing on one of the roots of the sciatic or ischial nerve, can generate a sciatalgia.

I remind you that the sciatic nerve is formed by the roots present between L4 - S3.

Other diseases that can lead to sciatalgia include spondylolisthesis, spinal stenosis, pyriform syndrome, pelvic tumors and compression due to the head of the fetus during pregnancy.

Generally, the pain travels from the back of the thigh to the back of the stinch and can also extend upwards, up to the hip or down to the foot. In addition to pain, there may be a feeling of numbness, paresthesias and difficulty in moving or controlling the leg, hence functional impotence.

Regardless of the musculoskeletal cause that caused sciatalgia or lumbosciatica, I advise you to always reason by looking at the maps that I enclose below and evaluate your patient with the functional test, palpatory and spinous processes.

In most cases you will have patients who will present with a sciatalgia on one side only and, in that case, my advice is to give space at a manipulative level only on the side of sciatalgia and in a very specific way, because in these cases, from experience, I tell you that the direction you give to the manipulations makes the difference in terms of regression of the symptoms and welfare of the patient.

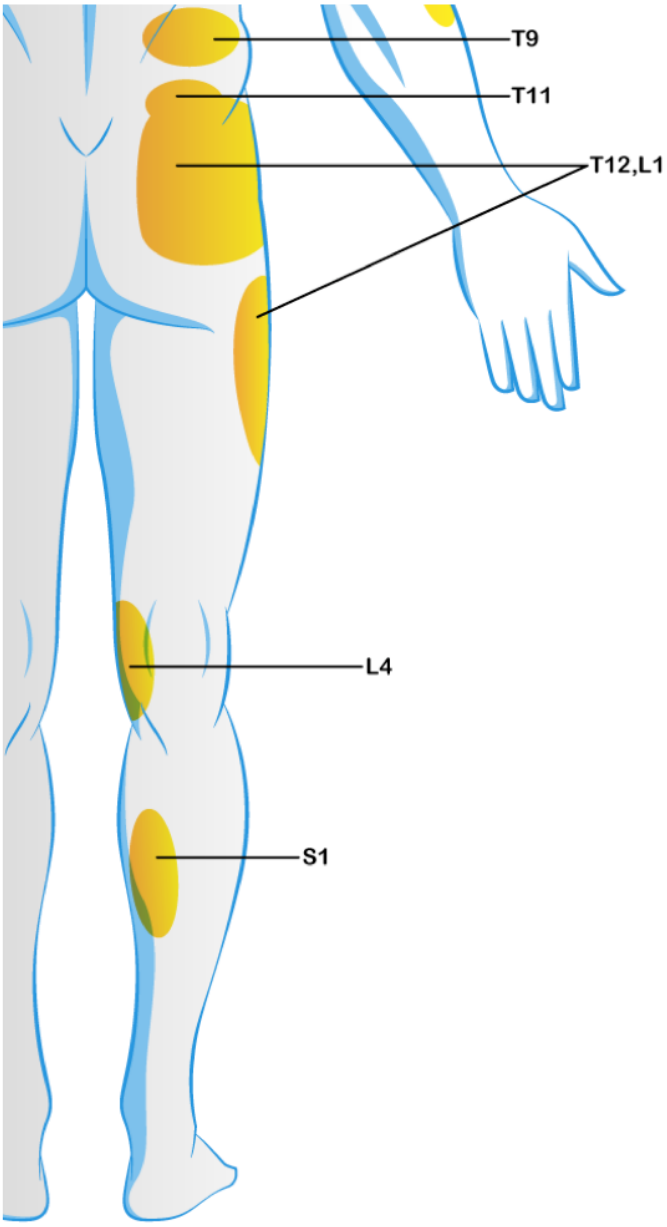
For example, let's imagine that our patient has a right sciatalgia and a disc hernia L4-L5 or L5-S1 paramediana right, my advice in this case is to manipulate always opening to the right, then, Lumber Roll with the patient on the right side, and direct lumbar and thoracic manipulations, pushing the spines from right to left.

Don't worry, in the video I repeat this reasoning and, at this point, it will already be clear to you, but I wanted to repeat it to you, because I found that first of all many other manipulative approaches open and close, then compress and decompress, for example by making a Lumbar Roll on both sides and on the same segments, even in case of herniated paramedian disc.

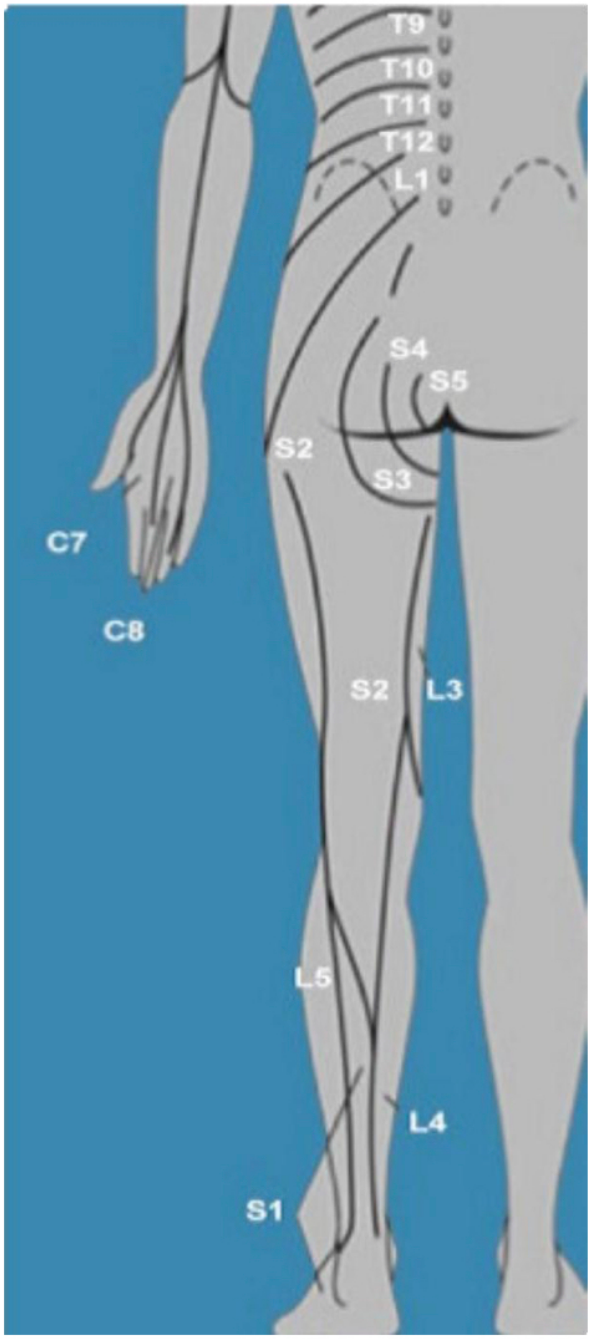
If your patient comes to you with bilateral sciatica, there will always be a prevalence of symptoms on one side over the other and therefore, in that case, my advice is to give priority to the most symptomatic side by first manipulating that and then the other. Also remember that, in those difficult cases, when we have patients with hernias and/or multiple disc protrusions, you can be a sniper using the maps that I attach.

From experience I can tell you that if you follow my clinical reasoning, you will almost always be effective and you will also help the patients that other colleagues of yours were not able to help, even if they also adopt a manipulative approach.

