



## **Evolution of Dental with Osteopathy.**

By Dr V.Vallee-Cussac  
Orthodontiste DO

Osteopathy has arrived at the doors of dental offices. We should be happy about this because, like hypnosis, osteopathic know-how opens up therapeutic perceptives. Relieve the patient during the session, calm inflammation, detect the anchoring of the teeth, facilitate extractions, work with the tissues, prepare them before, harmonize them after the dental act ... Here are some osteopathic concretizations accompanying the exercise of the dentist.

The manual perceptions that we use every day in the care for the search for a root canal or the adjustment of an occlusal contact point are refined by the osteopathic know-how thanks to the knowledge, the visualization and the feeling of the ground.

What comfort for the practitioner to know the posture on which he is going to intervene.

With the x-rays, the orthodontist analyzes the pattern of growth of the structures. Provided with osteopathy, information such as the fixity of a jawbone, the tension of a masseter, the expression of a scoliotic tissue complete his diagnosis and guide the treatment plan.

- In an edentulous patient, the choice of the vertical dimension for the prosthetic realization is delicate then the manual evaluation of the cervical tension or depression, physiological criterion, will be a decision guide.

Our expertise is no longer limited to the head, occlusion, TMJs, dysfunctions. It extends to the entire body of the patient for increased efficiency and service.

Let's see how osteopathy changes our point of view:

A teenager comes in for a consultation. His posture, the signs of bodily alerts such as tension or repetitive pain interest us: a joint that cracks, a pain in the neck, back, shoulder.



For this youngster, the mother reports a crippling pain for more than a year in the Achilles tendon which forced him to stop sport. His doctor talks about Sever's illness. The occlusal examination reveals a slightly rotating upper lateral incisor (reason for its consultation), the inter-incisor midpoints are consistent and class I is bilateral. The osteopathic opening on the

whole body will make it possible to find out what neuromuscular message sends the occlusion to know if it has a part of responsibility in this painful structural disorder. A left rotation and a right tilt of the mandible distorting the concordance of the media are diagnosed.

The treatment combines dental alignment by apparatus with balance or body neutral previously installed by osteopathy. Two appointments make the tendon pain go away.

Then the incisor rotation is corrected. At the end of treatment, dental occlusion is compatible with a balanced mandibular and body posture.

Similar daily clinical cases show that with osteopathy we have the necessary tools to go to the end of a global dento-postural correction. Patients and therapists note that the dento-osteopathic alliance resolves difficult situations:

- an occlusal plane that does not straighten out despite our multibagged mechanics and an intensifying scoliosis
- loss of control of the incisors with the appearance of capsulitis of the shoulder
- an open bite that sets in with repetitive low back pain.
- a painful TMJ which is associated with neck pain,
- a recurrence of dental disorder after childbirth.

The body disrupts the teeth, and vice versa. Osteopathic dentistry treats teeth in a balanced body for the sustainability of treatments and the health of our patients.

As promised, a few words to complete:

**"Chronic back pain"**

In the last "exchange / information" letter I reported to you a "chronic back pain" observation which allowed me to progress.

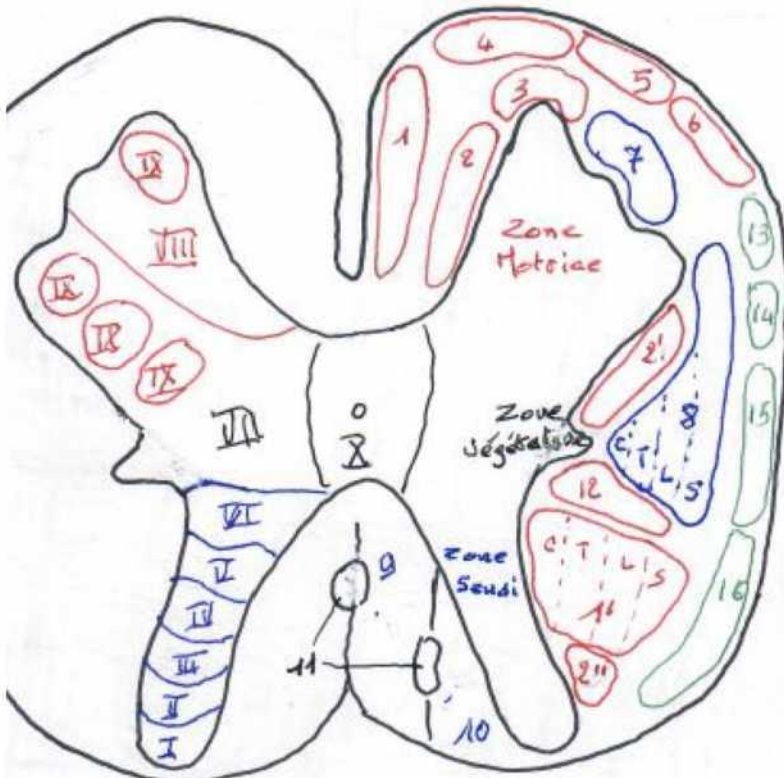
In vertebral treatments, both at the diagnostic and treatment level

