

'It is a fact, the intestine and the brain maintain a close relationship that influences emotional and cognitive well-being, the intestinal microbiome plays a crucial role in this connection.'

Michael Gershon (1996), discoverer of 'the second brain'.

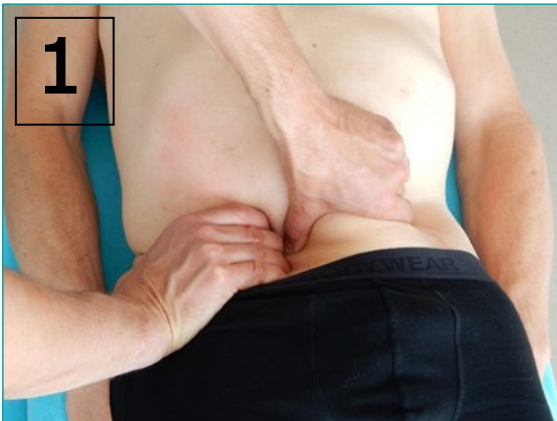


8. COLON

8.12. THERAPY COLON

The different parts of the Colon are treated with the same techniques as during the examination. The tissue is kept stretched after an impulse, after which the dynamics of the tissue are worked directly and/or indirectly in an interactive way. Normalizations for different parts of the Colon part can vary the duration it takes to create tissue response and often take a long time. This is relative to the amount of time a dysfunction has been present and the viscoelasticity (quality) of the Peritoneum.

8.12.1. Direct technique Ileo-Caecal Valvule (ICV)



Patient: in supine position (with or without knees flexed).

Osteopath: stands at the right side of the patient.

Direct technique, the mobility of the ICV is directly normalized.

Implementation: the osteopath palpates the medial side of the Caecum. In cranio-dorsal direction one encounters the ICV. Once contact is made, the osteopath places the fingers of the right hand against the Caecum's medial edge. The right thumb grasps the lateral edge of the ilium. The thumb (or fingers) of the left hand are placed on the terminal ileum, using the other fingers to grasp the neighbouring portion of the intestinal package (photo1). The hands may also be interchanged if necessary.

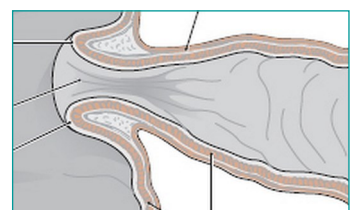
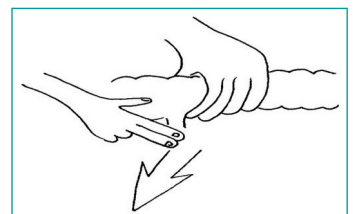
The osteopath then asks the patient to turn on his left side (photo 2) In accordance with the patient's respiration and tissue accessibility, the osteopath distracts the thumb and fingers away from one another, rather letting the intestinal package 'hang' as an opposing weight to facilitate the technique. With this orientation, the ICV is mobilized directly little by little.

Normalization: the thumb remains present on the Ileum terminalis, just before the ICV.

Direct: distract the terminal ileum in the direction of the left SIAS. Repeat this technique a few times and pick up the package each time. Ultimately, a totally free mobile ICV should be the result.

Remarks:

1. When turning the patient on the side, it is important that the osteopath maintains contact with the ICV. When contact is lost, the technique is performed too superficial.
2. A long-standing Immobile Discrepancy of The ICV is inconceivable that it will be resolved in one consultation.
3. The nociceptive sensor properties of the peritoneum may provoke significant discomfort (pain) during performance of this direct stretching technique.



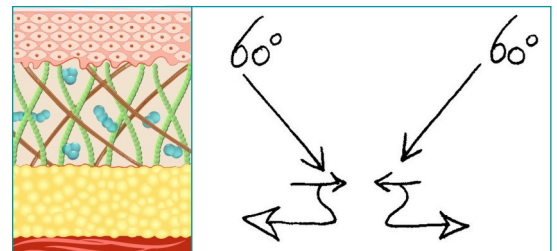
8.12.2. Indirect technique Ileo-Caecal Valvule (ICV)

Patient: lying in supine position.

Osteopath: stands at the right side of the patient.

Implementation: the osteopath places both hands, the index and middle fingers on either side of the ICV. Then the fingers are brought together (V-shape in 60°) until the moment a free movement of the tissue occurs.