Pain mapping



Dermatome mapping



Sciatalgia and Lombosciatalgia Treatment

- ✓ Direct Thoracic Manipulations
- ✓ Direct lumbar manipulations
- ✓ Lumbar Roll
- ✓ Periformis stretching
- ✓ Pyramidal progressions

Cruralgia and Lombocruralgia

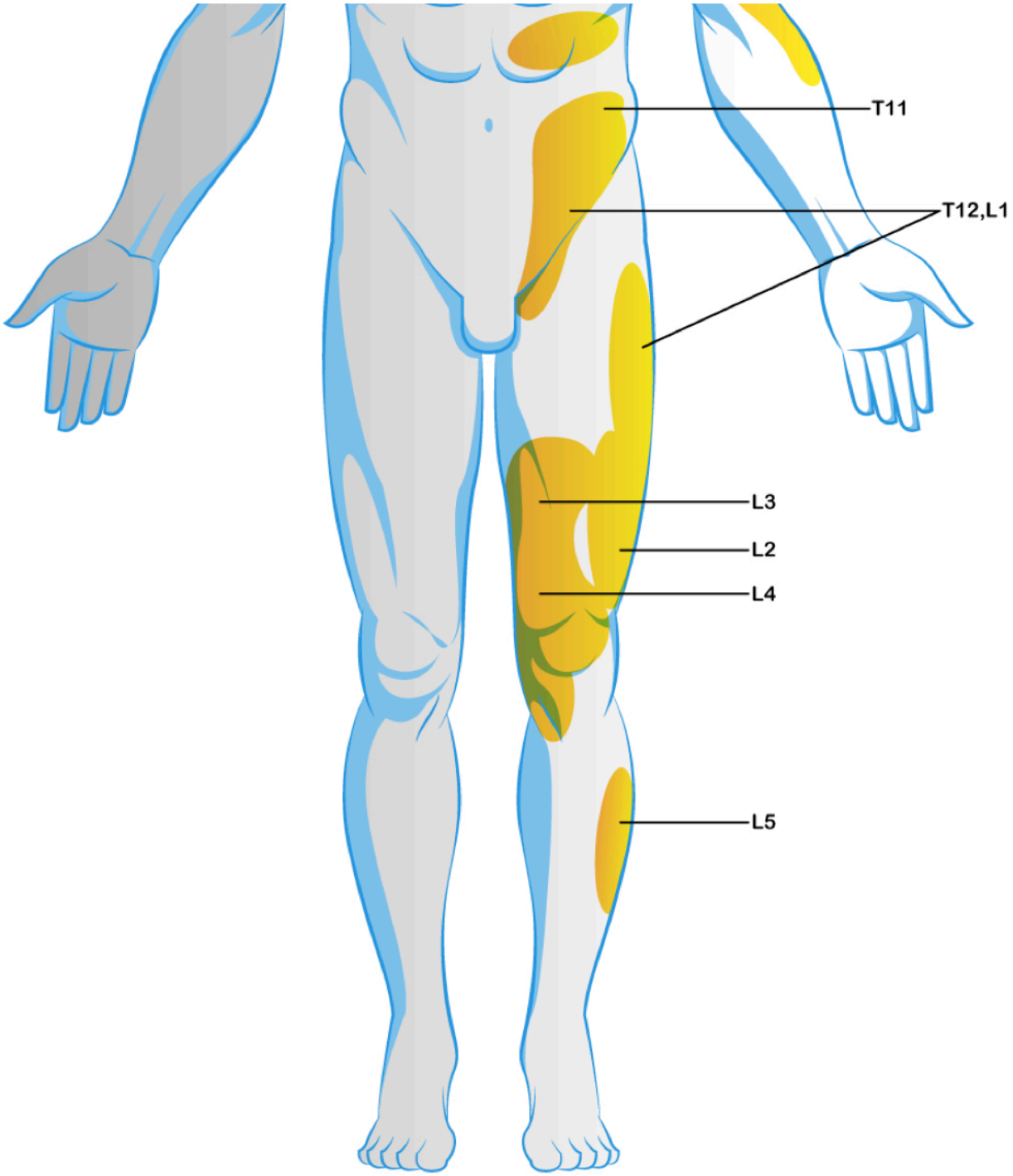
First of all, it is important to know that the cruralgia or umbocruralgia is a pain that can occur along the territory of innervation of the femoral or crural nerve.

Pain in case of cruralgia can radiate to the groin, to the thigh anteriorly and up to the knee. The difference with lumbocruralgia is only in the added lumbar pain which, on the other hand, may be absent in case of cruralgia.

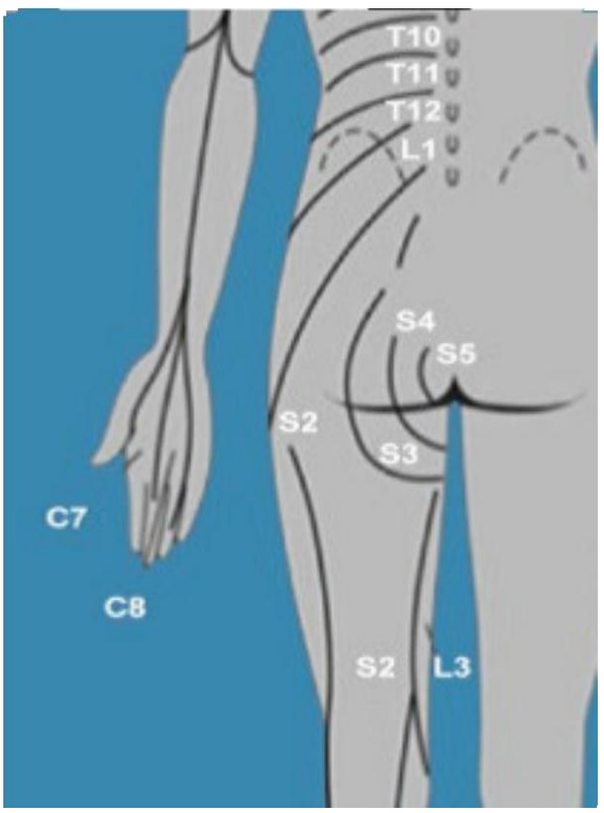
The symptoms are therefore pain, paresthesias (tingling) and muscular deficit in the area anterior to the thigh, groin and up to the knee.

The causes, usually, are attributable to one or more hernias of the disc or protrusions of the tract between the nerve roots L2 - L4, that is, to the lumbar vertebral discs of those segments.
Again, most of the time, you will have patients who will present with a cruralgia on one side only and in that case my advice is always to give space to manipulative level only on the side of the cruralgia.

Pain mapping



Dermatome mapping



Cruralgia and Lombocruralgia Treatment

- ✓ Direct Thoracic Manipulations
- ✓ Direct lumbar manipulations
- ✓ Lumbar Roll
- ✓ Modified Chicago Technique
- ✓ Stretching Ileo-psoas and Quadriceps
- ✓ Pyramidal progressions

Epicondilitis and Epitroclitis

Epicondylitis, (precisely humeral epicondylitis), literally means inflammation of the epicondyle, which, however, consists in an inflammation of the tendons that weigh on the elbow and, more precisely, on the lateral epicondyle. This inflammation, depending on the degree, can be very painful and since it very often affects tennis players, it is also called the tennis elbow.

Epitrocleite, on the other hand, literally means inflammation of the epitroclean, and the area of the elbow concerned is the medial area. This painful condition is also often called a golfer's elbow.

Although many sportsmen often suffer from these painful conditions, there are many other categories that can suffer from them such as pianists, musicians in general, writers and all people who put a lot of stress on these joints.

