LDT AND RENAL STONES. A CLINICAL CASE.

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When Sophia* came to the office with gastro-intestinal symptoms, I was a little concerned. Sophia is a Caucasian women, about 50 years old, long time patient, and never had gastro-intestinal problems before. During the last two weeks of May she had three episodes of alternated diarrhea and constipation with severe flatulence.

During my clinical evaluation I found stagnation in the renal pelvis and a severe restriction on the right side of the abdomen, area of the kidney/ascending colon that called for more investigations. I have some experience with visceral problems and explained her my findings, advising her to contact her internist and get a referral for a gastroenterologist. She unquestionably followed my advice and got an appointment to a gastroenterologist the following day.

The gastroenterologist also found anomalies during his physical examination and prescribed ultrasound and X-rays. The X-rays showed a very large renal calculus (1 cm long), with sharp and pointy edges, embedded in the walls of the inferior third of the left ureter. The calculus was transversal to the long axis of the ureter. The superior two thirds of the ureter were very much dilated by the urine reflux.

The gastroenterologist said that calculus should be removed surgically, because it was really embedded into the ureter's walls, and Sophia had almost no possibilities of passing it naturally, or only with very large dose of morphine. The problem was that with this kind of reflux, Sophia was in danger of developing pyelonephritis and having her left kidney severely damaged. She scheduled an appointment for surgery in the next four days.

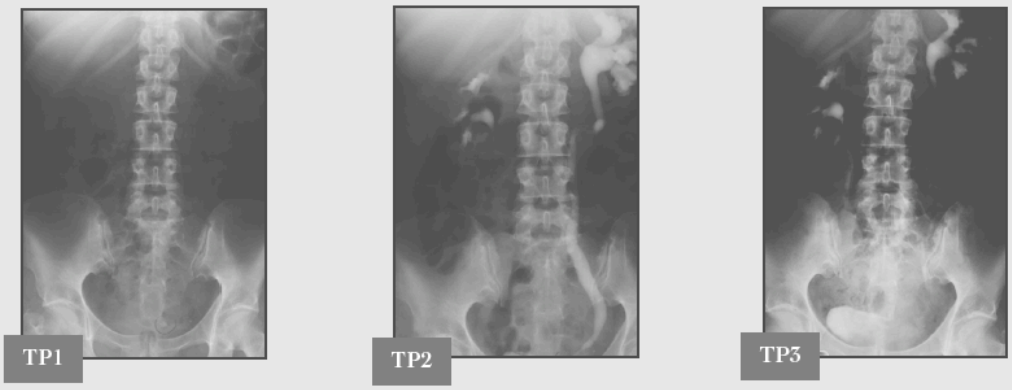
24 hours before the surgery, Sophia came for treatment bringing her diagnosis X-rays. I decided to try changing the long axis of the renal calculus and moving the urine flow back to the urinary bladder. I mainly used some LDT “imagery” technique I learned in LTD Advance1 course.

The techniques allow us to manually work on microscopic structures, such as cells, organelles, molecules, atoms, particles. It can be very challenging for someone to access such little structures, but it is like a muscle to train. It helps develop sensitivity and I had incredible results with these techniques. Finally, if they don’t work, this kind of approach does not harm a patient in any way. “First do not harm”. We are usually going very deep into the field of a client, so I asked the body if it is OK to be there and wait until I feel invited. Then a microscopic dance begins.

I dropped into my Heart and focused my intention on the left uterer and visualized the renal calculus. After connecting with the calculus I started moving it axially until I perceived its alignment to the long axis of the uterer. Then I induced the urine trapped in the superior area of the uterer back to the urinary bladder. When I felt the right movement, I supported the system for a little while and completed the treatment with regular LDT strokes to get rid of possible inflammation, spasm and prevent subsequent pain, the more basic applications of LDT. I didn't say a word to Sophia about what I exactly did to her.

The following morning she checked in for surgery. As usual, they did an initial X-ray to locate the calculus. To their, and my patient's amazement, the calculus was nowhere to be found, the reflux disappeared and the uterer had resumed its normal diameter! My patient never experienced pain or discomfort during the process of passing the calculus. She was simply discharged without surgery.

How many pain, surgeries, time and money can we avoid with this kind of approach? I am grateful to all the teachers, upon which shoulder we stand, to be able to have this kind of skill; before all, I would like to acknowledge AT Still, Father of osteopathy, for this kind of subtle and efficient manual therapy.



TP1: X-ray indicates large renal calculus embedded in walls of the inferior third of the left ureter. Notice the horizontal position of the calculus, which makes it difficult for it to move.

TP2: Superior two-thirds of the ureter were extremely dilated by urine reflux.

TP3: After Lymph Drainage Therapy the reflux had disappeared and the ureter had resumed its normal diameter.

* Name changed to keep confidentiality.