can be found in both gray matter and white matter, often on several levels. In white matter, this inflammation, may be localized and / or appear to spread through one or more tracts.

If we want to clarify, we find it more frequently on the Spino-thalamic, Spino-cerebellar tracts, Crossed pyramids... and more rarely on the direct Gracile, Cuneiform, bundles...

I only work on acute inflammation if it is very painful. I make sure to limit its effects as I know its "need for tissue repair".

I have always found it more difficult to intervene symptomatically on acute inflammation. But fortunately, treating in osteopathy with the whole allows to postpone these difficulties.



IFaisceau Pyramidale directe

1<sup>f</sup> Fasc Pyramidale croise

2 Tractus Raphe Sjoinajis 2'

Tract Pontoretici ^

2<sup>#</sup> Trac Bulboret ^^

3 T soljtary; spinajjs

Ted ^ spjnaj

**5JT Vestibul ^^**

6J] Olivo-spinal

7

T  
antérieur

SginoJ ^

8 T Spmg ^ hal ^

9 F Gracile

10 F Cuneiforme

11 Fibres associatives

12 T Rubro-spinal

13 T Spino-tectal

14 T Ventral Spjno ^

15 T Spjr ^ ^ erebdjei ^ ant

16

T Spmgcem post

Il manque le Fasciculus prognus constitue de fibres descendantes et ascendantes tout autour de la substance grise.

**Discussion**

about the article written  
by Dr Bensoussan on

**Chronic back pain**

MB, preamble/

1 You will notice that in what will follow I speak little about the whole, my credo! In addition, our structural and visceral know-how, etc. are taken into account in our treatment. But one hare at a time.

2 The article on chronic back pain that I sent to you elicited many reactions. I selected 2 who "jostle and educate".

- for example, I broke with all bone, all disc, all visceral ...

- My experience shows, often a frequent spinal inflammation compared to the chronically painful spinal level (will be developed in Cortex II) ... and we know how to relieve them!

I remind us:

- inflammation (pain) is considered chronic if it lasts for more than 3 months.

- that it "decreases rather than protects humans (Pr R Leriche)"

In this old observation, I found a posterior horn of the inflammatory cord. In hindsight this inflammation

In the gray matter, the inflammation in the rexed layers is more difficult to individualize and to outline.

The question that remains is how to treat inflammation?

First of all, it is necessary to make a diagnosis, to specify its limits, its hypo and hyper activity zones. The treatment can call on several skills, the use of the "mechanism" is efficient and very easy.

We have specified chronic inflammation, to distinguish it from acute inflammation.

## I Our colleague Sophie asks.

The information you sent us about chronic back pain is sure to help me. I feel like I can really feel the inflammation without being able to focus on the different parts of the spinal cord.

Because the multiplicity of structures affected makes it difficult to disentangle the skein, to say which structure is inflammatory, so much they are interdependent and intricate. Also, I have a hard time settling on which one I chose until the restriction is resolved. It's a bit messy.

So I created "my little neuro habits (outside the cortex)" in order to treat the inflammation on the entire affected bone marrow segment (often 2, 3 metamers) or on the myotome, the viscerotome, the neurotome (and Covid obliges) angiotome... Finally, the attack seems to be more often unilateral than bilateral.

