Chiropractic adjustive technique using pelvic and spinal stabilization

David DeCamillis, D.C.
18787 - 16th Avenue
Surrey, B.C.

This article is an attempt to outline in concise and usable form a chiropractic technique.

The only tool needed for this method of adjusting is a stabilizing belt. It is recommended the belt be six feet long, four inches wide and one that can be either cinched or buckled tightly. Its advantages are multiple: the chiropractor is subjected to less strain; he remains compact and therefore has an effective thrust; a lighter thrust will achieve the results; the patient is comfortable. The stabilizing technique is adaptable enough to be integrated into such adjustive systems as Grice's applied kinesiology,[1] Gillet's fixation and analysis,[2] Bonyun's discal techniques[3] and many others. The adjustments illustrated below comprise the core of this **stabilization technique.**

The belt is well suited to standard side posture lumbar, pelvic and thoracic techniques. The lower thigh is belted to the table just above the knee (Fig. 1). In this manner the patient feels more secure, the lower leg will not slide off the table, an effective traction is caused in the spine, and the adjustive thrust itself is more concentrated. This belt will also increase the effectiveness of your sacroiliac extension manipulation by its holding property. That is, by raising the caudad part of your table one foot (the lower leg again being stabilized) your line of drive can remain parallel to the floor resulting in considerably more thrust (Fig. 2).

Several techniques may also be innovated using the supine patient position. First, with the belt secured around either the anterosuperior iliac spines or the thighs (depending on the patient's flexibility) an effective spinous hook or spinous push can be used in both the lower thoracic and lumbar spines. The patient's fingers are interlocked behind his neck and the doctor's cephalad forearm goes through the triangle formed by the patient's contralateral upper limb (Fig. 3 — patient's left arm). Torque is now produced, the doctor takes his spinous contact and a specific thrust is made. If the patient is first laterally flexed away from the doctor, a spinous hook will result in excellent stretching of the multifidus[5], whereas homolateral flexion and a spinous push will result in a stretching of the sacrospinalis[6]. Since the thrust is so intense, this technique is good for those stubborn fixations in the thoracolumbar region normally difficult to adjust (Fig. 3 and 4). Second, with the shoulder girdles secured to the table, a similar technique may be developed, which is more effective in the lower lumbar spine. This time, the doctor's incident hand will be used to control the pelvic torque (Figs. 5 and 6).

*The incident hand is the hand that is not making the contact.

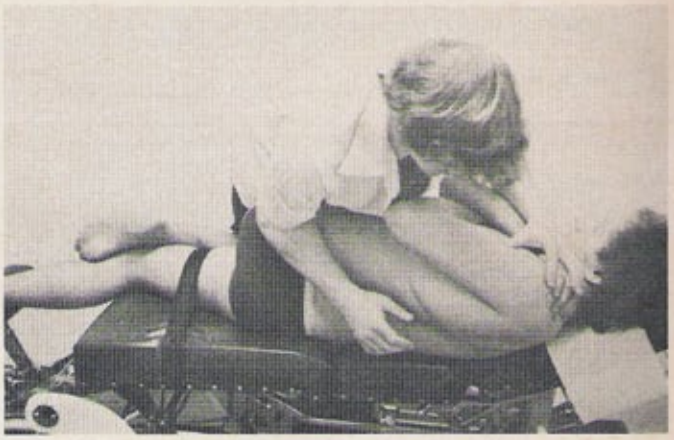

Fig. 1: Note how the patient's lower thigh is locked.

Fig. 2: Here, the line of drive is parallel to the floor and still along the plane of the sacroiliac joint. The belt will not allow the patient to slip down the table.

Fig. 3: This spinous hook adjustment demonstrates how the lumbar spine retains its lordosis.

Fig. 4: Generally speaking, the adjustor is compact in each of these moves.

Fig. 5: Note the amount of torque in the lower lumbar spine.

Fig. 6: This torquing adjustment is suitable for the more flexible patient.