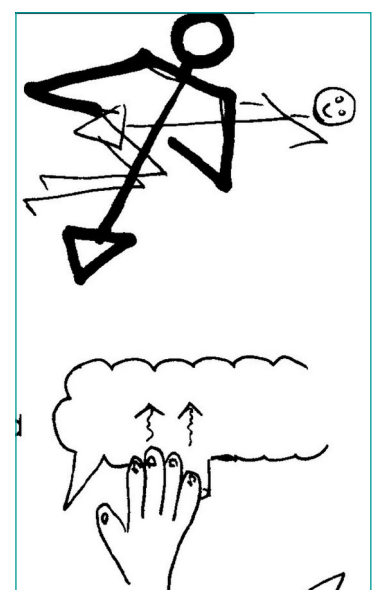
Normalization: the osteopath should follow the tissue, slowly, in the free direction, at each tension-equilibrium (PBLT) a new free direction is sought. Until finally a free movement of the entire tissue occurs.



Remark: This technique can take a very long time.

Indirect technique, the mobility of the ICV is indirectly normalized, by means of a PBLT.

8.12.3. Vibration technique Ileo-Caecal Valvule (ICV)



Patient: lying in supine position.

Osteopath: standing at the left side of the patient.

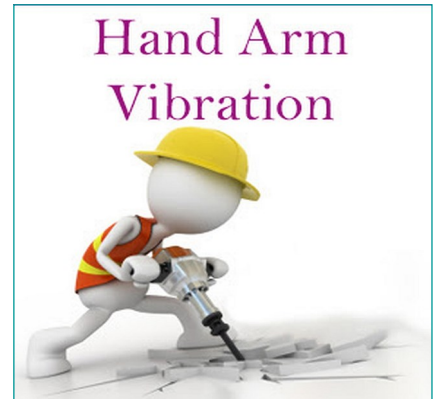
Implementation: the osteopath makes a tilt-sliding movement of the Pelvis to the left. The left palm lies posterior of the patient at the level of the right SI joint. The fingers of the right hand lie at the level of the ICV (photo 1). The fingers of the right hand perform a vibration in the direction of the left hand during an expiration from the patient.

Normalization: the osteopath assesses the degree of relaxation (preparation) of the ICV and the change of mobility in relation to the Caecum and the right Pelvis-region.

Preparatory technique

Remarks Vibrations:

1. *Passive rotation from dorsal to left lateral;*
2. *Left hand osteopath on the right SI joint (counter-action & fine adjustment);*
3. *ICV palpating (digits I-III formed in a triangle);*
4. *At expiration: vibration on the ICV;*
5. *Next Inspiration: move the Caecum further to lateral;*
6. *Next expiration: vibration;*
7. *Repeat several times.*



Remarks Mobilization Caecum global:

1. *Patient lying in left side position;*
2. *Osteopath on the right os Ilium (pelvis) of the patient;*
3. *Right hand osteopath raises the small intestine package to the right laterally;*
4. *Left hand osteopath fixes the Caecum on the patient's right os Ilium;*
5. *Right Thumb osteopath on the medial edge of the Caecum (against fingers left hand);*
6. *Combined movement of Sternum osteopath and both hands;*
7. *Movements of medial & lateral and pressure & relaxation with the Sternum.*

NB. The whole of Caecum and Ileum is mobilized in relation to the Peritoneum Parietal Posterior (PPP). This is a fairly large mobilization in preparation for more sophisticated techniques.

8.12.4. Mobilization Caecum local

Patient: lying in supine position.

Osteopath: standing at the right side of the patient.

Implementation: the osteopath palpates the Caecum with fingers and thumbs and then mobilizes the Caecum in a "pure" medial-lateral movement.

Normalization: the osteopath assesses whether mobility improves. He can also actively participate in breathing: inspiration towards lateral and expiration towards medial.



Direct techniques, mobility will be directly normalized.

8.12.5. Mobilization Colon Ascendens

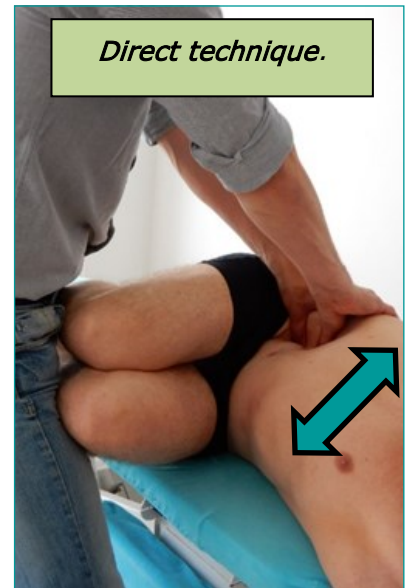
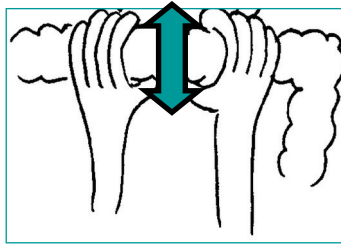
Patient: is rotated according to passive rotation on the left side.

