

The fronto-occipital hold is an alternative technique for examining the primary respiratory mechanism (PRM). In this hold, the physician will gently rest one hand on the frontal bone and the other hand beneath the occipital bone. With light palpation, they may sense the underlying motion within the cranium, making note of the amplitude, rate, and regularity of the CRI. In addition, they may identify dysfunctions and the preferred motion of the

frontal, sphenoid, and occipital bones.

## Treatments

### Decompression of the Occipital Condyles

#### Decompressed Octopus Cone

Decompressing the occipital condyles helps balance the reciprocal tension membrane (RTM) at the location of the hypoglossal canal. As a result, this will normalize CN XII. Commonly tested on exams is a newborn infant with difficulty feeding due to a tongue dysfunction. With the patient supine, physicians will rest the patient's head in their palms, with their index and middle fingers directly over the condylar processes. Then, they will apply a slight cephalic and lateral force at the base of the occiput and hold until a release is felt. Once complete, they will reassess their findings and note any changes to the amplitude, rate, and regularity of the CRI.

### Venous Sinus Drainage

#### Vines Sinner Drain

The venous sinuses drain about 85-95% of the blood from the cranium. As a result, physicians can target the occipital, transverse, and sagittal sinuses to increase drainage output. The order in which you treat each sinus goes: confluence of sinuses, occipital sinus, condylar decompression, transverse sinus, straight sinus, superior sagittal sinus, and lastly metopic suture. This process is repeated in a stepwise fashion until all the sinuses have been treated. One example is treating the transverse sinus. Here, the physician will place both first and second digit fingers across the superior nuchal line. They will apply a slight gentle pressure over the line until a release is felt on both sides of the sinuses. Once complete, they will reassess their findings and note any changes to the amplitude, rate, and regularity of the CRI.

### CV4: Compression of the Fourth Ventricle

#### Compression-by-vice on (4) Fork Vent

Compression of the fourth ventricle is an osteopathic procedure that allows physicians to improve the inherent motion of the C.R.I. In addition, it amplifies the healing process in sick patients and helps them relax during hard times by impacting on the nervous system functions. With the patient supine, the physician will interlace their fingers and gently rest the posterior-medial aspect of occipitomastoid sutures over their thenar eminences. The physician will resist cranial flexion and augment cranial extension. With time, the amplitude of the CRI will decrease until a still point is reached. Then, they will slowly release their resting force and reintroduce normal cranial flexion and extension motion. Once complete, they will reassess their findings and note any changes to the amplitude, rate, and regularity of the CRI.

### V Spread

#### V Spreading

The V spread technique is used to separate restrictions over suture lines. One example is the sagittal suture line. With the patient supine, the physician will cross their thumbs over the sagittal suture slightly anterior and superior to the lambda. Then, they will gently apply a soft force towards the parietal bones, separating the sagittal suture apart. Sometimes, the physician may palpate a sense of softening, warmth, or increase in motion directly under their thumb pads. Once complete, they will continue along the sagittal suture line and repeat the technique until they approach the metopic suture. Lastly, they will reassess their findings and note any changes to the amplitude, rate, and regularity of the CRI.

### Frontal Lift

#### Captain-at-front Lifting

A Frontal Lift can be performed to assist in balancing the RTM. Patients that receive this treatment typically complain of frontal pain or sinus pain. With the patient supine, the physician will place both hypothenar eminences over the lateral angles of the frontal bones and both thenar eminences anterior to the lateral aspect of the coronal suture. Then, they will interlace their fingers over the metopic suture and gently apply a compressive force. This will internally rotate the frontal bones and separate it from the parietal bones. Once the lateral angles of frontal bones move into external rotation, the physician will release the head and reassess their findings, noting any changes to the amplitude, rate, and regularity of the CRI.

## **Parietal Lift**

### **Pirate Lifting**

A Parietal Lift can be performed to assist in balancing the RTM. Patients that receive this treatment typically complain of pain over the top of their head along the squamous suture. With the patient supine, the physician will approach the parietal bones with the fingertips slightly superior to the parietal-squamosal sutures. Without touching the patient with their thumbs, they will cross those two fingers in the air, over the midline sagittal suture, and apply a gentle pressure to each opposing thumb. Applying such pressure will force slight approximation of the other fingertips on the cranium and induce an internal rotation on the parietal bones. Lastly, they will maintain this pressure and lift both hands cephalically until fullness is felt in their respective fingers, signifying external rotation of the parietal bones. Once the parietal bones move into external rotation, the physician will release the head and reassess their findings, noting any changes to the amplitude, rate, and regularity of the CRI.

## **Temporal Rocking**

### **Temple Rock**

Temporal Rocking can be used to treat a patient with an external or internal temporal rotation dysfunction. With the patient supine, the physician will palpate, with one hand, the zygomatic portion of the temporal bone with their thumb and index finger. They will rest their middle finger on the external auditory meatus and rest both index and little finger on the inferior part of the mastoid process. They will use their other hand to cradle the occiput above the table. During cranial flexion, they will apply a medial force over the ring and little fingers with cephalic lifting of the zygomatic arch in order to augment external rotation. During cranial extension, they will simply resist internal rotation of the temporal bone. Once complete, the physician will release the head and reassess their findings, noting any changes to the amplitude, rate, and regularity of the CRI.