In sensation, I have the impression of clearing the ground a bit blindly but it then becomes clearer on the most suffering metameric level ... Sometimes it is laborious for strong inflammatory sensations. I am not doing enough as I would like and so I then move on to a more direct local treatment (dorsal / lungs / large vessels ... for example)

Little by little I am familiarizing myself with the anatomy of the spinal cord and already find some sensations that interest me and that are quite specific ... Can you help me.

MB / Thank you dear Sophie for your participation. Our basis for reflection was chronic back pain, the one that we have difficulty in circumscribing, patients often returning to our practices.

You all know how to work on the joint, give it back mobility. The more skilled will find and treat the often associated "intraosseous lesion". Others will "relax" the aponeuroses, the distal and proximal musculature,

the dura-meric complex, still others will know how to approach the intervertebral disc ... Finally, the most informed will work on the locally dilated vessels ...

All this is very often enough to lift pain and inflammation at a distance ... But not always!

The inflammation, especially if it is continuous, crosses anatomical barriers and can cause spinal cord inflammation. We were never taught to look intraspinal. I don't even believe our masters ever thought of it. This was the meaning of the observation that I wanted to share with you.

The intervention of Sophie requires some developments I will choose 4.

1. The multiplicity and entanglement of the tissues affected, and says its difficulty in guiding its diagnosis and treatment. The advice we can give is to progress in visualization.

2. We can never say enough S/F, A/P. You have to put in the effort of anatomy. The spinal cord presents in its center the gray matter and in its periphery the white matter with the ascending and descending neurological tracts. You must know how to move there, I will help you and give you some tips in cortex II in May in Portugal.

3. In addition, she tells us to have created her "little neuro habits to treat inflammation ... (often on 2 to 3 metameric floors) especially myotome and viscerotome, neurotome (and this year Covid obliges: angiotome ...)

Often unilateral and less often bilateral".

These "little habits" lead me to make 3 remarks:

3.1 I process what I find and rarely the entire metameric, but Sophie's way is defensible, I like to see the creativity of my colleagues.

3.2 Return to anatomy. I understand that we choose the

metamer if we are not a little short on anatomy. But it is imprecise. We can be more "focused", on such or such tract, or nucleus ... Anatomy, anatomy, anatomy ...

3.3 I congratulate you on the delicacy of your perception. The involvement is very often on 3 vertebral levels and sometimes with irradiation ... We will see this in Cortex II.

4 I want to come back to the diagnosis and the treatment (at the heart of our meetings). The entanglement makes the choice difficult in inflammation. But should you choose?

If you are working with the "mecanism" it is not necessary, more often than not it will choose for you, but not always.

In this case do as described in the observation on chronic back pain that I sent you in the drawing. See the patient for the first time, "clear up the pathology", and see him quickly. The spinal neurological diagnosis awaits you ... As long as you visualize the ascending and descending pathways, the nuclei ... The anatomy!

Finally I insist; I taught you "mecanism"! Use it.

I know, some (I was) are prisoners of the teachings that have been given to us. We find it difficult to abandon them.

Keep them, but test the others. Do not forget ! The best interests of the patient come first. You don't betray anyone, you evolve!

Osteopathy is an apprenticeship, a know-how based on advanced anatomical and physiological knowledge. You must doubt, verify, question your perception, your visualization.

This visualization is not that of the dissected corpse (although it is a start) but that of a functional anatomy. Cad physiology which still conceals so many mysteries....

Finally, I have the weakness to think that an Osteopath must be a Humanist ...

- Beforehand I reaffirmed the position taken by the structure / function which made it possible to establish a working framework (but in our field research and perspective are open).

- The exercise consisted in perceiving

ask the patient / colleague to think of a pleasant moment. We let the pleasure take hold (it's fascinating because there are many variations on the notion of pleasure). Then we ask him to imagine an intruder who



the cortex to think (maybe you were not there). We put our hands, we connect the cortical assembly and we

thwarts this pleasure, and finally, to react physically to prevent it <sup>1</sup>

1 Our friend Patrick asks PM/ For my part, I note that the need for diagnostic and therapeutic neuro-osteopathy is an area that still requires manual learning that even experienced osteopaths do not yet master.

MB / Our job requires knowledge of anatomy and physiology in evolution, which feeds manual skills. We are all

in perpetual becoming.