I find the stabilizing technique is most effective in sitting lumbar and thoracic cage adjustments, the reason for this being that the torque can be focused at the vertebra to be adjusted and that a specific thrust to that vertebra will achieve the desired results. The patient straddles the table, his thighs are secured and the doctor either sits or stands behind him. To begin with, your motion palpation may be faster, more accurate and you can adjust the patient immediately. In the lumbar spine, the doctor may use a rotary manipulation, a rotary break (rotation-extension manipulation) or a break correction (lateral flexion manipulation). With a rotation correction the patient is relatively vertical in either the neutral or lateral flexion position to which ever side is required. The patient may now interlock his fingers behind his neck and the doctor (standing behind) will grasp the patient's homolateral arm with his incident hand; the patient may cross his arms and grab his shoulders in which case the doctor's incident hand will hold his homolateral shoulder, or, the doctor may grasp the patient's homolateral wrist and produce torque in that manner. The contact is made over the mamillary process of the fixed side and torque is induced. Once the end point is reached, a sharp thrust with both contact and incident hands is given (Fig. 7). With the rotary-break adjustment, the

Fig. 7: The lumbar spine here is quite vertical. The adjustor may reinforce the thrust by bracing his elbow onto his thigh.

Fig. 8: Lumbar rotary-break manipulation. (The chiropractor may also assume a standing position).

Fig. 9: Notice how the torque is focused under the contact. This allows for a more effective adjustment.

Fig. 10: Upper thoracic rotation manipulation. (The patient is actually more extended than shown here.)

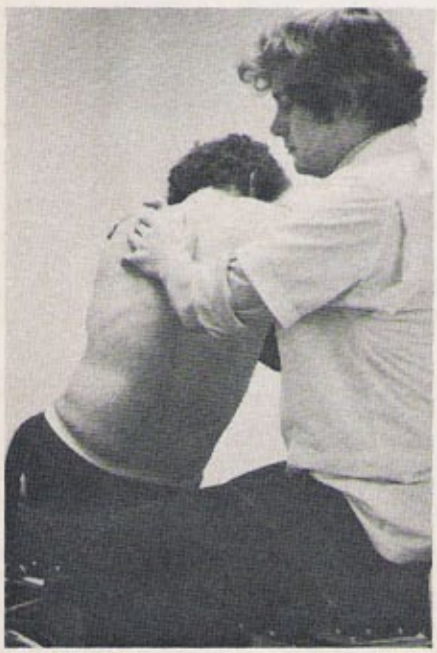

Fig. 11: The momentum of the patient's body aids the chiropractor's thrust.

Fig. 12: The chiropractor has a good feel for the amount of traction needed for this adjustment.

preamble is the same as above except the contact is made on the contralateral side of the spinous process (thumb or palm), the patient is laterally flexed away from the fixation and he is brought back into more extension than as described above. The end point is very evident and specific in this manipulation and usually a lighter thrust is sufficient (Fig. 8). I feel that a straight break adjustment in the lumbar spine is rarely called for. In the thoracic spine, due to immobilization caused by the ribs, and spinous tenderness, a rotary move is in order. For manipulating lower thoracics, the patient is vertical, for the mid-dorsals he is slightly extended and for the upper thoracics the spinal extension is greater. The contact for the mid and lower dorsals is palm or pisiform on the transverse process of the fixed side (Fig. 9), whereas the upper thoracics should have a thumb spinous hook combined with an index proximal interphalangeal contact on the transverse process (Fig. 10). Ribs four to twelve can be adjusted quite effectively by a similar method and by taking a palmar contact over the angle of the rib (Fig. 11).

The belt may also serve as a traction device when adjusting the cervical spine [7] (Fig. 12). In this manner, a shallow, fast thrust is adequate and the neck does not have to be taken to its normal adjustive end point.

In summary, the technique described herein appears to be most suitable to areas from the eighth thoracic to the fourth lumbar vertebra and is particularly beneficial to chiropractors themselves due to the minimal degrees of thrust required to perform the manipulations. Also, this technique apparently possesses a high degree of manipulative specificity.

A controlled clinical trial would be most helpful in determining the ultimate benefit of this technique to the chiropractic profession.

References:

1. Grice AS: Department of Biomechanics and Kinesiology. Canadian Memorial Chiropractic College, Toronto (Unpublished data)
2. Gillet H: Belgian Chiropractic Research Notes. Ninth edition, 1971, page 1
3. Bonyun J, Brunner D: The Bonyun Technique For Lumbar Intradiscal Instability, Fenelon Falls, Ontario, Sturgeon Lake Pub. Co. Ltd., 1976, page 1
4. States AZ: Spinal And Pelvic Techniques. Wheaton, Illinois, Kjellberg and Sons Inc., 1967, page 97
5. Grice AS: Ibid.
6. Grice AS: Ibid.
7. Maigne R: Orthopedic Medicine. Springfield, Illinois, Charles C. Thomas, 1972, page 220