Osteopath: places both thumbs on the medial side of the Colon Ascendens, hands and fingers on the lateral side.

Implementation: inspiration: Colon Ascendens rises + to lateral → follow.
 expiration: holds Colon Ascendens up & laterally (hold).

Normalization: after relaxation (preparation) follows a mobilization in a 'pure' medial-lateral movement.

Remark: the osteopath should stretch the M. Quadratus Lumborum by passive anteflexion of the patient's knees with the osteopath's pelvis. This creates a preload on the posterior retroperitoneal sliding surface.



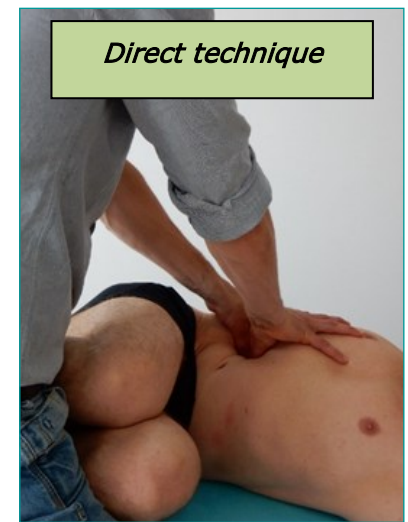
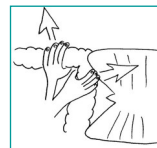
8.12.6. Liberate Flexura Coli Dextra

Patient: lying in left lateral position after passive rotation

Osteopath: stands at the left side of the patient in starting position.

Implementation: the osteopath places the thumb of the left hand on the medial side of the Colon Ascendens. He places the thumb of the right hand at right angles to the left thumb, caudal of the Colon transversum. Both thumbs are placed as much cranio-laterally towards the Hepar as possible.

Normalization: Inspiration: angle Opens → Follow.
 expiration: angle closes → Hold.



8.12.7. Gliding surfaces Colon Transversum

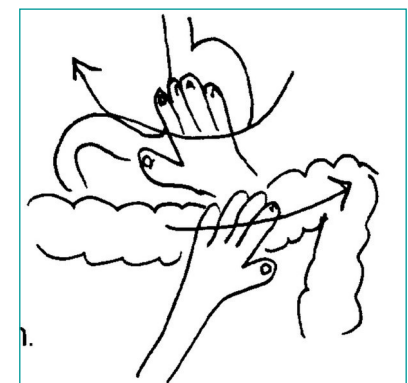
Patient: is in supine position, with raised knees.

Osteopath: **Gaster:** stands at the left side of the patient.
 Right thumb on the pylorus, hand on the stomach.
 Left fingers on the top of the Colon Transversum.

Implementation: inspiration and expiration: follow and mobilize.

Hepar: stands on the patients right side.
 Left thumb on the lower edge liver, hand on the liver.
 Right hand with fingers on top of Colon Transversum.

Implementation: inspiration and expiration: follow and mobilize.



Direct technique, the mobility of the sliding surfaces are directly normalized.

Remarks:

1. These are not real sliding surfaces, but the mobilization provides a lot of relaxation & dynamics, especially in the supra-mesocolic space. It's relative because of the position of the ligaments.
2. The mobilization of Gaster / Hepar in relation to the Colon Transverse should be opposite, thus increasing the dynamics.