PM / For cases of chronic pain, neuro osteopathy, it seems to me, must also be able to "trap in its" hands "the psychic component by being very wary of cortical regions and always not ending in the frontal brain regions ultimate complex analysis of all physical and mental ailments of

the body. Often, it accumulates all the information with regions or even clusters which remain on, inappropriately. So that the cerebral and bodily relaxation is only partial. MB / The psychic aspect is difficult to approach, but I do not give it up, I have a few ideas which still deserve work. I had "innocently" in its time, proposed an exercise of cortical

... And there we see (improper word we perceive) the brain thinking and many cortical areas light up or be the seat of thunderstorm .... Obviously the frontal cortex is always (almost always, let's leave a shadow of a doubt) involved, but also the areas 3,1,2, motor and premotor, ...  
- And you can enter all the information at will ... Everything is possible. There you see the psychic functioning of the brain since everything is thought out ...

PM/ "clusters that remain on inappropriately".

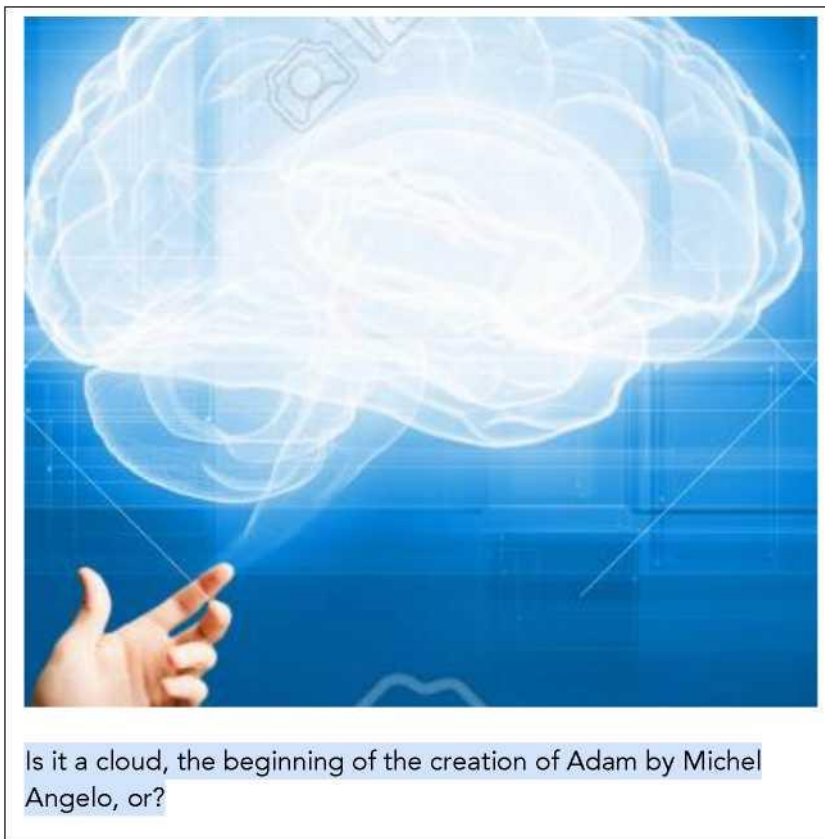
MB/ Inappropriate, not sure! It is common for "the thought to stay there" as the individual moves on. Often in the morning the problem of the day before is solved. Moreover, the "ways or voices" of the brain are difficult to penetrate and the culture (in the broad sense) of Mr. Dupont is not the same as that of Mr. Durand.

PM / Maurice when you do this you are inducer or you can observe the activities of multiple interactive clusters with thunderstorms that circulate in multiple places of the cerebral cortex. (This is possibly ok in learning) but there is suggestion induction so we introduce a bias The problem, when treating patients, is not to be in suggestion or induction, but to find for its clinical symptomatology the adaptive response the undergone, adaptive or poorly adaptive neuro-functional remodeling of the cerebral cortex in response to its problematic reasons for consultation. Indeed, many cortical areas are involved with the frontal areas which always intervene. In addition it is necessary; correlate with the neocerebellum which controls and refines the functions of the cortices, especially the frontal cortices. Let us not forget that even the primary visual cortex of retinal information perception presents a dual motherboard including cluster mapping of emotional tint. What about the primary auditory areas?  
MB / What erudition! The induction that would bother me would be the one that came from my hands. The one I propose is equivalent to the one that a discussion would generate, moreover you will note that the response strategies (of the patients) are all differences. Obviously during learning, we clear our hands, but when it comes to a patient, we are a receiver, an information analyst, and then we

propose a treatment (all of this deserves to be detailed). And in agreement with you all the lit (perceived) zones must be considered.

