Oncological Terrain - OT table - Guidelines

Quantum Biophysical Semeiotics: Basics practical tools

Auscultatory Percussion of the Stomach

The *auscultatory percussion of stomach* playes a primary role in Quantum Biophysical Semeiotics - QBS. Doctor who knows this method and can apply it properly and safely, can observe, in easy and rapid manner at the bed-side, a very large number of both signs and reflexes, which allow him to recognize several pathologies, even potential or in their pre-clinical stages. Notoriously, the stomach is innervated by two gastric nervous plexes, linked to *celiac plexus*, where a large number of reflexes, originating from almost every tissue and organs, end. Interestingly, if we stimulate by digital nail pressure or otherwise by pintching cutaneous trigger-points, in the stomach occur, as already known, volume and form modifications, termed as *gastric aspecific reflex*, vagal and sympathetic, and *tonic gastric contraction*, as in case of appendicitis (Figure 1 and Figure 2), cancer, starting from its initial stage of Inherited Real Risk, rheumatic and autoimmune disorders.

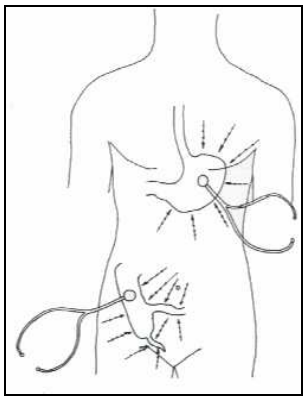

Figure 1

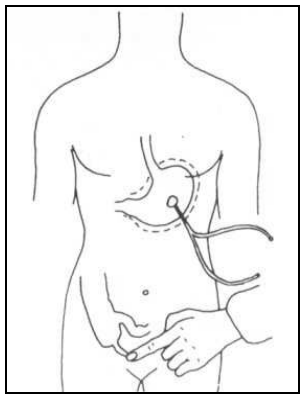

Figure 2

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1- Position of the patient

The patient is lying down in supine position, psycho-physically relaxed, with open eyes to lower melatonin secretion (Figure 3).

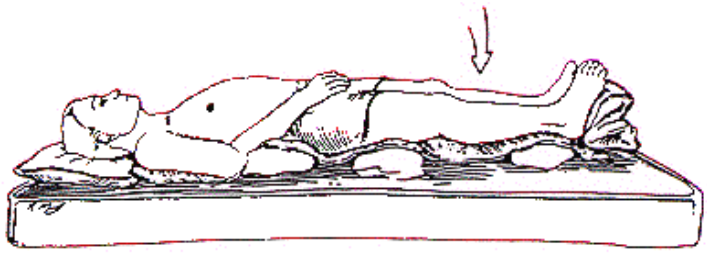


Figure 3

2- Demarcation of the greater curvature of stomach

A short piece of great gastric curvature in its inferior segment have to be ascertained, seen that the stomach can be in different position depending of the patient physical structure (Figure 4, Figure 5, Figure 6).

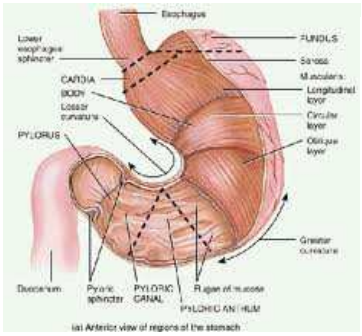


Figure 4

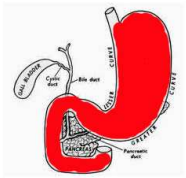


Figure 5

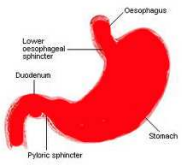


Figure 6

3- Sthetoscope positioning

The patient helps physician by fixing the bell-piece of sthetoscope on cutaneous projection of the interested parenchyma (i.e., stomach, urether) with a finger-pulp (Figure 6). In the case of Gastric Aspecific Reflex, the bell-piece of the stethoscope is fixed upon any point of cutaneous projection of the stomach.