8.12.8. Liberate Flexura Coli Sinistra

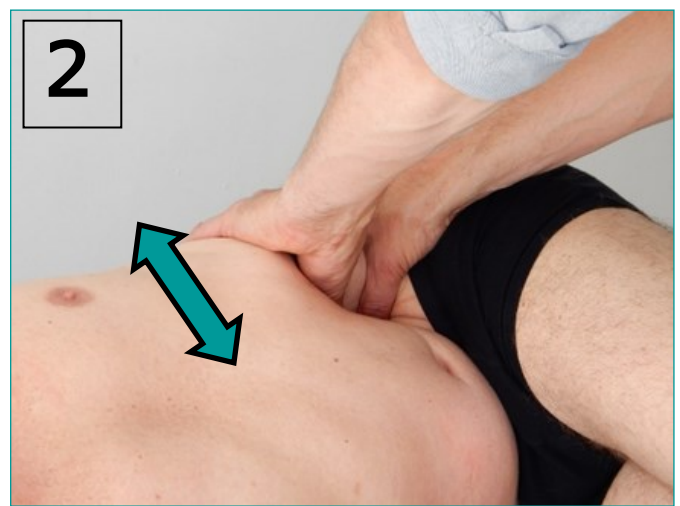
Patient: lying in right lateral pos. after passive rotation.
Osteopath: at the right side of the patient in starting position
Implementation: the osteopath places the thumb of the right hand on the medial side of the Colon Descendens. He places the thumb of the left hand at right angles to the right thumb, caudal of the Colon transversum. Both thumbs are placed as much cranio-laterally as possible towards the spleen.
Normalization: inspiration: angle opens → follow.
 expiration: angle closes → hold.

Direct technique



Direct technique, the mobility is directly normalized.

8.12.9. Mobilization Colon Descendens



Patient: lying in right lateral position after passive rotation performed by the osteopath.
Osteopath: stands at the right side of patient in starting position after passive rotation performed.
Implementation: the osteopath places both thumbs on the medial side of the Colon Descendens and the fingers on the lateral side.
Normalization: the osteopath mobilizes the Colon Descendens from medial to lateral and vice versa.

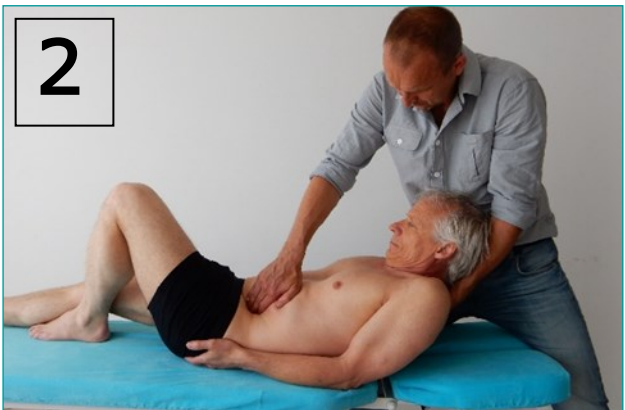
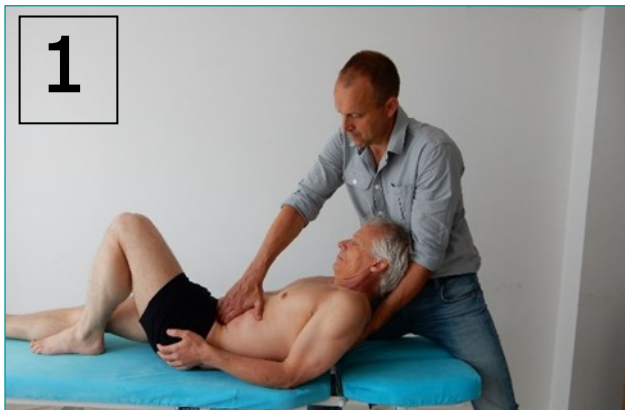


Remarks:

1. The Flexura Coli Sinistra is deeper (posterior) than the Flexura Coli Dextra, next to it the angle of the FCS is sharper (40-50°) than that of the FCD (80-90°). The osteopath's hands must therefore penetrate deeper to reach the desired level.
2. The Descendens Colon is also deeper (posterior), it forms a sliding surface with the Intestinum on Toldt's fascia, located deep in the abdomen. Further on (towards the caudal level) the Intestinum forms a posterior sliding plane with the Mesosigmoid.

8.12.10. Normalization Sigmoid

Direct technique



Patient: is in a supine position with knees raised and leans on his elbows.
Osteopath: stands right behind the head of the patient and at the patient's right shoulder. If necessary, the knee or upper leg of the osteopath is placed under the patient's back (Tvc) as support.
Implementation: the osteopath makes a digging movement with the right hand in the ventro-cranial direction (photo 1). The osteopath then supports this movement with a traction of the left hand on the fascial structures of the trunk in combination with a slight flexion of Thoracic and Cervical spine.



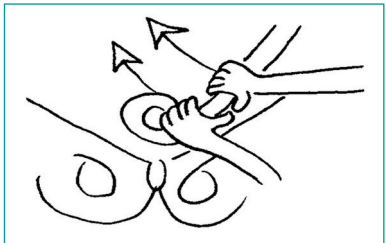
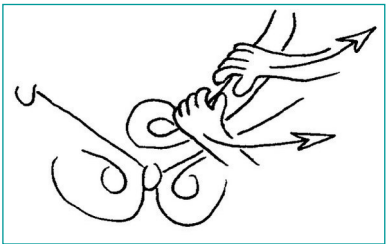
Normalization: the osteopath normalizes degree of freedom of movement that arises.