Very often, microtraumatisms are the number one cause of these painful conditions - whether and as a result, repetitive movements, whether at work or in sports, and direct traumas - resulting in inflammation of the tendon insertion of these muscles on the elbow.

Usually, the pain is subtle and manifests itself during the combined use of the hand, wrist and elbow. The pain may increase in the evening or after the day. Usually, the symptoms become more intense due to the extent and duration of the pain, with a greater impact on the functionality and progressive reduction of the working life, until what is called a real functional antalgic impotence.

The diagnosis is almost exclusively clinical, although the ultrasound examination may showthe presence of endotendinous degeneration.

My manipulative approach to these two painful conditions is based on the gradual

Restoration of normal loads and stresses on the elbow.

In addition to the cervical and cervical-thoracic tracts, the wrist is particularly important because, very often, it is the dysfunctions of the wrist that cause the elbow to vraccarcate and trigger the mechanisms that can lead to epicondylitis or epicondylitis.

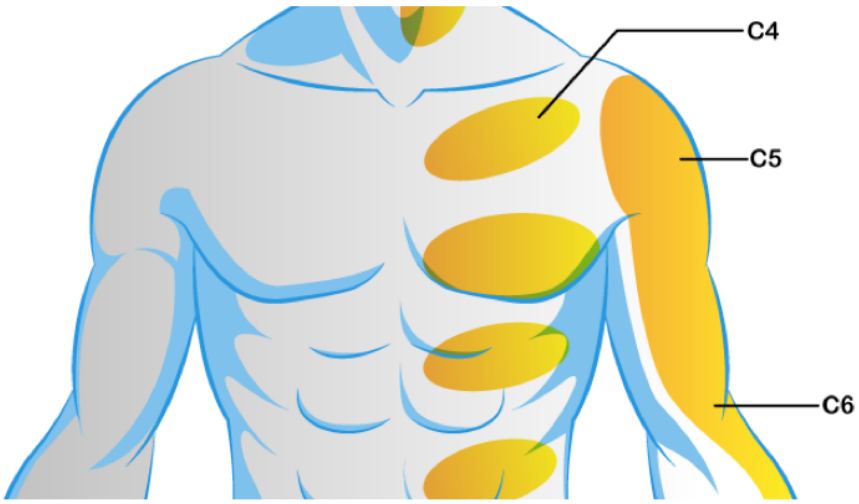
In fact, I remind you that in epicondylitis the tendon most involved is that of the short radial extensor muscle of the carpus and in epitrocleite it is the tendon of the radial flexor muscle of the carpus.

To manipulate the wrist, first perform the palpation to determine whether you should, for example, sterilize or anteriorize the semi-moon. Generally in epicondylitis you will always have to

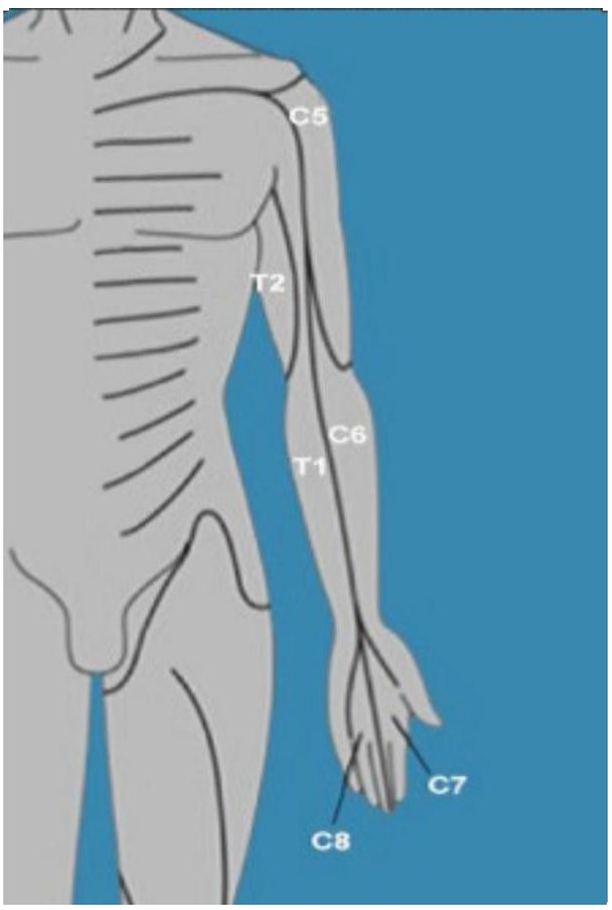
anteriorize the semi-moon and then push it from the posterior to the anterior, whereas in the case of pitrolcleite you may find the anteriorized semi-moon and/or distal radius and then you will have to posteriorize.

As for the other painful conditions, we will treat both the vertebral segments involved and the peripheral joints, which may have a biomechanical correlation with the elbow.

Pain mapping



Dermatome mapping



Epicondylitis and Epitrocleitis Treatment

- ✓ Cervical Manipulations
- ✓ Cervico-Thoracic Manipulations
- ✓ Direct Thoracic Manipulations
- ✓ Scapulo-Thoracic Manipulations
- ✓ Scapulo-Omeral Manipulations
- ✓ Standing variant
- ✓ Wrist and elbow manipulations
- ✓ Flexor exercises and wrist extensors + squessed shoulder blades
- ✓ Pyramidal progressions: flag

Carpal tunnel syndrome

The **carpal tunnel** is a passage located at the palm of the hand, and is formed by the bones of the carpus and the transverse ligament of the carpus, which serves as the roof for this tunnel.

The thing that is almost never said, is that in the carpal tunnel there passes only 5% of the median nerve so, the compression, even if there may be in the tunnel, is always present along with other compressions throughout the course of the median nerve.

Therefore, this syndrome (a set of symptoms) is often called Double Crush Syndrome
By people, i.e. double crushing syndrome.
Since the compressions far from the tunnel are often even greater than those present in the carpal tunnel, it is very important to carry out a conservative therapy to decompress the median nerve throughout its course and not only in the carpal tunnel.

In my opinion, surgery, as a solution to carpal tunnel syndrome, should therefore be proposed only when conservative therapy has failed and this because, even if it is a minimally invasive operation, it can still have complications, as well as recurrence.

Obviously, when the patient has chronicized and the enervation of the muscles involved has been prolonged for a very long time, so as to cause a significant hypotono-trophy of the muscle eminence tenar especially, the surgery could be the only solution even if, in my experience, an attempt to try to avoid it would still be indicated.