Whether it is "mechanism or reset" (which is a form of mechanism), we address the structure even if it is visualized and therefore thought by

the practitioner. I advise those who



PM / The only problem when an anxiety-depression and / or burnout points its muzzle and becomes chronic regardless of the initial cause (traumatic physical or micro inflammatory or psychic or mystical etc ...) occurs, the frontal brain by default selective sorting weighting braking and information moderation (by default of chemical mediators), is no longer able to play its permanent role of filter and dysfunctions, pain, etc. .. self-maintain.

MB / Do you remember the "Reset" technique I suggested. Repeated several times, it calms thunderstorms. But appealing to "mechanism" is very effective; try and tell me. Whether it is "mechanism or reset" (which is a form of mechanism), we

dodge with the back of the hand to give it a try first...

PM / The ultimate guardian of the frontal brain shop, especially the anterior and neocerebellum brain are inseparable to be optimal The problem is that the so-called self-healing "mechanism" of the body can be repeated as the chemical and neurochemical mediators are exhausted. Or this neurochemical view of physiologisms would be wrong.

MB/ The word "reset" may not have the same meaning for you and for me, by this word I describe a manual sensation of putting at rest of a cortical zone which "rustles".

PM/ The problem is also the fact that in the phase of physical and psychic self-catabolic exhaustion of the physical body, there would not be a parallel self-destructive domination of the adrenergic and noradrenergic system 'according to my readings of physiological and physiopathological articles or there sympathetic hypothalamus involvement included) These are my first impressions. I hope not to be too confused in my explanations. Too theoretical maybe but many modest treatments that I do, always show cortical involvement and the deep White Matter of the frontal (in the form of circulating dynamic thunderstorms. Could we say a kind of reset of reformatting of the hard drive of the 'mainframe possible only on condition of not having discharged the minimum basal catabolic energy.

MB / This is theoretical and beyond me, I'm not sure how to answer. I share your point of view on the remodeling of the brain by the thought (again struc / fonc) can be by the means again of the mechanism, because a storm, a restriction, a cortical lesion only makes sense (by definition) because the mechanism is there. This is a notion that I will explain in writing.

PM / Osteopathy for me is not physiological enough. In its concept, "mechanism" is restorative physiology that only the body knows in principle, and our palluches at least for those who are experienced objectify at best to this physiological body so that it can itself take the right tracks for this. regenerate which does not always imply an immediate result.

MB / I don't know my friend! There are a lot of questions.

- The concept of "mechanism" as I have defined it is still in the dark, even if it has a manual and palpable meaning. Our hands spot the "mechanism", follow it, help it, refocus it, stimulate it ... and check the lesion for collapse ... We must progress

again, again and again!

It's hard to say, but my experience shows that the answer is immediate if you are in the right place, even in the cortical tissue. Where I follow you is that this response is often not sustainable. Especially if the "cortical wait" requires structural remodeling in which case I recommend coming back to it several times. However, what we are terribly lacking is physiological and anatomical knowledge.

PM / Consider that the cortex + the deep nuclei (thalamus, amygdala, insula ...) are formatted, deformed, veiled via the messages from all the sensory and sensory receptors in the body throughout life.

MB / I wouldn't say distorted, I prefer to say "acquisition of culture, different experiences"... and these differences could obviously be "pathologies".

PM / So all traumas, dysfunctions ... including embryonic, fetal and adult growth until the last day are contributory. So why would the mechanism not be able to perform the restorative remodeling of all strains of all kinds including the hard skeleton too. IF the brain of patient X could be grafted without rejection on a body of person Y and vice versa.

What would happen to the respective brain - body remodeling? It's exciting, but there is work to be done!