Remark: The support on the elbows creates a preload on the posterior lodge. The preload facilitates the normalization of mobility. The technique is known as the 'pickpocket movement'.

8.12.11. Mobilization Sigmoid

Direct technique

Patient: in supine position, with raised knees.
Osteopath: stands on the left side at the level of the pelvis. Places fingers of both hands on the inside of the Sigmoid loop and places both thumbs on the outside of the sigmoid loop.
Implementation: inspiration: Sigmoid moves to lateral and cranial. The osteopath actively follows the Sigmoid in her movement.
Normalization: expiration: the osteopath moves the Sigmoid actively to the right shoulder of the patient.
Extra: The mobilization can be accompanied by apnoea.
 Apnoea: sigmoid normalizes by itself (indirectly).



Nota Bene:

1. The Sigmoid can function in a strong retraction. In addition, the Sigmoid is then no more than a little-finger-thickness in diameter and then usually lies deep against the left SI joint, posterior to the Intestinum.
2. Both the Caecum and the Sigmoid can cause many musculoskeletal complaints, as mentioned. The patient will experience these as sensations in the leg, ranging from tingling, 'flowing', throbbing, 'energy', pain, etc.

8.12.12. Immobile discrepancies Colon (IDC)

Patient: supine, with knees raised.

Osteopath: stands at the side of the patient, at the height of the pelvis.

Implementation:

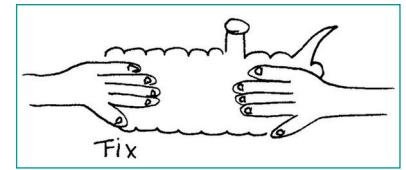
Colo-Caecal:

Left hand in 60° on Colon ascendens (FCD) for fixation.

Right hand 60° on the Caecum → expiration and apnoea.

Direct: left hand fixates (superior), right hand stretches (inferior).

Indirect: press both hands to dorsal until resistance, then follow.



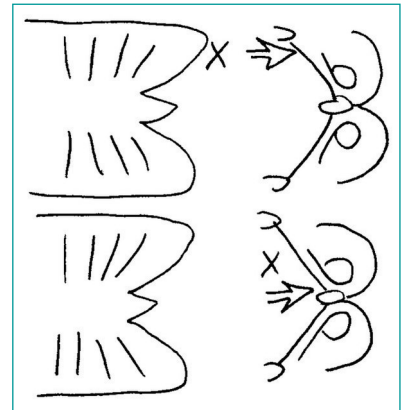
Colon Descendens - Sigmoid:

Right hand in 60° on Colon descendens (FCD) for fixation.

Left hand in 60° on Sigmoid, → expiration and apnoea.

Direct: right hand fixates (superior), left hand stretches (inferior).

Indirect: press both hands to dorsal until resistance, then follow.



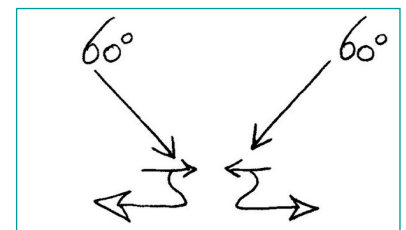
Sigmoid - Rectum:

Right hand in 60° on Sigmoid for fixation.

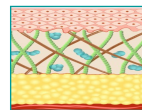
Left hand in 60° on Rectum (deep).

Direct: right hand fixates (lateral), left hand stretches (inferior).

Indirect: press both hands to dorsal until resistance, then follow.



Nota Bene: think of the 60° orientation of the hands, due to the orientation of the collagen-fibres.



Direct or indirect techniques, depending on the implementation.

Remark:

1. The direct action is to fix the part of the colon in which it is bulged, and then stretch the bulged part.
2. The indirect action is press with both hands to dorsal, until resistance occurs, then follow the tissue in the free direction.

Fixation & stretching.

DIRECT

Pressure to dorsal until resistance then follow.

INDIRECT

Nota Bene:

- The Immobile Colon Discrepancies ('invaginations') of both the Colon and the Intestinum are more difficult to feel.
- First of all, of course, the 'normal' tension and mobility of every part of the 8 meter intestine must be known and felt very often.
- In the context of completeness and the preventive nature of Osteopathy, the normalizations are mentioned in this book.