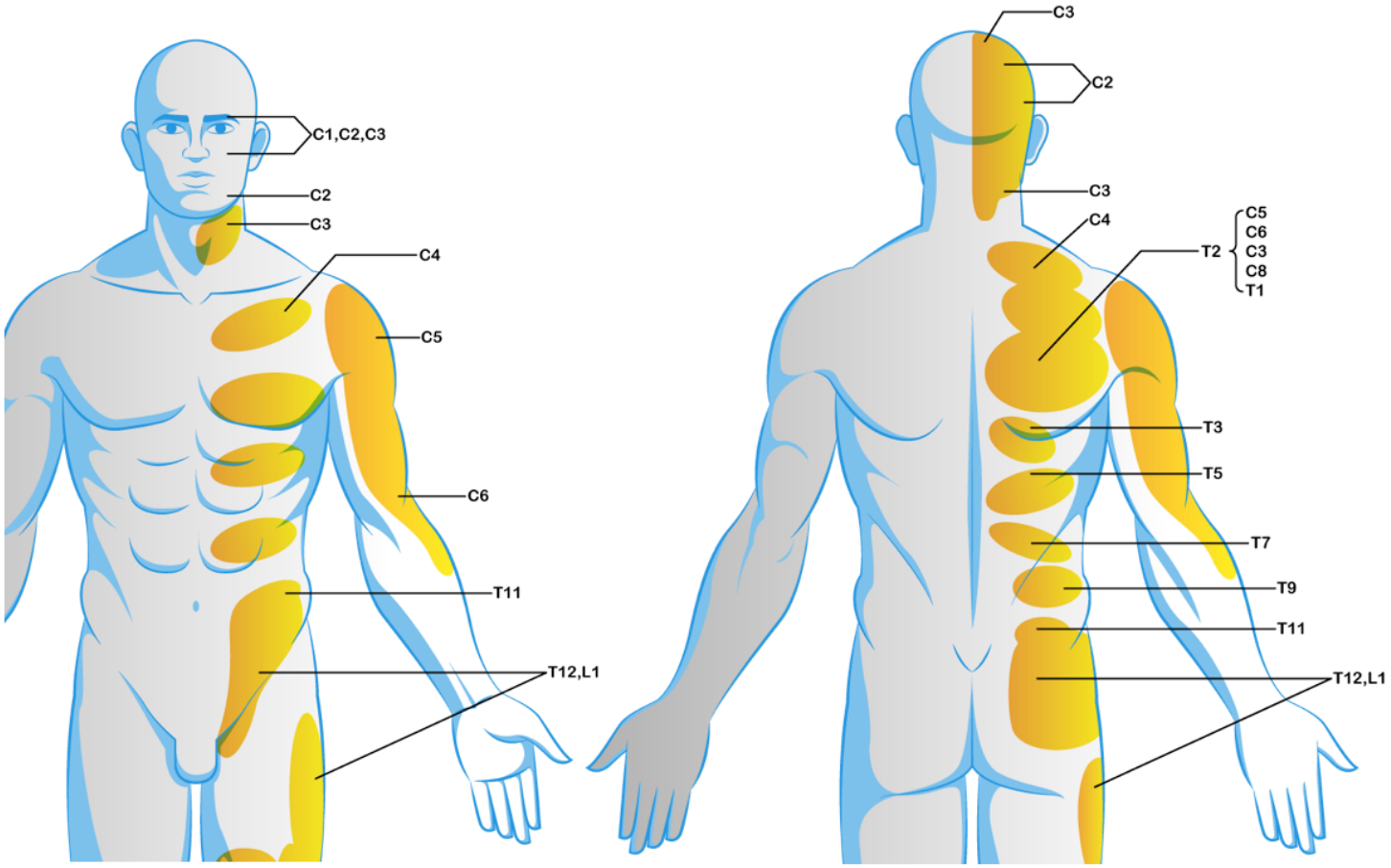
My manipulative approach in this case will in fact follow the reasoning of the double Crushingevenly on the basis of the English definitionDoubleCrushSyndrome.

For tendonitis of the wrist follows the same clinical reasoning, so, even in this case, I recommend that you follow the maps of pain and that of the dermatomeric areas and always evaluate your patient globally, as I explain in the video.

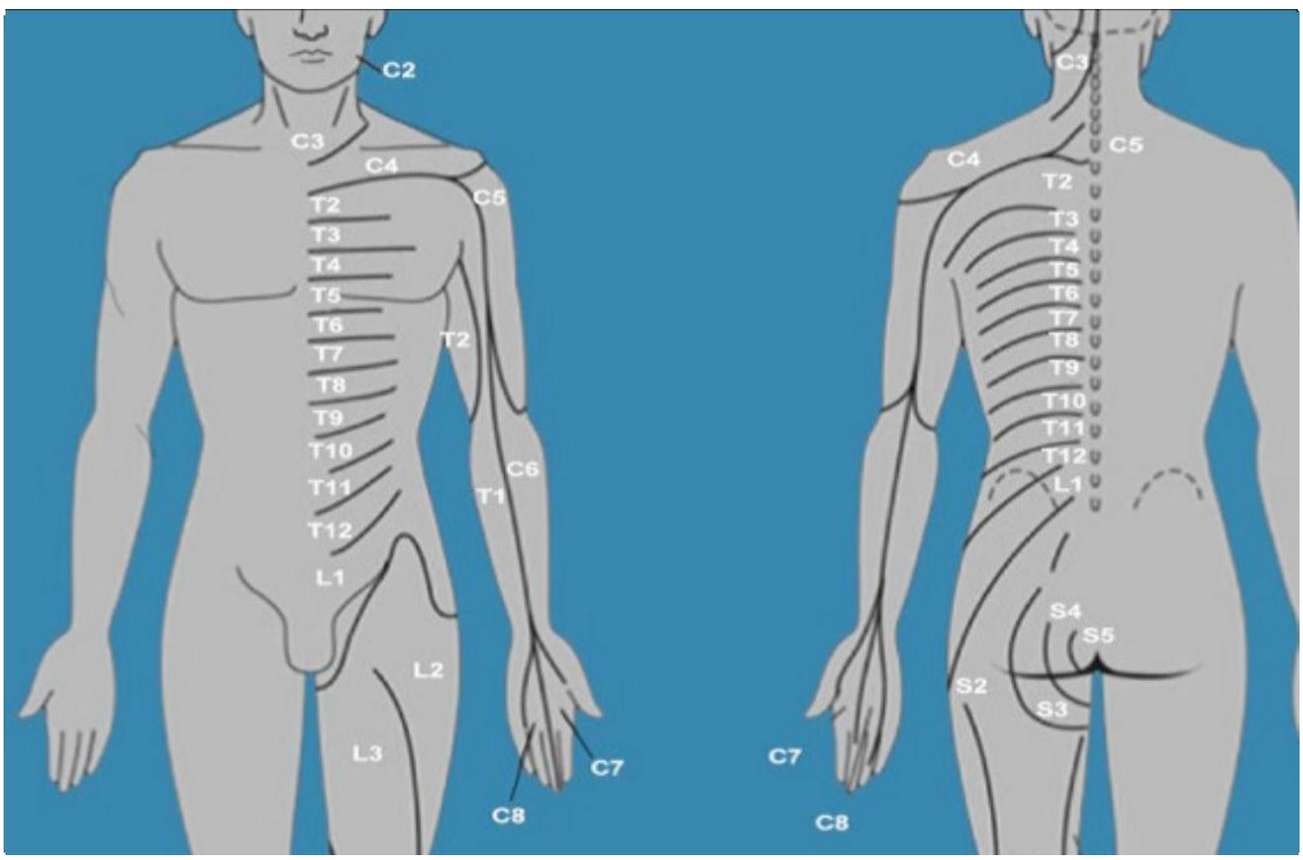
Obviously, in the case of wrist tendonitis, radicular compression is certainly lower than in carpal tunnel syndrome, but in this case vertebral manipulations will help us to rebalance the loads on the wrist.

With regard to both **carpal tunnel syndrome and wrist tendonitis**, you refer more to dermatomeric mapping than to pain mapping, because in the latter you find a poor representation of the painful area concerned.

Pain mapping



Dermatome mapping



Carpal Tunnel Syndrome Treatment

- ✓ Cervical Manipulations
- ✓ Cervico-Thoracic Manipulations
- ✓ Wrist and elbow manipulations
- ✓ Exercises: carpal tunnel decompression
  + Brachial plexus decompression
- ✓ Pyramidal progressions: flag

Gonalgia, Meniscosi, Patella tendinopathy

We already know that "**gonalgia**" is a generic term for knee pain, meniscosis is a degeneration that can affect one or more menisci and the patellar tendon is a knee disorder affecting the patellar tendon.