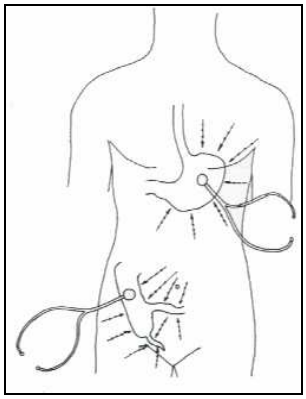


Figure 6

4- Percussion of trigger points

Doctor performes the percussion with middle finger, bended like a little hammer, *directly*, *very softly*, and *gently*, on the skin (trigger points, green dots in the Figure 8), two time subsequently on the same point before moving on, towards (green arrows, Figure 7) the bell-piece of sthetoscope (1 cm. away), along centripetal and radial lines, as quickly as possible (green dots, Figure 8).

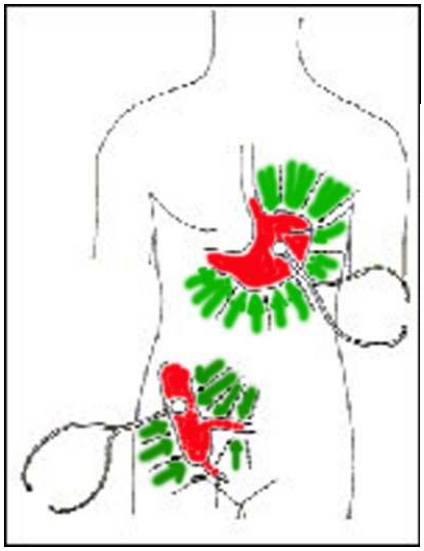


Figure 7

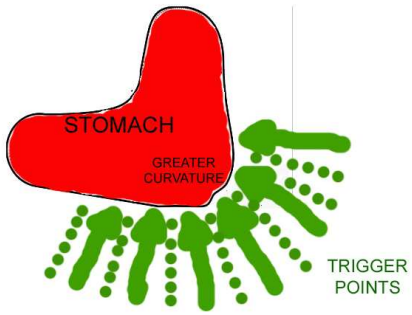
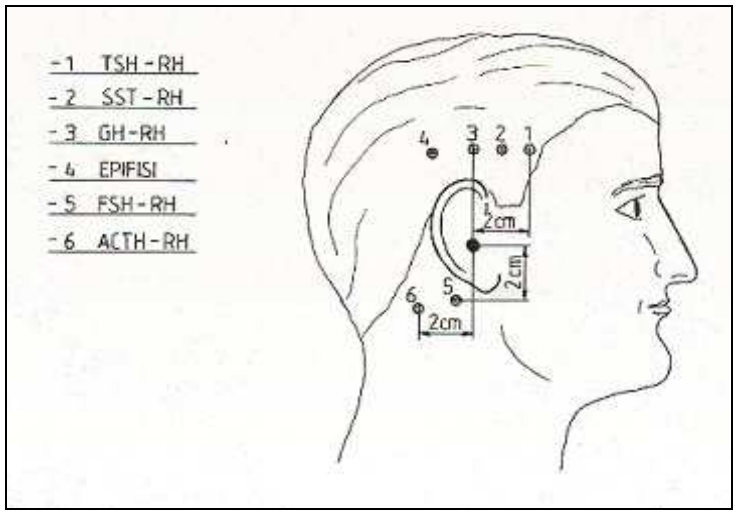


Figure 8

Pay attention! When digital percussion beats "directly" the stomach projection (or the cutaneous projection area of whatever viscera, of course, red areas) percussory sound is perceived clearly modified, more loud, and it appears as "originating near doctor's ears". At this point, it is advisable to perform the auscultatory percussion for the second time, at least in initial stages, when there is no great experience, in order to avoid some mistakes, for instance, due to peristaltic wave. Digital percussion must be just on green dots (trigger points), and never on parenchimas (red areas of Figure 7 and Figure 8).

