

MS and CP Mechanisms

Here are mechanisms for how Advanced BioStructural Correction™ can improve Multiple Sclerosis, ALS, Cerebral Palsy and other like conditions that have been ignored though show workable by neurosurgeons for over 30 years.

[An explanation for lay people as well as professionals.](#)

A Swedish neurosurgeon, Alf Breig, noted that the neurological effects of multiple sclerosis and other like conditions were based on the effect of breakdowns in skeletal structure and alignment causing tension (stretch) on the central nervous system and other parts of the nervous system. He published many papers on the separate experimental findings over the course of the 1950s, 60s, 70s and 80s. He collated the first 25 or so years of his research in the book, *Adverse Mechanical Tension in the Central Nervous System* in 1978. After a further decade of research confirmation and additional finding, he published the findings with the additional data and confirmation in 1989 in the book, *Skull Traction and Cervical Cord Injury*.

Breig's work has been confirmed by several other neurosurgeons, Yamada¹⁻¹¹, Lee¹² and others. Further, there is literature noting the causal link between trauma caused structural problems and MS¹³ as well as case studies demonstrating reduction of symptoms and lesions with structural treatment¹⁴ that has been all but ignored by the various societies looking for a chemistry answer that will never be found.

The works follow a few main points: The first is that the general theory held by Medicine, Chiropractic and other healthcare disciplines that pinching of a nerve causes reduction of nerve function is incorrect as a basic mechanism. It does occur but the reason for it is not the pinching effect. The basic mechanism behind reduction of nerve function is stretch of the nerve. Breig showed those effects in experiments over the course of 30+ years but it was Yamada especially and others who definitively demonstrated the mechanism during research on Tethered Cord Syndrome.

One can read the details in the references below. The basic data and the effects can be explained without going into the biology and chemistry. The basic point is that if nerve cells are just stretched to a certain point, with NO DAMAGE TO THE NERVE CELLS, the nerves cease to function. Lay people working to understand this section need to know the difference between Upper Motor Neuron problems and Lower Motor Neuron problems, see the box to the side.

When structure becomes misaligned and begins to breakdown, IF it does so in a way that causes the stretch of the brain, brain stem and spinal cord you will often get the production of hard lumps of tissue from the rubbing of the various tissues in the spinal cord. (These are the "sclerosis" tissues — "sclerosis" is from Greek and means hardening. Multiple Sclerosis is just a Latin term meaning many hard lumps of tissue. It is a descriptive term because the medical people have no idea how it works).

Once the sclerotic (hard) lumps of tissue are in the brain, brain stem and/or cord, they only cause problems if the cord is stretched from head to tail (buttock). Without the additional stretch from a person being stuck forward

the nerves are not stretched enough to adversely affect them. This is also true of things outside the spinal cord like disc problems and bone spurs. The best way to explain this is a diagram from Breig's book.

A few terms to understand for the caption are listed below:

Upper Motor Neuron

is a nerve cell going from the brain down the spinal cord. It ends on and controls the actions of the Lower Motor Neurons by inhibiting the LMN from constantly firing.

When the UMN is absent or not working the Lower Motor Neurons continuously fire causing the constant contraction of the muscles it controls.

This is called spastic paralysis because there is no control of the muscles (paralysis) yet the Lower Motor Neuron constantly firing on it causes constant contraction of the muscle (spasm).

Lower Motor Neuron

is a nerve cell going from the spinal cord to a muscle in the body. It will constantly fire and cause muscle contraction unless inhibited by the UMN. When the LMN is not working there is flaccid paralysis because the LMN is not firing and the person cannot cause the muscle to contract. It is always loose (flaccid).

