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Hip and Groin Pain/Discomfort: Its Diagnosis and Treatment

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This article is written based upon the personal experiences in my practices. I have found that the diagnosis and treatment of hip and groin discomfort requires spinal and extra-spinal inspection and treatment. It requires the examination and treatment of muscles, tendons, ligaments and joint dysfunction.

Part I

It is my observation that most hip and groin discomfort observed is initiated by dysfunction of the lower lumbar spine and consequent sacroiliac dysfunction. In general, what is usually observed is the following:

1. The lower lumbar spine (usually L-5) fixates. The fixation is almost always an LP (left post) listing. L-5 also may develop general inflammation with or without a listing dysfunction. L-5 predominates and usually rotates with spinous right. Other lumbar may be involved.
2. The left and/or right sacroiliac joint will fixate in the AS position (anterior superior, with the PSIS as the point of reference). If there is lumbar disorder, the left ilium always fixes in the AS mode.
3. The hip joint proper will develop strain because the SI joint no longer assists in hip flexion. Hip popping or clicking may result. Strain in the gluteal muscles due to over-stretching will develop. Reactive stress on the hip flexor muscles will develop lumbar extension and can contract and strain. The end result will be hip and groin strain/discomfort.

Proper analysis depends upon proper static and motion palpation procedures. One must be proficient in the analysis of AS (anterior superior) and PI (posterior inferior) motion and fixation patterns. There is a sidedness observed. The fifth lumbar is the usual primary difficulty. It will misalign and fixate in the LP position mainly, or it may develop degenerative inflammatory disorders. Other lumbar may be involved also. The sequela which develops is as follows:

1. The left and/or right ilium will fixate in the anterior superior position, usually secondary to a lumbar disorder.
2. As described, the hip and groin will develop stress and possible symptoms. A most classical example is right hip clicking during hip flexion.
3. As described, the hip flexors develop strain in opposition to the gluteal antagonists, which have become hypertonic. The groin develops strained symptoms. The adductors may also antagonize the flexors. Spinal muscles attaching to the ilium may become hypertonic as well.

The key, most of the time, is to correct the lumbar disorder. Correcting a fifth lumbar fixation LP listing or compression disorder, usually starts the ball rolling. The appropriate lumbar correction will surely free the left AS fixation and usually the right AS fixation. After correcting the lumbar problem, re-palpate to see what the status of the SI fixations are. The left side usually is free. The right side will often become free, but not always. If right hip and groin discomfort are present, then an AS correction is in order on the right. Correction of the lumbar will be done by adjusting or flexion traction, as discerned.

The right ilium may fixate in the AS position independent of the lumbar status, but usually never the left. It is due to trauma or micro-trauma of some sort. It can be corrected with an AS adjustment on the right side. Motion and static palpation are the determining analytic procedures of choice in determining status and procedure.

This is a condensation of procedure to follow:

1. Static and motion palpate the SI joints seated and standing. Static and motion palpate the lumbar seated and prone.
2. If the left ilium is fixated in the AS position, there is an L-5 or L-4 problem. The L-4 or L-5 problem is the usual problem; with rotation usually present.
3. Re-palpate the SI joints. The left SI will be free if the lumbar was properly treated. The right SI may or may not be free. If there is no groin or hip discomfort, do not rush to adjust the right side. If there is significant right L/S pain with AS fixation right, then adjust the right AS.

The above presentation was a general condensation of observations and procedures. The concepts revolve around processes called nutation and counter-nutation. According to Kapandji (Physiology of the Joints, Volume III), movement of the sacral base anteriorly and inferiorly is called nutation. Motion posteriorly and superiorly is called counter-nutation. As the sacral base moves, the ilium moves in the opposite direction. If

the sacral base moves posteriorly and superiorly, the ilia ideally move anteriorly and superiorly, with the PSIS as the point of reference. If there is a lower lumbar problem, one or both ilia will fixate in the AS positions. This is a self-protective mechanism, not to be lightly messed with. The problem is usually the lower lumbar spine with the ilia assuming the AS position, the sacral base will move posteriorly and superiorly to stabilize the spine. When the process goes too far, groin and hip discomfort will result.

Reckless adjusting of the AS fixations can weaken the spine due to nutation. