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Anterior Cervical Fixations and Comparison of Correction Methods

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In previous articles I proposed some clinical observations and conclusions on the subject of sidedness. A brief summary of this topic is as follows:

1. The right and left sides of the spine favor opposite directions of motion. The right side favors anterior superior motion; the left side favors posterior inferior motion.
2. When testing the cervical spine for motion, intersegmental testing should be done in the supine position, although it can also be tested in the seated and prone positions. Testing should be done by evaluating from the anterior and posterior aspects of the cervical spine. I have found that the right side seeks the anterior direction, and the left side seeks the posterior direction.

Anterior cervical fixations occur, therefore, primarily on the right side. There are two classifications of anterior fixations. They are:

1. **Rotation fixations,** where segmental rotation results in anterior fixations, most commonly seen at the C-1/C-2 and C-2/C-3 levels. These fixations are evaluated while performing rotation and testing from the anterior and posterior positions.
2. **Flexion fixations,** where the cervical spine resists flexion at specific intersegmental levels. This is tested from the front of the neck using motion testing, by exerting A-to-P pressure over the anterior TP/pedicle regions or intervertebral spaces, while the neck is flexed. It is a simple, yet sophisticated procedure.

(Procedures for evaluating anterior fixations are omitted to keep the subject matter brief and conceptual.)

Symptoms of right-sided anterior fixations are numerous. Examples of encountered symptoms are right-sided anterior or posterior neck pain (anterior fixations mostly encountered on right side); soreness; stiffness; SCM rigidity and swelling; right-sided headaches (mostly arising from C-1 and C-2 fixations);

swallowing difficulty, and others.

Correction of such right-sided anterior fixations (and sometimes on the left side) can be accomplished in three main ways with passive treatment:

1. **Direct Manual Adjusting -** This has been explained in previous articles and will not be detailed here. Direct traditional manual adjusting is most effective for rotation fixations. The correction of a right-sided cervical rotation fixation must be coupled with the correction of a left-sided posterior fixation (rotated and fixated P-to-A on the left side, simultaneously).
2. **A Single-Thrust Instrument -** Such as an Activator-type instrument, which can be used directly over the anterior fixation while the patient is supine. This is most effective at the C-1/C-2 level. To make it more comfortable for the patient, the doctor's thumb can be placed over the anterior fixated segment, and the instrument thrust is made over the finger.
3. **Oscillatory Multi-Thrust Instrument Adjusting -** This procedure works the best of all the procedures I have used for the correction of anterior flexion fixations, but it also is effective in the correction of anterior rotation fixations. In comparison, traditional manual adjustive or oscillatory methods do not work well for the anterior flexion fixations. The single thrust instrument also does not work as well as the multi-thrust instrument in the correction of anterior flexion fixations.

Because of the repetitive summation of impulses of the multi-thrust instrument, it has been more effective than the single-thrust instrument also in the correction of cervical anterior rotation fixations.

To correct for an anterior cervical rotation fixation with a manual rotation procedure, there must be, for example, an anterior fixation on the right side and a posterior fixation on the left side. The adjustment couples the left posterior fixation correction with the right-sided anterior rotation fixation. However, there are many instances where right-sided anterior fixations are present, but no left sided fixations are present. When this occurs, one cannot couple a left-sided posterior correction with a right-sided anterior correction. At this time, the single or multiple-thrust instruments are the treatments of choice; and as I have mentioned, I have had better results with the multi-thrust instrument. (The instrument that I have used is the Arthrostim adjustive instrument.)

There are other categories of corrective procedures that can be utilized to correct anterior fixation, such as DNFT and Toftness. I do not have direct experience with the latter it should be effective also in the correction of anterior fixations. Having worked with DNFT techniques, I do know that they are effective,

and they are used in the same application.

Right-sided anterior fixations are the most under-evaluated and under-treated spinal joint fixation complexes I have encountered. To evaluate and treat effectively these fixation dysfunctions requires sophisticated motion palpation testing and choice of technique. It is in the best interests of patients and doctors to understand and possess variable methods of evaluation and correction of cervical anterior fixations.

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