MB / You discuss, finally, the concept of "mechanism". How to answer with words when it comes to know-how, a craft! However, more often than not the "mechanism" is spontaneously restorative, and for reasons that I do not know it can stumble ... But we know how to help!

As you know, the craftsmen, companions that we are, indefinitely put their work back on the workbench ...

## EVENEMENTS

Nous nous excusons de n'avoir pas pu tenir nos engagements d'enseignement pendant l'année 2020, mais Covid-19 contraint. **Il n'est pas exclu que nos projets suivants soient encore perturbés.**

*"Le temps des viroses est arrivé"*

### Seminaire de Pediatrie du 15 au 17

janvier 2021

**A Namur/ Belgique**

Sous la présidence de **Marie-Caroline Willieme**

M.C Willieme est très expérimentée en Pédiatrie. L'«Osteopathie pédiatrique» est la même que celle que nous faisons tous les jours augmentée de savoir-faire et d'originalités propres à l'enfant. **COMPLET**  
[seoc.contact@gmail](mailto:seoc.contact@gmail)

### Journée Scientifique le 11 janvier 2021 91 *L'feuiCCy*

Sous la présidence de **V. Vallee-Cussac**

A.ORIN: Comprendre la perception  
S.KATTANDJIAN: Traitement des hémorroïdes

V.VALLEE CUSSAC: L'enveloppe maxillo faciale

T. DUSSOL: Aires cérébrales et Organes en OC (d'après Dr Hamer)

Besoin de renseignement demandez a: [seoc.contact@gmail.com](mailto:seoc.contact@gmail.com)

### AMOC

Nos amis de l'AMOC ont comme vous le savez le projet de distribuer l'ICC (Introductory Cranial Course) américain en France et en Europe. Par ailleurs ils programment des cours avancés, de perfectionnement et... prenant ainsi la suite, de la SEOC avec mon accord,

**Malheureusement cette année leurs projets sont perturbés par la COVID... Pour de plus amples informations voir site AMOC Osteopathie**

### Seminaire Vasculaire a Neuilly

les 25, 26, 27 janvier 2021

Ce cours est pour moi d'une extrême importance car:

- On peut limiter les séquelles du COVID mais pas seulement.
- Ubiquitaire, la vascularisation est la globalité autrement.
- Le traitement est-il possible sans une bonne nutrition des tissus ?

Pour tout renseignement, contenu du cours reportez-vous au site SEOC ou questionnez-nous a: [seoc.contact@gmail.com](mailto:seoc.contact@gmail.com)

### Neuro I en Hollande du 1 au 4 octobre 2020

avec Osteopatic Study

Annule

**Remplace par un Cortex I les 1, 2, 3, 4 mai 2021 a Lagos Portugal. J'y songe, et il serait Complet avant d'être officiellement annoncé**

Pour tout renseignement questionnez-nous a: [seoc.contact@gmail.com](mailto:seoc.contact@gmail.com)

### Les projets retardés par le Covid

- 2 séminaires dentaires dont le final pourrait être la prise en charge de certains cas d'Orthodontie par l'Osteopathie.
- Un enseignement de gynécologie/huiles essentielles pour lequel nombre d'entre vous ont beaucoup travaillé
- Fin de l'enseignement de Neurologie avec le SNA et un séminaire d'intégration de toutes nos connaissances.
- Enfin traiter la Structure de façon novatrice ! Une autre façon pour la Globalité et le Traitement.
- Je ne sais pas si cela sera réalisable mais vous êtes nombreux à demander un cours sur l'hypnose.
- Ces cours se feront au Portugal, sauf exception et organisation conjointe avec l'AMOC ou autre.

Questionnez-nous:

[seoc.contact@gmail.com](mailto:seoc.contact@gmail.com)

### Le séminaire d'Osteopathie Cortex II se tiendra les 8, 9, 10, 11 mai à Lagos (Portugal)

**Neurologie II** de 8h à 14h suivi d'un repas de travail pris en commun. Vous serez libre vers 15h/15h30.

Nos amis Portugais, pour l'instant, n'autorisent que 10 participants par séminaire.

Attendez que le cours soit définitivement programmé sur le site avant de vous manifester  
Pour tout renseignement questionnez-nous:

[seoc.contact@gmail.com](mailto:seoc.contact@gmail.com)