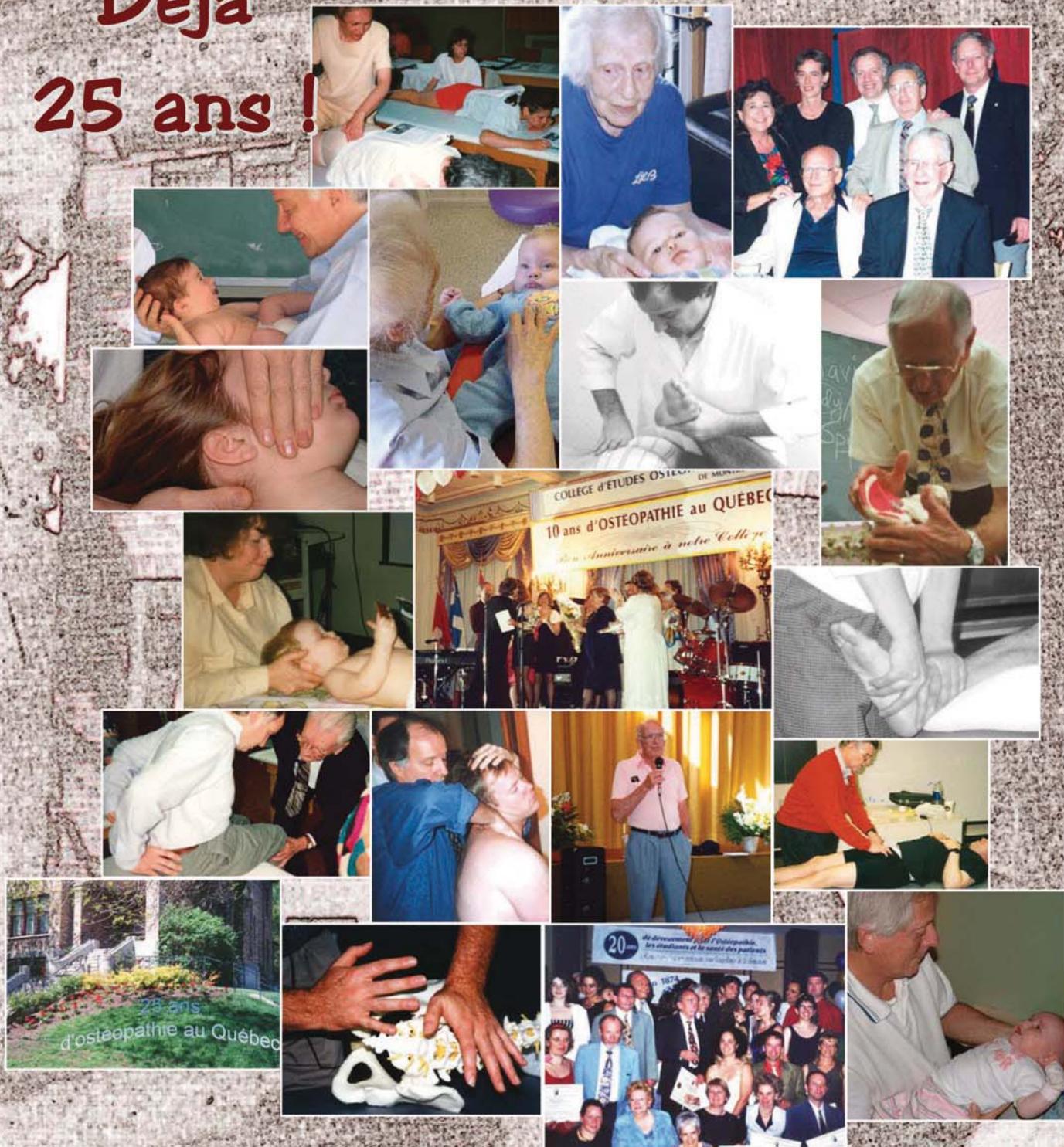


# L'OSTÉOPATHIE

## *...Précisément*

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**Philippe Druelle, D.O.** est renommé internationalement pour ses développements sur la méthodologie clinique, le traitement de l'encéphale et la chaîne centrale. Depuis 1983, il élabore des approches visant la dynamique des membranes, des liquides et des champs endocrâniens, l'activité systémique du cerveau, la dynamique des ventricules latéraux et du 3ième ventricule, la libre circulation des fluides et des énergies.  
*Philippe Druelle , D.O. is internationally renowned for the quality of his work addressing the central nervous system dysfunctions and corresponding target sites. Founder of numerous colleges and active in the research field.*



**Dr Viola Frymann, D.O.** se dévoue pour la profession, l'enseignement de la tradition et le traitement des jeunes enfants présentant des handicaps. Professeur émérite, élève de William G. Sutherland, D.O., elle a enseigné en Europe, en Amérique du Nord, en Russie et au Japon. De plus, elle a participé au développement de la recherche et a publié de nombreux articles et livres.