Meniscosis, by itself, may not give symptoms and may only be an occasitic finding; in gonalgia the pain may be non-specific and, instead, in patellar tendinopathy the pain usually affects the part of the tendon below the patella, and almost always the pain is caused by a continuous solicitation of the patellar tendon.

My manipulative approach, as always, involves the use of both vertebral and peripheral manipulations and will be useful in all three painful conditions and, even more so, in **patellar tendinopathy**, because we know that it is often caused by a misalignment of the tibia and femur with the patella, or by excessive rotation of the tibia.

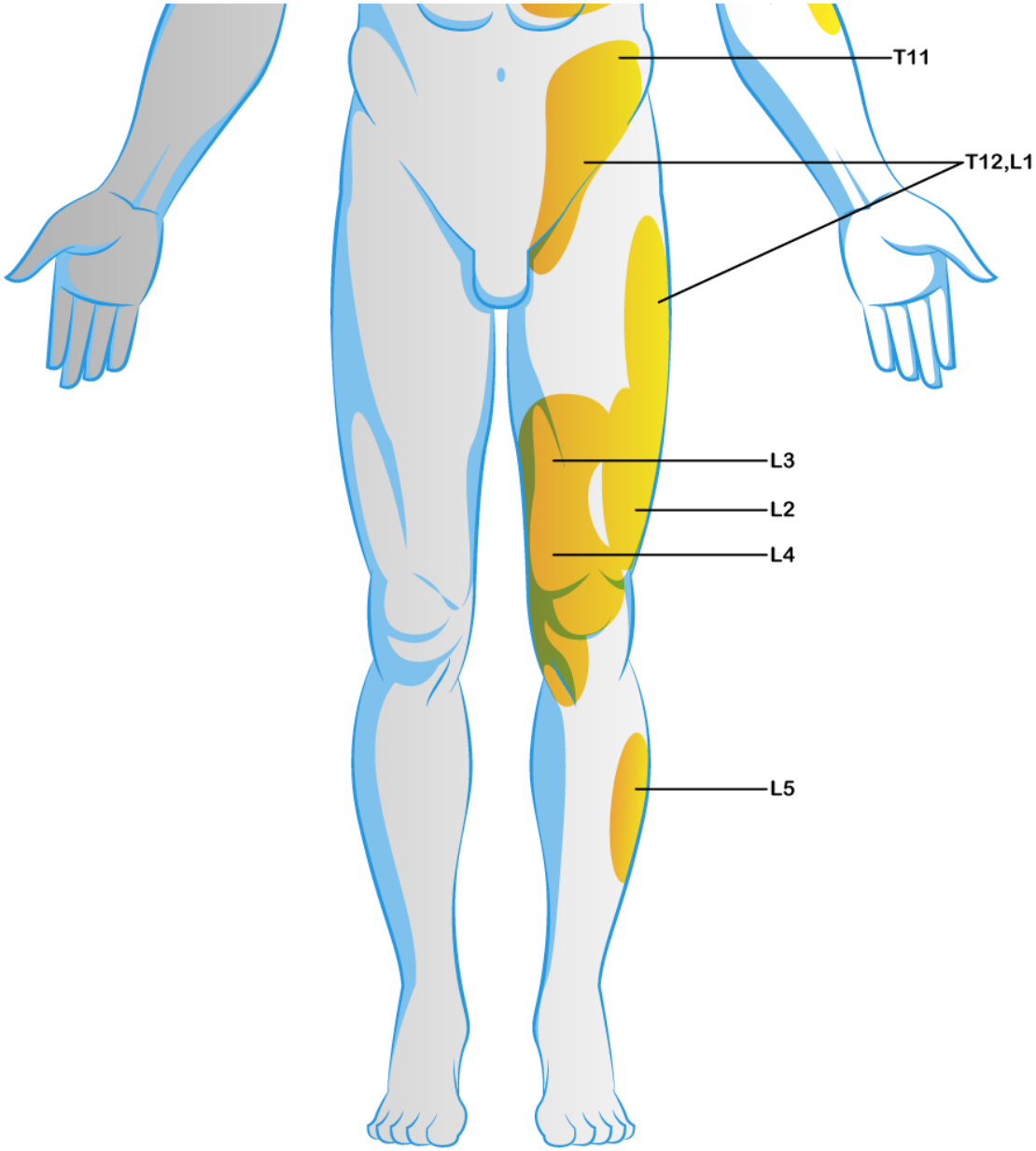
To get in tune with my manipulative approach to the problems of eye pain, you have to consider it as a victim, because in reality it is a joint victim of the loads it suffers from above and, therefore, from the spine, hip and ankle, but not only.

Yes, not only because if you are a true "biomechanic" you will realize that even a shoulder problem, especially on a weightlifting or crossfit sportsmandoing overhead exercises such as squat snatch in the presence of a more or less important shoulder problem, can go to overload the knee and give a problem just so far away from the site of the initial pain. That's why your approach must always be global and you have to start thinking about how they relate to each other.

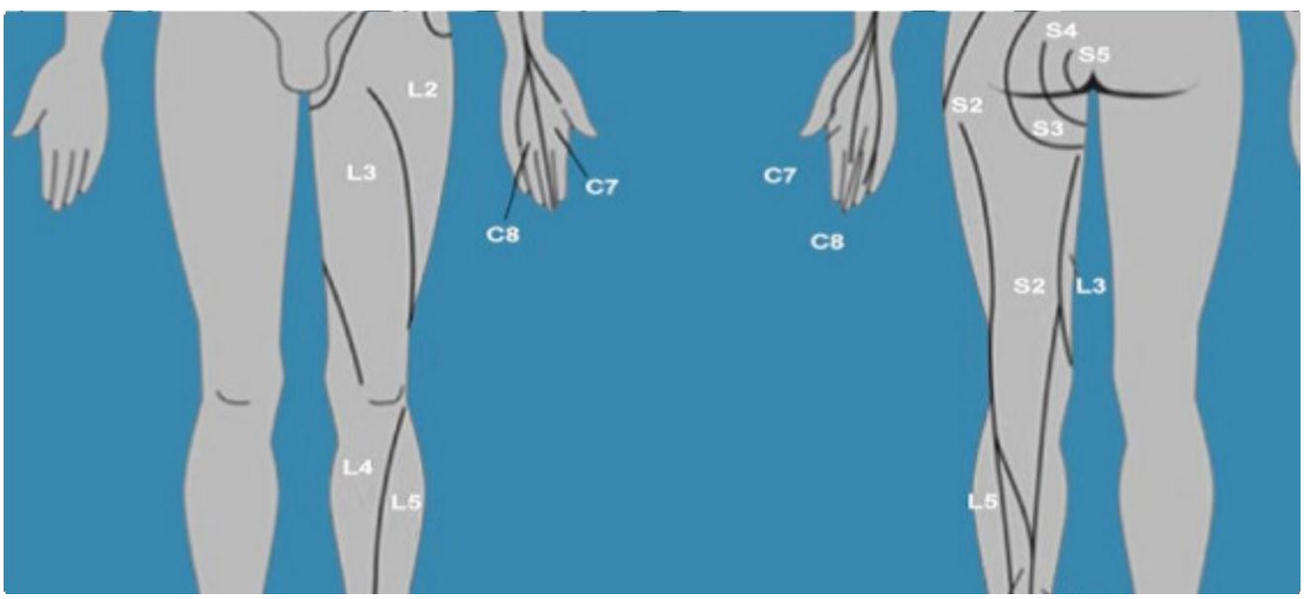
My suggestion, as I have already told you, is to always evaluate the patient with tests: functional, palpatory and spinous processes, looking at the maps and associating, then, the peripheral manipulations on the knee that I taught you.

