

Jones Institute Newsletter

Spring 2011 Issue



Case Study:

BADWATER ULTRA MARATHON WINNER

The patient is a 39-year-old female ultra marathon runner who was training to compete in the Badwater Ultra Marathon, a 135 mile race through Death Valley California in late July of 2007. I was one of the four support persons to aide her during the race.

In late June 2007, she did a 38-mile trail run, without incident. A few days later, she developed left quadriceps and lateral thigh pain. She tried to run, but could not, and even had an antalgic gait. Evaluation showed neuromuscular dysfunction of the left iliacus, psoas, inguinal, lateral trochanter and other lower extremity points. These were treated with Strain/Counterstrain, with short-term results. The runner felt that she had a quadriceps strain, but there was no mechanism of injury, and it did not fill the criteria of pain with resistance and loss of mobility in the opposite direction. However, she could not flex her hip to pick her knee up during swing phase of gait, without pain and gait deviation. Obviously, she was unable to run. She and I were frustrated with the poor response to my treatment, and on July 6, she tried a 2-mile run, but could not complete it. In mid July, I attended the Strain/Counterstrain 4 class for the second time, and the instructor Randall Kusunose introduced some new information of the correlations linking the treatment of specific Strain/Counterstrain cranial points and the positive effect on specific lower extremity weaknesses. I returned home and saw the runner on July 15, and incorporated these treatments. Initially, her left straight leg raise was 3+/5, with pain, gluteus medius 3+, piriformis 3+ and quadratus 3/5. She had also had the same return of exquisite tenderness of the left pelvis points previously treated. Within a couple of days, she had a great deal of strength return within her lower extremity, and the left anterior pelvis points were minimal as of a few days later. Evaluation on July 20 showed negligible left anterior pelvis tenderness, which was never the case, even over the past few months. Manual muscle testing showed 5/5 throughout. She decided to attempt the race, beginning on July 23. The temperature exceeded 117 degrees, with a 25 mph wind. She ended up winning the women's competition in this documented most difficult running race in the world, in 34 hours and 34 minutes, with the last 12 miles gaining over 4000 feet of elevation, where the temperature did not go below 100 degrees until 5 miles were remaining. A truly remarkable accomplishment, achieved by physical and mental toughness, and significantly aided by the Strain/Counterstrain techniques discussed previously. She recovered quickly over the next couple of days.

This experience adds to my conviction that Strain/Counterstrain in its purest form, as well as in its new and developing associated techniques, is a tremendously powerful tool. I have found the cranial techniques related to weaknesses throughout the body have been extremely helpful to aid patients, not only with chronic pain, but acute problems in the elderly, in the young, and also for a world champion athlete.

-by Larry Ham, PT, ATC, JSCCI



Questions or comments? Contact us:

Jones Institute
7937 Corte Domingo
Carlsbad, CA 92009
Tel: 760-942-0647 • Fax: 760-942-0645
Email: info@jiscs.com

WEBSITE: www.jiscs.com • www.jonesinstitute.com

The 2011 Advanced Course Schedule

SCS V&L – for the Visceral & Lymphatic Systems:

Boston, MA	June 10-12, 2011
San Diego, CA	July 15-17, 2011
St. Paul, MN	August 26-28, 2011
Seattle, WA	October 21-23, 2011

Pre-requisite: SCS I or II

SCS III - Cranial & Advanced Techniques:

Mobile, AL	May 13-15, 2011
Somerville, NJ	August 5-7, 2011
Santa Rosa, CA	August 26-28, 2011
Reno, NV	Sept 30 – Oct 2, 2011
Boise, ID	October 28-30, 2011

Pre-requisite: SCS I or II or PP or UQ

SCS IV - Facilitated SCS & RX Strategies:

Vancouver, WA May 20-22, 2011
(One other possible location – TBA, watch the website!)

Pre-requisite: SCS I, II and III.

Lab Assisting is available for anyone who is registered to take the certification test.

Please visit the website, look at 'Certification' for details on lab assisting at a course.

CERTICATION TEST August 20-21

We are always on the lookout for recent SCS case studies or articles you find interesting! Help us spread the word!

Send them to info@jiscs.com

Sore Throat? Try Treating the Hyoid Bone.

Since before the days of A.T. Still clinicians have been treating restricted mobility of the hyoid bone for a myriad of symptoms that range from sore throats, hoarseness, loss of voice, chronic coughs and musculoskeletal pain involving the cervicals, thoracics and cranium. The etiology of these symptoms and how you address these conditions with Counterstrain is worthy of a brief discussion.

The hyoid bone is the most mobile bone in the body. It does not articulate with any other bone but is suspended just below the mandible by two Stylohyoid ligaments. Gently hold the hyoid with a thumb and index finger and you can easily move it from side to side, up and down and forward and backward to assess the inherent mobility.

There are eight supra-hyoid muscles that elevate the hyoid bone and half that pull it forward (Genio and Mylo-hyoid) and half that pull it backward (Digastric and Styohyoid).

There are eight infra-hyoid muscles that depress the hyoid. Four that originate from the sternum and attach directly to the hyoid or attach to the thyroid cartilage and continue to the hyoid via the thyro-hyoid muscles. The final muscle is the Omohyoid that originates from the superior border of the scapula attaching to the lateral edge of the hyoid. When contracting the Omohyoid depresses and pulls the hyoid bone backward.

The hyoid bone hangs in this suspension of ligaments and muscles and is also attached to the Larynx or voice box by three thyro-hyoid ligaments that run down the thyroid in front of C3-5. This is important because running behind this structure are the cervical branches of the external and internal carotid arteries, the internal jugular veins and the cervical nerves. Aberrant muscle contractions that depresses and pulls backward the hyoid complex can put pressure or impinge on these nerves and vessels resulting in pain, soreness, and fluid congestion of the surrounding tissues. The mal position of the hyoid complex and the related muscle imbalance strains the Larynx and causes tension on the vocal cords and the local circulation impairing vocalization.

Counterstrain techniques for the Omohyoid, Digastric, Suprahyoids, anterior columns and cervical and thoracic techniques will regain normal balanced suspension of the hyoid complex restoring full mobility and symptoms abate.

-by Randall S. Kusunose, PT, OCS, JSCCI