*Dr Viola Frymann, D.O. is dedicated to the profession, teaching according to Tradition and to treating young children presenting handicaps. Professor emeritus, pupil of William G. Sutherland, D.O., she has taught in Europe, in North America, in Russia and in Japan. Furthermore, she participated in the development of research and has published several articles and books.*



**Michèle Dangreau-Mussat D.O.** est très appréciée en Europe pour sa grande expérience dans ce domaine et pour ses qualités humaines. Sa conférence, le premier jour, sera sur " Le partage du vécu ostéopathique en maternité - comment contacter son médecin intérieur ".

**Michèle Dangreau-Mussat D.O.** is very well respected in Europe for her great experience in the field and for her human qualities. Her conference on the first day will be on the "sharing of osteopathic experiences in pregnancy, how to contact one's own inner



**Reuben Bell D.O.** New England College of Osteopathic Medicine. Director of Medical Humanities Department. Associate Professor of Biology & Basic Science at Brynathyn College. Master in Science "Zoology" 1977. D.O. Doctor in Osteopathic Medicine, graduated 1979 at Oklahoma College of Osteopathic Medicine. Seminary 1991-1997 and ordained 1997 Church of New Jerusalem. Pastor 1999-2003 (Boston area). Professor in Osteopathy associated with the Medical department at the University of New England college of Osteopathic Medicine.



**Paul Chauffour D.O.** Diplômé de Maidstone, président fondateur de l'AFDO en 1973, il est considéré comme un expert dans le domaine du traitement des artères en Ostéopathie. Il s'est passionné aussi pour les interrelations entre les systèmes et le "Lien Mécanique" qu'il a développées et enseignées aux USA, Europe et Russie. Son enseignement est généreux et apporte de très bonnes solutions pour les patients.  
**Paul Chauffour D.O.** Graduated at Maidstone, founding president of the AFDO in 1973, he is considered as an expert in the field of fasciae and arteries.



**Christian Fossum D.O.** Gradué du Collège Norvégien d'Ostéopathie, vice-principal de l'European School of Osteopathy, Christian Fossum est reconnu pour ses qualités de professeur en Europe et en Russie où ce cours a eu beaucoup de succès. Son enseignement est clair et dynamique.

**Christian Fossum D.O.** A graduate of the Norwegian College of Osteopathy, vice-principal of the European School of Osteopathy.



**Bruno Ducoux D.O.** Diplôme d'Ostéopathie DO Paris, 1985. Membre du Registre des Ostéopathes de France. Membre fondateur de l'Académie d'Ostéopathie (France) (1997) rédacteur d'ApoStill et Vice-Président de l'AO (1999-2001). Conférencier aux Etats-Unis et en Europe. Enseignant en cours post gradués en Europe et en Amérique du Nord : "Intégration émotionnelle en ostéopathie" et "Le chemin de l'ostéopathie" Anime des stages "Ostéopathie -communication avec les dauphins" aux Açores 2004 : membre du comité exécutif du WOHO : World Osteopathic Health Organisation Pratique l'ostéopathie en libéral à Bordeaux et à la maternité Saint Martin de Pessac.



# *Le syndrome de la tête plate ou le bébé qui dort sur le dos.*

Par Viola Frymann  
D.O.FAAO

## Résumé

*Alarmées par le syndrome de mort subite chez les nouveau-nés et les jeunes bébés, les associations pédiatriques ont convenu de recommander de faire dormir les bébés sur le dos, craignant qu'ils s'étouffent dans leurs draps en étant posés à plat ventre.*

*C'est depuis ce moment qu'une campagne de sensibilisation lancée en 1992 a contribué à diminuer de plus de 50 % les taux de décès.*

*Mais plusieurs mères inquiètes se présentent maintenant chez le médecin parce que leur bébé se retrouve avec un méplat*

