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## Osteopathy In The Cranial Field Magoun Pdf 16

In our study, children with restrictive skull growth patterns (average 6.35 per cent reduction in A-P cranial growth) had significantly lower risk of AOM compared with children without restrictions (relative risk [RR] 5.9; 95 per cent confidence interval 3.9 to 9.6) in univariate and multivariate analyses. Restrictions in A-P cranial growth at initial evaluation were also associated with an increased risk for subsequent AOM in multivariate analyses (RR 3.9; 95 per cent confidence interval 2.4 to 6.4). There are many possible explanations as to why children with restrictive cranial growth patterns have an increased risk of AOM. Developmental studies suggest that the thickness of the calvarial sutures is greater in children with restrictive cranial growth patterns. This could lead to compression of the sinuses, superior sagittal sinus, and especially the optic nerve sheath. This compression would result in transient ischaemia and Wallerian degeneration, stimulating sheathing of the optic nerve. The lower risk of AOM associated with restrictive cranial growth patterns may be partially attributable to the few children who presented with cranial abnormalities or restricted growth patterns at birth. This study cohort represents the data from a study of normal development and growth of the head during childhood and early adolescence. Long-term follow up is necessary to identify risk factors for AOM in this age group. Further research should be conducted to confirm these findings in a group of children with risk factors (including anatomically based AOM) and determine whether growth patterns or skull features may influence the occurrence of AOM in adulthood. Furthermore, the measurements obtained on standard lateral cephalometric radiographs are the best available measure of A-P cranial size and shape. Additional research should identify which anatomic features are most strongly associated with an increased risk of AOM.





This does not necessarily mean that MMT is superior to all other modalities, nor does it mean that in most cases these modalities will be ineffective. All other methods besides MMT have their place and utility as a complement to MMT. MMT, however, can be used independently to evaluate the cranial field (or area) and the activities of the cranial system. This method usually eliminates the need for other modalities. Cranial diagnosis is always the key to cranial treatment

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and is done solely on the basis of using MMT and its diagnostic possibilities. A system of cranial diagnosis based on the concept of cranial biomechanical stress is being developed, and it will become a central focus of future publications. Only when cephalic stem dilation has occurred to the point where very little lateral dura mater is present in the lateral aspect of the middle cranial fossa can MMT be performed successfully by non-surgically disengaging the transverse sutures in the frontal, ethmoidal, sphenoidal and maxillary bones of the cranium.

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If a similar technique is applied to the cranium of a newborn infant, then it could be possible to split the cranium in half lengthwise along the sagittal suture and lift it from the base of the skull and the facial plane, thereby allowing direct access to the dural spaces of the cranial fossae without opening the dural sacs of the brain. In a cranium where the dura mater is in excellent condition, and the sutures are not split, and no fractures, distortions or lesions of the transverse and sagittal sutures are visible on the ocular examination, cephalic stem dilation is usually

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