5- Digital pressure applied on epiphysis (simultaneous to point 4)

Intense digital pressure applied upon **cutaneous projection of epiphysis (**Figure 9**) or of SST-RH (**more practical and easy to find, located above the external auditory meatus), brings about **Epiphysial - Gastric Aspecific Reflex (Ep. G. A. R.),** called the Rinaldi's Sign.



Epiphysis and SST-RH - Figure 9

6- Auscultation of Ep. G. A. R.

The **Ep. G. A. R.** is characterized by 3 key measures: Latency time, Intensity and Duration of the Reflex.
The time that passes since the beginning of percussion till the initial auscultation of the reflex is called **Latency Time (Lt)**, and is expressed in seconds.
The time that passes from when you start listening to the first reflex until his death is called reflex **Duration (Du)**, which is also expressed in seconds.
The **Intensity (In)** of the reflex refers to the observed gastric dilation and/or contraction, and is expressed in cm.

Microcircular Functional Reserve

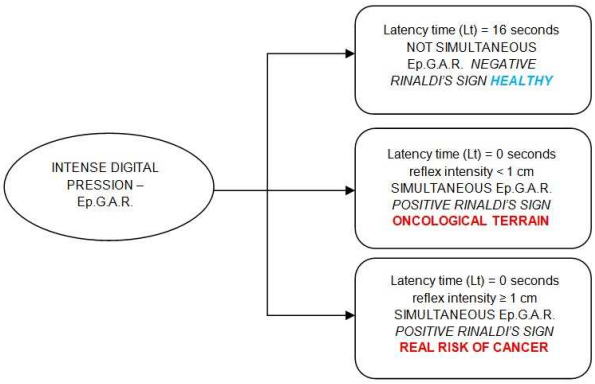
Alterations of mit-DNA and n-DNA cause CAEMH, a parenchymal gene mutation that induces, in case of intense CAEMH, a 'Local Microcirculatory Remodeling' (LMR), a congenital microvascular remodeling possible to evaluate and investigate getting information about, for instance, heart parenchymal cells through several QBS signs and behavior, according to Angiobiopathy theory. Through the observation of EBD (Endoarteriolar Blocking Devices) and their structure and functioning on parenchymal microvessels we can study the LMR and investigate if there is OT (Oncological Terrain) or inherited real risk of cancer and entothelial dysfunctions. A lowering microcirculatory blood flow is brought about by LMR due to newborn-pathological, type 1 subtype a) tumoral, EBD synonymous of reduced tissue oxygenation. Through quantum biophysical semeiotics we can measure and evaluate the 'Microcirculatory Functional Reserve' (MFR) activity of related parenchymal microvessels. MFR is correlated with microcirculatory bed or Tissue Microvascular Unit (T.M.U.) and is possible to evaluate it through the observation of tissue oxygenation, tissue pH, T.M.U. structure and function, local metabolic situation, myocardial preconditioning and EBD investigation.

Tissue Oxygenation and Rinaldi's Sign

Tissue oxygen supply can be assessed clinically in a precise way. In health, **intense** digital pressure applied upon cutaneous projection area of the epiphysis, brings about **Epiphysial and SST-RH - Gastric Aspecific Reflex (Ep. G. A. R.)** after a latency time (Lt) of 16 seconds (table 1), informing on tissue oxygenation at rest: negative Rinaldi's Sign.

Under the above mentioned conditions, if **Ep. G. A. R.** appears immediately, simultaneous to the intense pression of epiphysis trigger points, so that Latency time is equal to zero, Lt = 0, the *Rinaldi's sign* is positive revealing the Oncological Terrain of the patient. In this last case **Epiphysial and SST-RH G. A. R.** is infact simultaneous and its intensity is correlated to the numbers of EBD type 1, subtype a) tumoral, pathological neoformed, whose quantity is possible of accurate assessment on the basis of the parametric values of middle uretral reflexes.

