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The doctor should gently extend and flex the neck and head about five to eight degrees.) The lighter your touch, the easier to detect the hypo mobility.

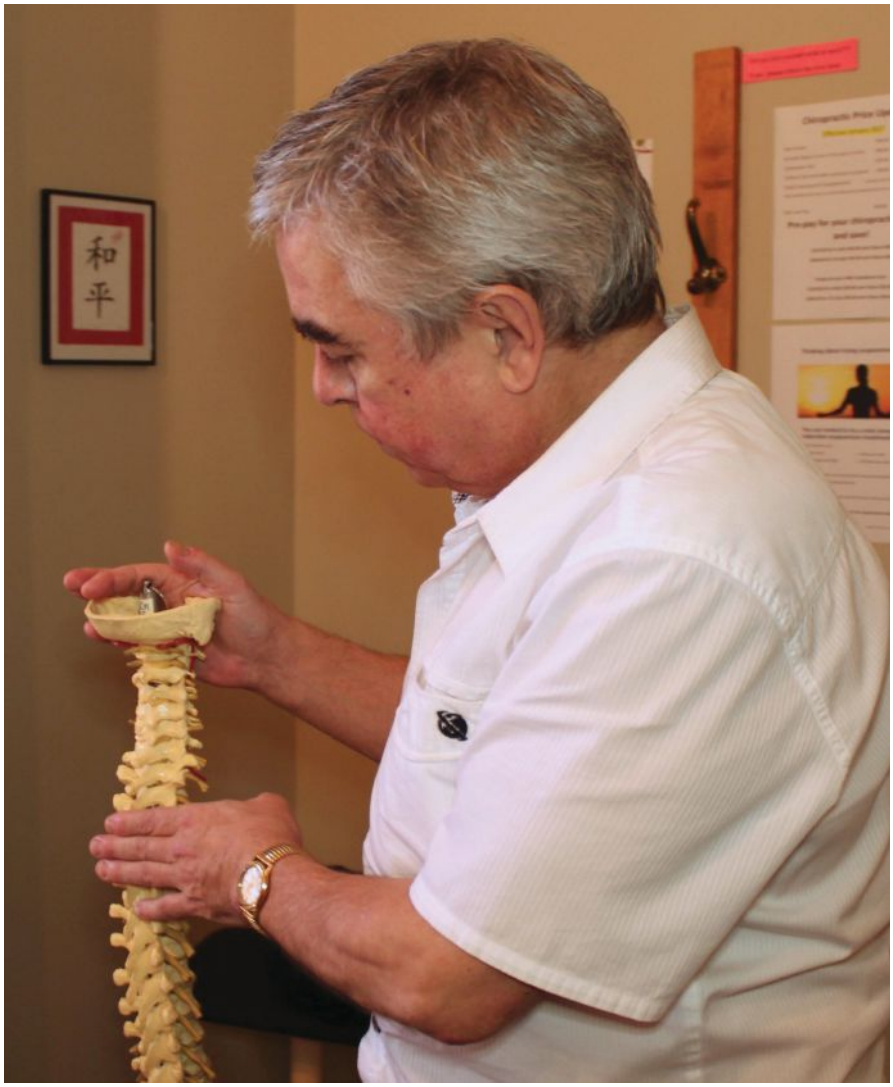
3. Attempt to adjust the hypo mobile thoracic segment your usual way. The segment may not adjust if there have been adjustments close by. The body will only allow so much to happen in a given visit, especially in a small area. This is one reason why we sometimes adjust a patient twice in one day.

If the segment will not adjust manually and is hypo mobile in extension, then consider doing the following to enhance the cervical curve and increase rotation bilaterally.

Sit the patient at the end of an adjusting table equipped with a pelvic drop piece mechanism. Have the patient lie supine with a pillow covered with face paper under their head so that the spinous interspace of the hypo mobile thoracic segment is 5cm caudal to the gap between the thoracic and pelvic panels of the table. The patient's legs may hang down off the end of the table or with knees bent and feet up on the table if there is a low back problem.

Place your hand under the spine with thenar contact on the spinous of the hypo mobile segment. The patient's arms are crossed over their chest. With a broad contact over the patient's arms use the drop piece at light tension to set the segment P-A and I-S to enhance the cervical curve. Do this three times in succession.

Sit the patient up and check the active rotation of their neck to the end point right and left. If the procedure was successful, you will observe a symmetric increase in active rotation commonly eight to 10 degrees and as much as 20-40 degrees bilaterally. Yes, this means their rotation may improve noticeably and in some cases miraculously.



Palpation hand position for detecting the hypo mobile interspinous space.

Quite often the patient will be delighted and surprised that such increased comfort and range of motion has resulted from a seemingly noninvasive intervention. This procedure is highly applicable for patients who text heavily, or are on devices excessively. It is also very helpful in many cases where osteoarthritis precludes neck adjustments. In some cases if you do this technique first, you may not have to adjust the cervical spine if active rotation becomes 90 degrees bilaterally.

Recently I treated a new patient who had a lower cervical discectomy and anterior arthrodesis (fusion) eight years ago. Opon the first exam, his active cervical rotation was 60 degrees bilaterally and very uncomfortable. Without the opportunity to adjust his lower neck due to the fusion, I applied the ECC technique to the T2 segment on his third visit. I was amazed and surprised that the active cervical rotation was 90 degrees bilaterally and the patient was instantly much more comfortable moving his neck.

I hope readers will employ this valuable approach in the quest to correcting the cervical spine.

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Photo: Courtesy of Paul Hunter