Also in this case the direction of direct manipulation and of the Lumbar Roll must give space to the side of the gonalgia; therefore, remember the speech made also in the case of sciatalgia or cruralgia

Pain mapping



Dermatome mapping



Gonalgia treatment, meniscosis, patellar tendinopathy

- ✓ Lumbar Roll.
- ✓ Knee Tests and Manipulations
- ✓ Quadraceps and ischi-crural stretching
- ✓ Pyramidal progressions and Squats

Metatarsalgie, Plantar Fasciitis

Metatarsalgia is a pain in the metatarsal, i.e. in the anterior region of the sole of the foot. The term metatarsalgia is generic, so it is not a specific pathology, but simply a painful symptomatology that can appear due to anomalies of support and therefore prolonged postural imbalances over time that often also produce plantar callosity, right next to the painful metatarsal heads.

Plantar fasciitis is an inflammation of the plantar fascia, i.e. of the apo-norosis, that fibrous cord that starts from the medial, i.e. internal part of the heel and moves forward to the root of the toes.

The main causes of plantar fasciitis are microtrauma due to sports activities that involve running but also overweight, obesity and poor posture can promote plantar fasciitis.

Symptoms of plantar fasciitis are pain that can be located below the heel, in the case of proximal plantar fasciitis, or more below the sole of the foot in the case of distal plantar fasciitis. Usually the pain is greater in the morning during the first steps that are taken.

Both in the case of metatarsalgia and plantar fasciitis it is necessary to go and correct those postural imbalances and overloads that are almost always the cause of these problems.

Always refer to the maps that I enclose below and perform the vertebral manipulations accordingly to go and balance the loads that the foot receives: then starting from above.
Immediately afterwards it associates peripheral manipulations only if these manipulations can be performed without evoking too much pain, then assesses with palpation, first the metatarsal heads and the plantar fascia and then manipulates if possible, otherwise devotes the first sessions to the global vertebral manipulative treatment and associates on the contracted muscular part, including the calf and the lumbral muscles of the foot, a simple ischaemic compression.

In ischaemic compression, which you will probably already know, a gradually increasing pressure is applied until in the muscle fascia that you are treating the point in tension, which many also call trigger point, gives under your toes.

If you don't know this very simple but effective technique, I'll explain how it works right away.

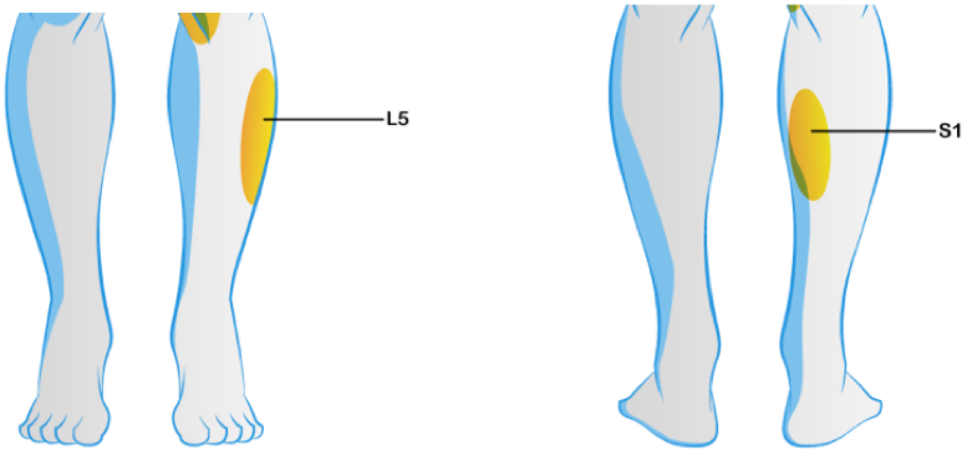
You just need to exert initial pressure on the tensile point that will gradually give way to the pressure. When you reach a greater depth, you will feel a new opposition from another point of tension and at that point you only have to keep the pressure reached, but without increasing it and simply wait.

After a certain period of time, usually around a minute, you'll feel at the touch of a button that the point of tension begins to give way again. Then you can increase the tension again, to reach a deeper level of penetration, until you feel opposition again.

You can then proceed for consecutive sessions of penetration, being careful to avoid any opposition from the point of tension. I recommend stopping when you feel resistance because otherwise you unnecessarily evoke pain in your body and you may even damage your tissues.

If you do not stop, not only will you unnecessarily inflict pain on the patient, but you will also damage the tissues, increase the person's level of tension and stress and in some cases aggravate the condition instead of improving it.

Pain mapping



Dermatome mapping

Metatarsalgia Treatment, Plantar Fasciitis

- ✓ Direct Thoracic Manipulations
- ✓ Direct Lumbar Manipulations
- ✓ Lumbar Roll
- ✓ Ankle and foot manipulations
- ✓ Plantar stretching + ischemic compression + Foot massage with a tennis ball
- ✓ Pyramidal progressions

Pubalgia or rectal adductory syndrome

Pubalgia is a pain in the pubis, and that's how far we've come. However, this is too general a definition. This painful condition is also called Rectum-adductory syndrome and is the most frequent form that is also called ad-dominal pubalgia.

The most frequent causes are microtrauma and functional overload often present in sports that involve running, as in football, where ball control can lead to overloading of adductors.

The main symptom is precisely the pain in the pubis, but it can also extend into the ad-dominal area and involve an important muscle called ileo-psoas. Usually the pain of pubalgia is exacerbated by certain movements such as opening or closing the knees with the knee flexed.

To deal with this painful condition with my manipulative approach, you have to consider the reasoning that we already did when we talked about cruralgia.

Obviously these are not the same painful conditions, but the site of the pain is similar and the manipulations that we will use are similar too. However, a particular attention in this case you must have it in facing the discourse that I propose, about the thermal exercises, because they will be really necessary to obtain better results.