Epiphysial and SST-RH Aspecific Gastric Reflex (Ep.G.A.R.)
Intense digital pression on cutaneous projection of epiphysis– Rinaldi's Sign



Scheme 6. Legend. Ep.G.A.R. (Epiphysis Gatric Aspecific Reflex); Lt (Latency time)

Oncological Terrain

Epiphysical - Gastric Aspecific Reflex (Ep. G. A. R.)
intense digital pressure on cutaneous projection of epiphysis or SST-RH centre

Latency time (Lt) in seconds	**MFR in seconds (Du)**	**fD & equilibria ***	**tGC – tonic Gastric Contraction (In)**	**Diagnosis**
Lt = 16 Negative Rinaldi's Sign	3< MFR <4 normal MFR, associated activation, outcome +	fD ≥ 3 (ideal value fD=3.81) stange attractor	**Absent**	Health
Lt = 0 positive Rinaldi's Sign	MFR = 4 compromised MFR	2<fD<3 limit cycle	**tonic Gastric Contraction - tGC -** local autoimmune syndrome - accompanied by gallbladder - and splenic contraction - decongestion: **positive tCG**	Oncological Terrain (see tables about different types of cancer to refine the diagnosis)
Lt = 0 positive Rinaldi's Sign	4< MFR≤ 5 growing compromised MFR	1<fD≤2 limit cycle	**tonic Gastric Contraction - tGC -** local autoimmune syndrome - accompanied by gallbladder - and splenic contraction - decongestion: **positive tCG**	Inherited Real Risk of Cancer (see tables about different types of cancer to refine the diagnosis)
Lt = 0 positive Rinaldi's Sign	MFR>5 absent MFR	fD=1 fix point	**tonic Gastric Contraction - tGC -** local autoimmune syndrome - accompanied by gallbladder - and splenic contraction - decongestion: **positive tCG**	Overt Cancer (see tables about different types of cancer to refine the diagnosis)

*Table 1. Legend: MFR (Microcirculatory Functional Reserve); fD (fractal Dimension); Lt (Latency time of reflex); Du (Duration of reflex); The two colums in 'OT table' about EBD and Microcirculatory Activation are here note explained here because have to do with urethereal reflexes and Microclinical Angiology. Here we explain just gastric aspecific reflexes. *see tables about different types of cancer to refine the diagnosis about fD*

Intensity of Gastric Aspecific Reflex – FAQ

What is the unit of measurement of the intensity of gastric aspecific reflex?
The intensity of the reflection is measured in centimeters. Both the gastric aspecific reflex (dilatation of the stomach) and the tonic Gastric Contraction – tGC - can be measured in cm. There is a distinction between physiological expansion and contraction of gastric tonic: the last one only happens in case of disease.

When we say that the Gastric Aspecific Reflex – G.A.R. - is physiological? And when is it pathological?
G.A.R. is "physiological" if the Latency time (Lt) of the reflex, duration (Du) of the reflex, and duration of its disappearance (fractal Dimension - fD) are physiological. G.A.R. is "pathological" if the three parameter values (Lt, Du, fD) are abnormal. If there is Inherited Real Risk and initial pathology (or disappearing pathology) only Du and fD are abnormal, while Lt falls within the normal range.