*très prononcé au niveau occipital, souvent plus accentué à droite ou à gauche (tête croche ou plagiocéphalie) selon le côté ou la tête du bébé a tendance à se poser ou lorsque le lit d'enfant n'est accessible que d'un côté.*

*Les ostéopathes voient aussi venir ces bébés affectés de symptômes variés de congestion des voies respiratoires supérieures, parfois compliqués d'otites. Reflux gastrique et même régurgitation en jet peuvent même faire partie de ces symptômes.*

*Dr Frymann élabore sur le sujet en parlant des conséquences tardives, jusqu'aux problèmes académiques vécus par ces enfants. Elle analyse les types de lésions retrouvées au niveau des sutures crâniennes, le retard de développement de certaines structures osseuses et ligamentaires du crâne ; les nerfs crâniens les plus souvent affectés et les céphalées découlant de ces différentes dysfonctions.*

*Le bébé braillard peut même être obligé de pleurer pour stimuler sa respiration ! Une naissance difficile peut aussi être responsable de l'apparition de cette tête plate. Dr Frymann complète son article en décrivant les différentes étapes du traitement ostéopathique à offrir à ces enfants et quelques petits trucs à enseigner aux parents pour potentialiser l'effet de votre traitement.*

## *The Flat Head Syndrome Or “Back to Sleep”*

Fig. 1a  
Bald area across occipital squama

Concern over the loss of life of newborn or young infants due to Sudden Infant Death Syndrome (SIDS) lead to a directive from the American Academy of Pediatrics that healthy newborn babies, and those within the first months of life should be taught to sleep on their back. This "back to sleep" campaign was launched in 1992. Since then the rate of SIDS has declined by more than 50%.

This is not the position of choice of most babies, however they can be positioned on the back, or on the side if supported until they become accustomed and cooperative in this measure.

At the time when this directive was first made it was not uncommon to use a sheepskin cover on the mattress to provide a warm, cozy, comfortable resting place for a baby. Such a surface however has a hairy quality which may compromise breathing if prone, especially if this infant is not yet able to lift and turn the head spontaneously. A baby's bassinette or crib should have a mattress covered with a fitted cotton covering that does not crease or wrinkle and thereby compromise respiration.

But, to return to some consequences of the "back to sleep" practice. If the baby has a significant amount of hair early in life, and especially if it is dark, the first observation is a relatively bald area across the occipital squama.(fig.1.) One of the presenting complaints may be spitting up or vomiting



after feeding for which a diagnosis of reflux has been made, and medication to counteract this reverse peristalsis may have been prescribed.

Now observe the baby's head in profile when the child is held in a sitting position or supported on mother's shoulder. Focus attention first on the ear. Next note the form of the head behind the ear. Do you see a gentle convex curve like a "C" or is it flat, closely resembling the L shape. This does indeed justify the term, a "flat head syndrome". This flatness of the head, with time, may become asymmetrically deformed, with protuberance of the posterior quadrant of the head on one side (**figs 1b, 2**) because the skull of the developing infant is more pliable and malleable than that of an older child, the "flat head" progressively becomes a crooked head, namely plagiocephaly.



**Fig. 1b** Flatness of the occiput



**Fig. 2 ... asymmetrically deformed**

Furthermore the distortion posteriorly and laterally may compromise the three developing parts of the sphenoid anteriorly distorting the orbit and impairing the function of the extraocular muscles. The resulting visual perceptive dysfunction is a common component of the academic problems of children. The cosmetic form of the head however is not the most vital concern. Let us consider the anatomic physiology of the region. The base of the occiput articulates with the base of the sphenoid the Sphenobasilar, syncondrosis, the primary center of motion of the primary respiratory mechanism (PRM) moving in flexion - extension, the inhalation, exhalation rhythm of the PRM. The base of the occiput also articulates bilaterally with the petrous portion of the temporal bones and drives them into the external and internal rotation motion of the PRM. The base of the developing cranium is like a saucer with the sphenoid anteriorly, the occiput posteriorly and the petrous portions of the temporals like a wedge bilaterally between them. The petrous temporal contains the organs of the inner ear, the middle ear and the Eustachian tube which extends from the tympanic membrane of the auditory canal to the nasopharynx. A common problem during the first three years of life is recurrent otitis media when secretion of mucus accumulates in the middle ear and eustachian tube, and may then become infected, leading to impaired hearing. Research (Mills) has confirmed that impaired motility of the various developmental parts of the temporal bone contributes to recurrent otitis media. Dysfunction in the petrobasilar, petrojugular and occipito mastoid sutures may result from traumatic compression through the occiput as in the "flat head syndrome". The vagus nerve X which innervates the gastro-intestinal system may be compromised in the jugular foramen through which it leaves the cranium. The result may be spitting up, or vomiting in the newborn, and digestive idiosyncrasies in childhood and later.