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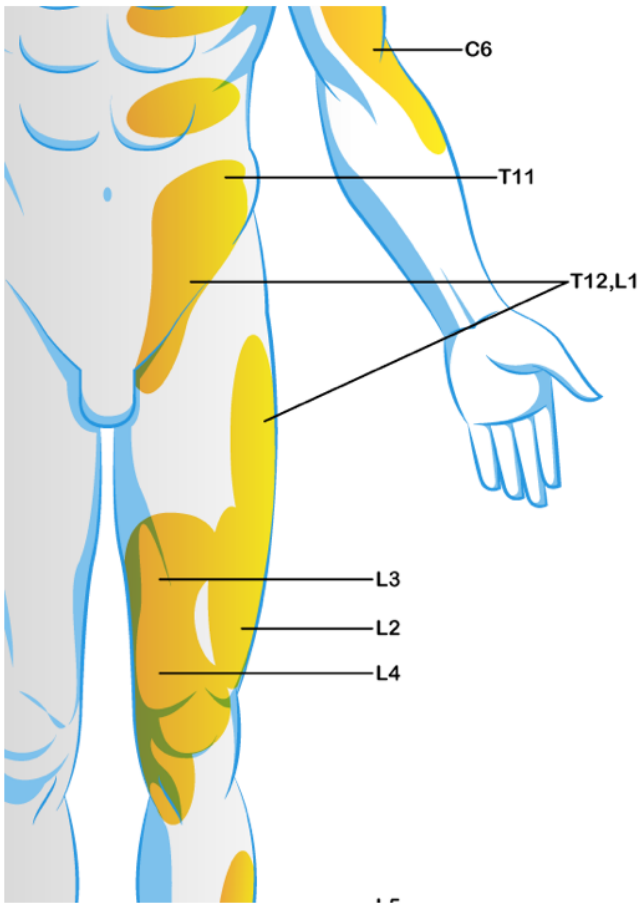
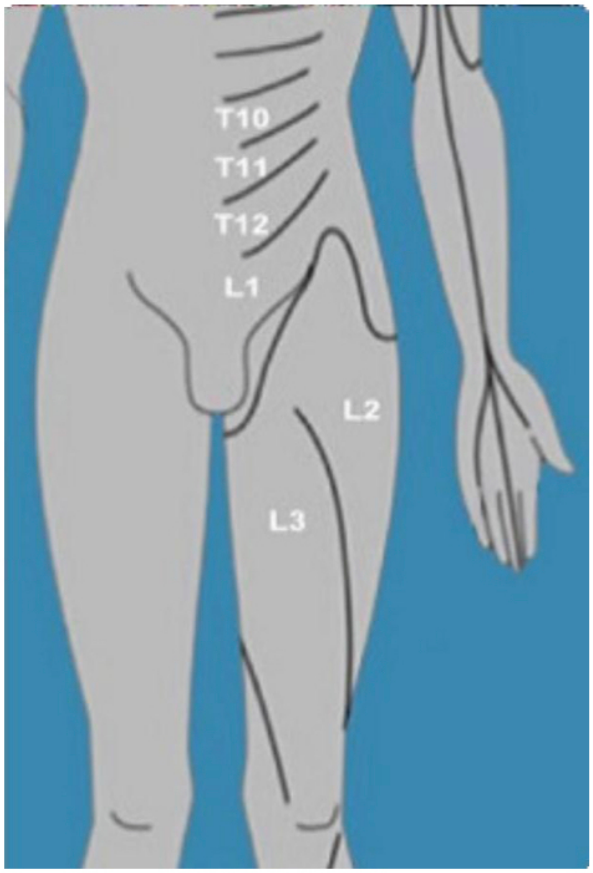
Pain mapping



Dermatome mapping



Groin pain Treatment or rectal-adductory syndrome

- ✓ Direct Thoracic Manipulations
- ✓ Direct Lumbar Manipulations
- ✓ Lumbar Roll
- ✓ Chicago Technique modified
- ✓ Stretching Ileo-psoas, Quadriceps, Abdomen
- ✓ Pyramidal Progressions

Trochanteritis and Coxalgia

The term **trochanteritis** literally means inflammation of the trochanter, i.e. of a bone, and for this reason it is not a correct definition.

Since when we talk about trochanteritis, inflammation can be present in the tendons that are inserted on the trochanter and in the serous bag in which they are wrapped. In fact, this painful condition should be called peritrochanteritis, precisely because the in- flame can look at what is around the bone and not at the bone.

The large trochanter is the point where the tendons of five muscles are inserted: lateral, i.e. the middle buttock and the minimum buttock and the pyriform medially, the external shutter and the internal shutter.

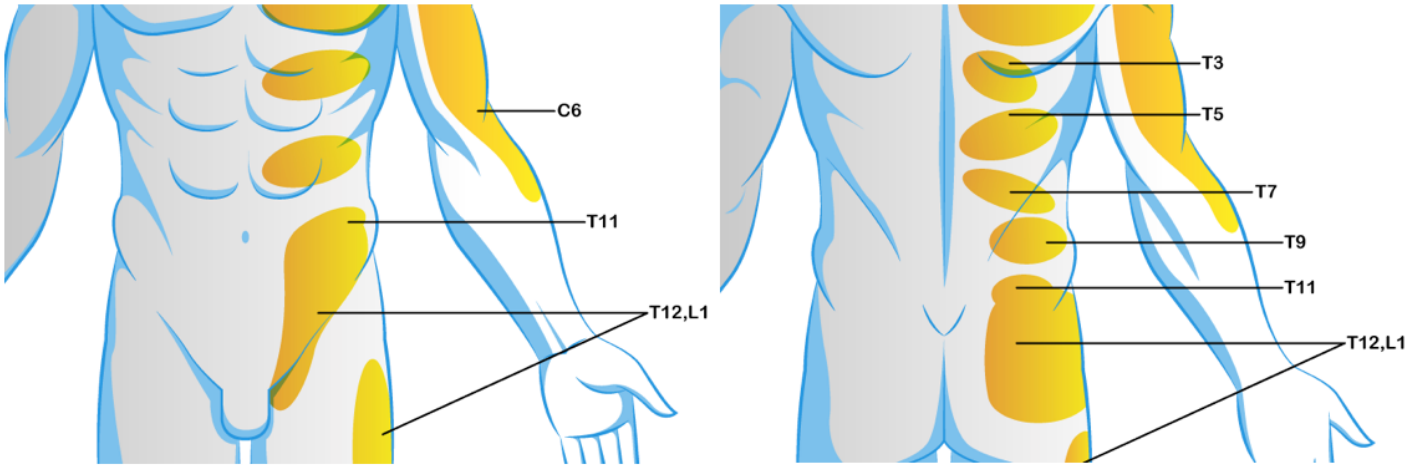
Generally women suffer more from it and both sportsmen and sedentary people can have this inflammation, even if the causes would always be attributed to a postural imbalance and repeated microtrauma over time.

From experience I tell you that very often, even if the patient comes to you with a diagnose of trochanteritis, in reality a real inflammation is almost never present, in fact the diagnosis is clinical. We will deal with this painful condition with my manipulative approach in the same way whether the inflammation is present or not.

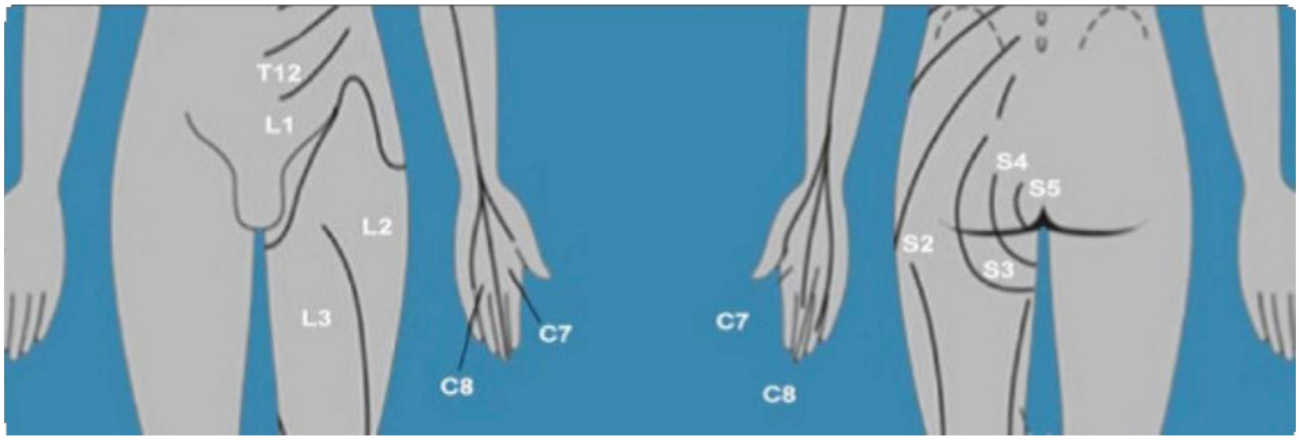
Coxalgia, on the other hand, is simply a generalised pain in the hip and causes it if it is almost always due to postural imbalances or hip arthrosis.