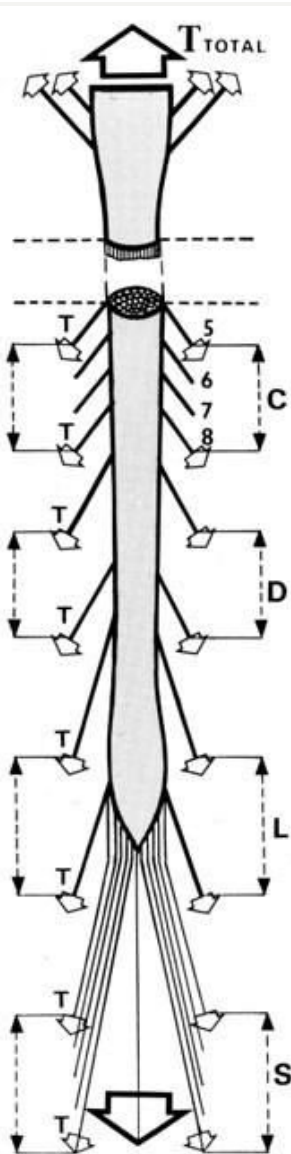


Fig. 93. The cranialward increase in tension set up in the spinal cord on flexion.

The total force (T_{total}) focused in the upper part of the pons-cord tract is the resultant of the component forces acting in the individual nerve-roots (T).

Inset. The higher the level of a pathological structure in or beneath the cord the greater is the tension it produces. The resulting increase in the total force will be transmitted practically undiminished to the lumbosacral nerve-roots (53, 250). The cranialward tension produced by a herniated lumbar disc, on the other hand, cannot exceed about one-thirtieth to one-twentieth of the tension produced in the lumbosacral nerve-roots by a similar protrusion located at the cervical level.

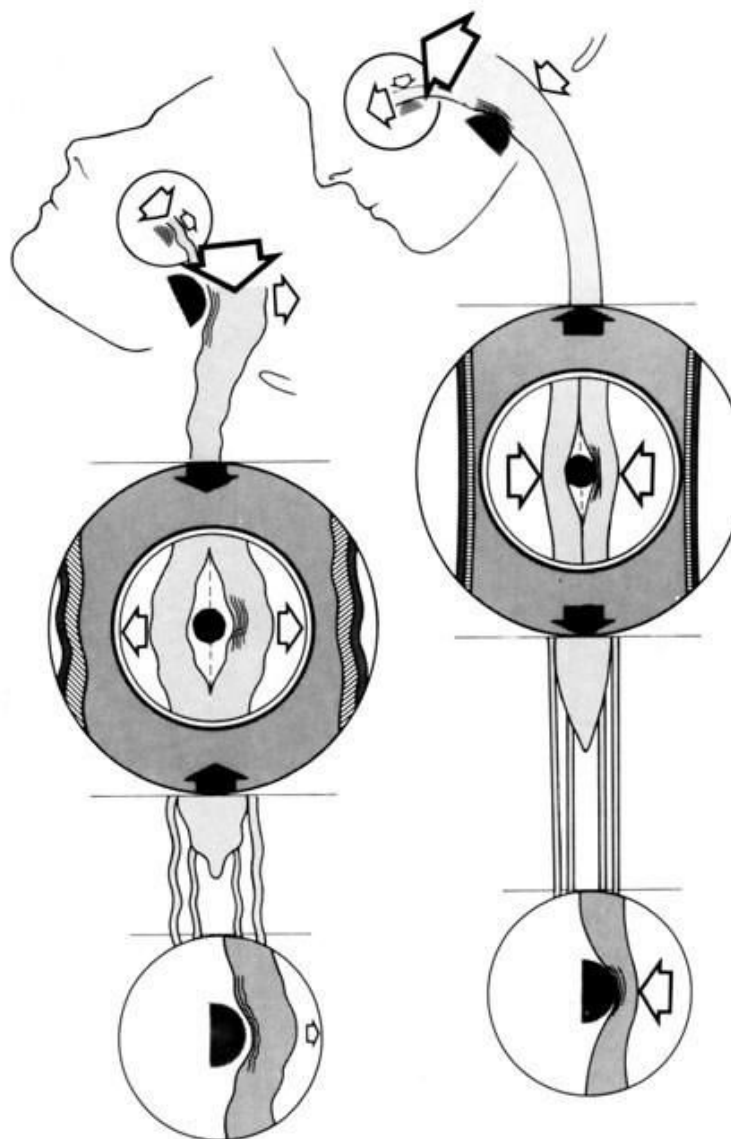


Fig. 94. The origin and elimination of stress produced by impinging bodies (hatched shading) at various levels of the pons-cord tract.