Impairment of temporal motion at the Occipito- mastoid articulation may have far reaching effects due to impairment of venous drainage through the jugular foramen, the pathway for 95% of venous drainage. Nasal congestion and sinusitis may develop recurrently and incapacitating headaches may be described. Never underestimate a complaint of headache in a child. Examine the cranial mechanism, identify areas of impaired inherent motion and thereby restore optimal well-being.

The osteopathic considerations are not confined to bony structure however. The boney mechanism is sustained in its anatomical integrity and its physiologic motility by the dural membranes which, through the sutures, are continuous with the periosteum of the cranium and also with the whole fascial mechanism of the body. Furthermore the dural membranes, firmly attached to the occiput at the Foramen Magnum continue as the spinal dura to attach to the sacrum below.

During the examination of the newborn, or the infant note the respiration. Is there a smooth rhythm of thoracic motion or is it irregular, sometimes deep, interrupted with gasps or rapid with ineffective thoracic excursion. The crying baby may need to cry to stimulate breathing. Palpate the position and motion of the temporal bones. Are they restricted in motion by that flattened occipital squama particularly impeding motion at the occipito mastoid. Here the PRM is disturbing the secondary respiratory mechanism, namely breathing. When free efficient respiration is restored by normalizing the PRM the infant will no longer have that necessity to cry. Now they will smile.

In conclusion therefore when the infant is presented to you with a flattened occipital area which may already be bald think anatomy, the occiput and its developing articula-

tions, the temporal bones and their integration with respiration, and the auditory apparatus. The neurological pathways descending between occiput and temporal, and the sphenoid may all exhibit dysfunction due to the extended effect of the compression from the occipital flattening. Never fail to note the fascial integration of the whole body from the flat occiput, by the ligamentum nuchae, the spinal and pelvic ligamentous mechanisms. From there the return will consider the pelvic diaphragm, the thoracic diaphragm, the mediastinal fasciae and then to the cranial diaphragm attached to the lips of the transverse sinuses on the inner surface of the flattened occipital squama.

## Prevention

If you receive an inquiry from a mother of a newborn baby concerning the sleeping position, first examine the child. Look at the form of the head, the freedom of motion of the head and neck when in a sitting position or supine. In the prone position does the infant spontaneously lift and rotate the head. This is a most important observation. If the child was born prematurely marked weakness may be noted and this baby is not yet ready to be placed prone unobserved. Until the infant can and will lift the head when lying prone and turn it from side to side, I think it is legally and physiologically wise to recommend that the child be arranged on the back or on the side with pillow support to prevent rolling forward while sleeping. It is my opinion that the child who has a long or difficult labor, and has received some compression of the condylar parts of the occiput and neighboring structures is more likely to develop the "flat head syndrome". This child should therefore receive corrective osteopathic treatment as soon as possible.

(Research has revealed that 80% of 1250 neonates had suffered some significant restrictions of the cranial

mechanism.) Re-evaluation should be repeated at intervals to maintain free anatomic physiologic integrity.

Treatment must be designed for the specific patient but generally it will include:

- 1) Decompression of the condylar parts of the occiput.
- 2) Gentle direct decompression of the sphenobasilar synchondrosis. gently grasp the greater wings of the sphenoid with the thumb and middle finger of the right hand and the apophysis of the mastoids with the other thumb and middle finger.
- 3) Any developing suture may be decompressed by a V spread technique.
- 4) In the presence of irregular respiration place the index fingers on the mastoid apophyses of the temporal and gently follow them into symmetrical rhythmic external and internal rotation.

But during waking hours the child should spend as much time as possible prone on the floor with gentle stimulation of the feet beginning the alternating motion of crawling. Someone should also position them-

selves on the floor beside this little one to talk to them, provide interesting objects to watch and manipulate thus making it fun for them.

When the child demonstrates an ease of raising and turning the head, and now selects the prone position for sleep, provide a sleeping surface with a taut fitted covering that cannot compromise the functions of the nose.

**Fig. 3 and Fig. 1c Plagiocephaly and torticollis often go together**



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