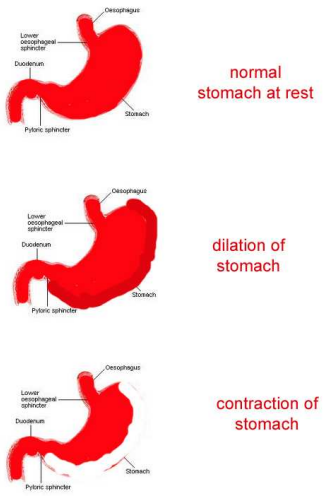


Figure 10

How does the stomach contract and how does it expand?
In Figure 9, there are three cases: *stomach at rest* in its normal shape, *dilated stomach* (in full, with the exception of part-pyloric antrum, duodenum close to the contracts) after auscultatory percussion, and *contracted stomach*. In the case of dilated stomach, the stomach collapses, decreases in thickness, and thus the reduced thickness provokes the stomach expansion, occupying more space than upon an imaginary plane, and given that stimulates the bottom of the big bend in the stomach, it goes down, inter alia, transhipping the start line of the stomach at rest (the central one in Figure 10 in this expansion is highlighted, for example, a 1 cm down, with a different red color). In the case of *tonic Gastric Contraction*, **which always occurs after the dilation or expansion**, but the stomach thickens, and so physically appears to be a contraction, or it goes up, compared to the initial line of the lower part of the great gastric curve at rest (figure 10 below): this contraction is marked with a white line (i.e., 1 cm) in the figure 10 below.

When does the contraction of the stomach appear?
The contraction appears at the end of the duration of the first reflex, which may persist for three or more seconds. The expansion is always observed, however, and it always appears after

the latency time, while the contraction, if there were, appears a few seconds after gastric aspecific reflex (expansion or dilation).

Where is made the measure?
The measure is taken comparing the baseline of the greater curvature of the stomach - stomach at rest (Figure 10), with the new position of the borderline of the stomach (if upwards in case of contraction, or down, in case of dilation).

In which specific cases appears tGC (tonic Gastric Contraction)?
The tGC is not always, but depends on the case: i.e., there is tCG in Oncological Terrain, inherited real risk of cancer, iappendicitis, reumathic diseases; there is tCG in Overt CAD but not in the real risk of CAD.

Why does the stomach contracts in some cases of inherited real risk, and not in others?
For instance, only in the inherited Real Risk of malignant tumor is observed tGC, but not in other inherited real risks because the EBD (Endoarteriolar Blocking Devices) are different, depending on different pathological conditions. We can observe different kind of structural obstacles (technically, different type of EBD, i.e., different structures) to the supply of energy - matter - information towards the relative parenchyma.

Why does the stomach contract? What are the biological, physical and chemical motivations?
This happens because it does increase in vagal or simpathetic tone respectively, slow-growing. In confirmation of this fact it is here suggested a simple experimental test: even in healthy, three seconds after the start of the apnea test, the stomach shows Gastric Aspecific Reflex, followed immediately (adrenaline acid histangic have reached the critical level) by tGC. The expansion however, is physiological, and always appears after the latency time of reflex (followed then by the contraction, if there is, depending on whether the subject is indeed in good health, and on the specific real risk or pathology).

"Interestingly, if one stimulates by digital nail pressure or otherwise by pintching cutaneous trigger-points, in the stomach occur ***obviously volume and form modifications****, termed as Gastric Aspecific Reflex – G.A.R., vagal and sympathetic, and tonic Gastric Contraction - tGC, as in case of appendicitis. Aiming to corroborate proper application of the method, the doctor can use the apnea test (healthy subject does not breath) or boxer's test (healthy individual clenches fists) or the* ***Restano's manoeuvre*** *(simultaneous performance of both tests); these tests bring about sympathetic hypertone, that induces gastric aspecific reflex, before of "sympathetic" and than (only appearently) of "vagal" type, in any case short lasting: in later one, in the stomach, fundus and body are dilated, whereas antral-pyloric region contracts. In facts, in healthy, there is a perfect balance also in nervous system, On the contrary, during sympathetic hypertone antral-pyloric region is dilated, too. In case of infiltrative disorder, the site involved by cancer, obviously, does not dilate, whereas all parts dilate intensively in acute diffuse gastritis, e.g., related to the seriousness of disorder."*

The stomach swells in some of its parts, in other parts contracts if these parts are sick, infiltrated, hardened. Where will place the doctor the hands in order to measure the intensity?
The doctor only has to calculate the distance between the baseline of the stomach (greater gastric curvature borderline at rest) and the new line, achieved, measured in cm, and observing the distance traveled by the greater gastric curvature in its gastric dilatation and, if there is, the next contraction.