Right. Bending tensile stress set up in the nervous tissue in the vicinity of impinging bodies on elongation of the spinal canal accompanying flexion.

Left. The stress is eliminated throughout the tract by relaxation of the cord produced on extension.

Top, in the circles. Impingement may arise from the margin of the petrous bone (206), calcified tissue (132), a tumour or the like (15, 74, 163, 210), all located near the trigeminal nerve-root.



Below the circles. Clivus tumour or anteriorly located foramen magnum tumour, or the like.

Centre right (magnified). An intramedullary firm body (Figs. 88, 99) setting up a bending tensile stress in adjacent nerve-fibres.

Centre left (magnified). The relief of this tension by relaxation of the cord.

Bottom right (magnified). Stress set up in a nerve-root by a herniated lumbar disc.

Bottom left (magnified). Relief of this tension by relaxation of the nerve-root.

- **Cranial** means head so **cranialward** means toward the head.
- The **pons-cord tract** is the brain stem and spinal cord considered together as the single thing it is. Anatomists call the top part of the spinal cord just below the brain the “pons”, also known as the brain stem, because it is shaped a bit differently from the rest of the cord.

- **Pathological** means abnormal, so a **pathological structure** is an abnormally shaped or abnormally positioned structure.
- **Tensile** is an engineering term meaning having to do with tension or stretch — in this case stretch of the spinal nerves from the head to the tail.
- **Petros bone** is a hard bone on the side of the head making up the inner ear.
- **Trigeminal nerve** is a nerve directly from the brain to the face controlling those muscles.
- **Intramedullary** means inside the cord.
- **Extramedullary** means outside the cord.
- **Lesion** is a word that means the point of any type of abnormal structural change in the body.
- **Space Occupying Lesion** is any lesion that takes up space abnormally.

Taking the diagrams with the head and pons-cord tract. The one on the left is with the cord slackened. The one on the right is with the cord stretched. They demonstrate what happens when there are various space occupying lesions around or in the cord. Specifically noted in the text are an extramedullary tumor near the top of the spinal cord, some sort of intramedullary (in the cord) space occupying lesion in the middle of the cord and extramedullary lesion toward the bottom of the cord (herniated lumbar disc).

Breig notes that there is enough change in tension of the cord with flexion and extension of the head to make a large difference.

With MS the specific concern is with the intramedullary sclerotic lesions. What the middle parts of the diagrams show is the effects the sclerotic inside the cord lumps of tissue have on the nerves. On the left, with the cord slack, even with the lump of tissue the nerves function normally with no loss of function because they are not stretched, or not stretched enough, to cause problems.

On the right, with the cord tensioned, the lump of tissue increases the tension on the nerves so they stop functioning. Keeping in mind the nerves either carry sensations or control muscles. If the ones carrying sensation are affected the person feels things that are not there or experiences a loss of the ability to sense things (that are transmitted by that nerve or those nerves). If the ones controlling muscles are affected (keep in mind these are Upper Motor Neurons) there is spastic paralysis of the muscles affected.

Breig demonstrated on quite a few patients and specifically came to the conclusion that the effects of slackening the cord are the same as removing the lesions (better actually because no associated damage due to the surgery).

Multiple Sclerosis Example

Looking at this patient before and after her first treatment with the Advanced BioStructural Correction™ protocol you can see that the length of the cord is reduced with structural correction.

Watching the videos below you can see the vast improvement in function that comes with structural correction that actually works.

The point is that a body with its structure corrected stays upright with little muscular effort and provides for a more optimum spinal length and less to no tension on the cord and brainstem.

That is what the Advanced BioStructural Correction™ protocol does and that is why the effects on any neurologic condition improves.

How much any one body's condition can or will improve depends upon its structural condition when treatment it started.

