Lumbar Traction and Sacroiliac Joint Function

By Joseph D. Kurnik, DC

The sacroiliac joints have an important function in stabilization of the lumbar spine. Through the process of nutation or counternutation, the sacrum can be re-angulated. This re-angulation, even though minor, can affect the stress and stability of the lumbar spine, especially at the L-5/S-1 level.

During palpation examination and visual analysis, what one finds often is sacroiliac compensation for lumbar disorders in the form of AS (anterior superior) and PI (posterior inferior) hypomobile fixations (dysfunctions). Sacroiliac compensation also exists for thoracic kyphosis, dysfunction, and other problems. With relationship to the lumbar spine, L-4/5 and L-5/S-1 facet and lumbar disorders can exist that cause frequent ilium AS fixation patterns, and less frequent PI ilium fixation patterns. As previously described in other DC articles, the lower lumbar segments exhibit rotation patterns which cause sacroiliac compensatory AS and PI ilium fixation patterns. In addition to lumbar rotation patterns, lumbar facet imbrication (facet compression) patterns can exist, especially in the L-4 and L-5 levels, which cause further sacroiliac compensations.

With regard to AS ilium fixation compensation reactions to lower lumbar facet compression, the most frequent and usual reaction is the bilateral AS ilium fixations, and less frequently the left or right AS fixation compensation. If lower lumbar rotation is not a concern, but lumbar posterior compartment compression is the concern (such as an L-5/S-1 facet syndrome with L-5/S-1 disc thinning); then segmental traction of L-5/S-1 can be done. Typically, a contact on the L-5 spinous process is made, and the L-5 segment is tractioned superiorward. If the AS fixations are monitored prior to and after traction, you can frequently witness a partial or complete release of the AS ilium fixation patterns. This is a useful diagnostic tool. If no AS ilium fixation release is noticed, the procedure is not what is needed. If the AS fixation pattern is compensatory, you will usually see a change in the SI patterning with the proper treatment.

There may be other contributing factors: thoracic kyphosis, lumbar rotation dysfunction, or thoracic dysfunction. Several such factors may be simultaneously contributing to the SI compensatory patterning. If so, and if each of these are treated, then SI functioning should improve as determined by motion palpation.
With regard to the tractioning of the lumbar segments with spinous contacts, frequently there will be too much tenderness at the site of the pain, and you are unable to traction comfortably the compressed lumbar or lumbosacral joint. A deviation from normal procedure may solve this problem. Instead of tractioning by contact on the spinous process, contact the midsacral region with one palm. With the other hand, depress the traction table so that the caudal end flexes anteriorly towards the floor, while the contact hand tractions the sacrum inferiorly and anteriorly. Frequently, the lumbar tenderness will be absent or reduced, symptoms will improve, and sacroiliac fixation compensation will be reduced (i.e., the AS ilium pattern will be absent or decreased).

In summary, the pre-analysis and postanalysis of sacroiliac functioning often supplies information about the effectiveness of your treatment.

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