My manipulative approach for both these painful conditions is very similar, and for this reason, as I have done for the other painful conditions, I have combined them with you in a single treatment-ment.

Pain mapping



Dermatome mapping

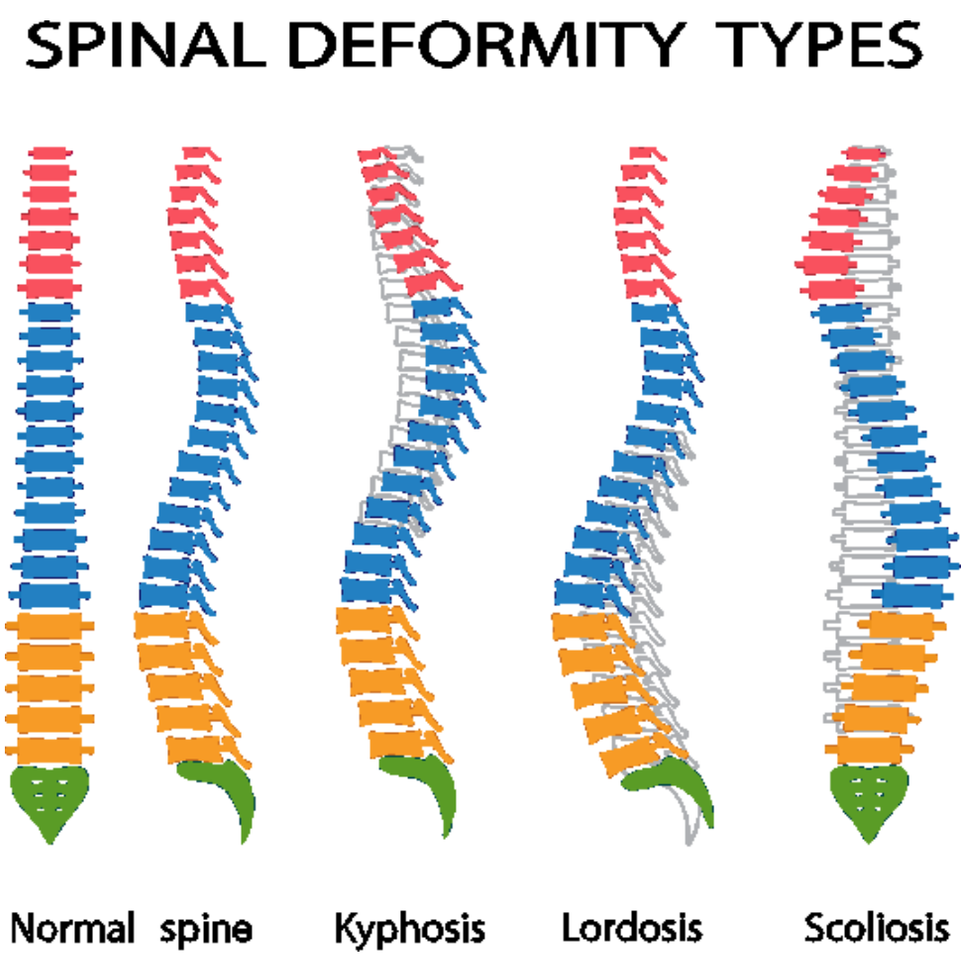


Trochanteritis and Coxalgia Treatment

- ✓ Direct Thoracic Manipulations
- ✓ Direct Lumbar Manipulations
- ✓ Lumbar Roll
- ✓ Stretching Ileo-psoas, Pyriform
- ✓ Pyramidal progressions

Scoliosis, Hyperlordosis and Hyperciphosis

It is important to remember that for paramorphism we mean a postural attitude, and is therefore modifiable; and for dysmorphism, instead, we mean a permanent anatomical modification of a bone structure, as you can see in the image below.



While the paramorphisms can be corrected with various strategies that we will discuss later on and in the video, the dysmorphisms, if of moderate entity, are addressed to limit the natural imbalances and their worsening and, only more serious, may be a specific surgical intervention.

The main causes, or rather, more than anything else, the aspects that favour the paramorphisms that we are dealing with, are:

- What is called **poor postural hygiene**: that is, when the patient maintains incorrect positions over time by watching television, at the table, in the office and in front of the computer.
- **Overweight**
- **Sedentariness**

With my global manipulative approach we're going to recreate a musculoskeletal balance. Lethal, going to act on those that will be more precisely defined in this way:

o Gross attitudes in which we therefore have an increase in physiology
Curvature of lumbar lordosis.

o Kyphotic attitudes instead we need an increase in physiology
Curvature of dorsal kyphosis

o Scoliotic attitude where there is an attitude of deviation in the lateral direction and rotation of the spine, and more frequently in the dorsal and cervical tract.

In addition to a real spinal re-education, which we will perform using almost all the vertebral manipulations that I taught you, it will be necessary to prescribe to the patient a program of exercises of global muscle strengthening and proprioceptive, to give stability and improve the results obtained with the manipulations.

We will use for this purpose the pyramidal progressions, which are the exercises kindly granted by the association of Professor Giuseppe Monari with whom I did a Master's degree at the University of Tor Vergata (Rome).

It will also be necessary to instruct our patient on the importance of maintaining a good posture over time, even during the activities of his daily life.

To keep track of the results you are achieving with your patient, I recommend, as I do, that you take pictures of your patient on all levels of space during the initial evaluation and then in the third session.

In reality, you can improve your patient's overall posture even after just one session, but it is important to establish a treatment plan that goes from 3 to 6 sessions, to have better results and more lasting over time.

As always, the patient will obviously not have to have any pathology and you will have to take care that there are no contraindications to the manipulations.

I advise you to see the patient one week later, between the first and second session, then after two sessions and in the third session after a month. During the third session, take a look at the situation and take the photos again, to get feedback on the work done together and, if necessary, review your patient by setting up longer and longer treatment sessions, ranging from one month to three months apart.
Constantly monitors and motivates your patient to do the exercises at home that he or she has been working on.
Prescribes times when they will have a degree of increasing difficulty.

Paramorphism correction: Scoliosis, Hyperlordosis and Hyperkyphosis

- ✓ Cervical Manipulations
- ✓ Dorsal Manipulations
- ✓ Lumbosacral Manipulations
- ✓ Scapulo-Omeral standing manipulations
- ✓ Manipulation of the Thoracic Cage
- ✓ Pubic Symphysis Manipulation
- ✓ Tibio-Astragalic Manipulation
- ✓ 1st Metatarsal Manipulation
- ✓ Specific exercises (video) + Pyramidal progressions

Conclusion

Congratulations on having decided to learn my immediate treatments; I hope and are
I'm sure my teachings will make a difference to you.

The main purpose of this course is to improve your professional life and the health of your patients.

I wanted to pass on to you what I've learned in so many years of study and experimentation. Remember that my success is your success and continue to love this extra-ordinary work that the universe, or God if you believe, has led us to do to help others.

I'm sure that this video course in many cases will make you do what ironically my patients call "the miracle", but remember, even if it may seem unscientific and very sweet, that the most effective therapeutic technique in the world is love.

I wish you the greatest success as a professional and I am glad to have contributed to your professional training!

Good job.

Marco Aruffo

Immediate Treatments

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Immediate Treatments

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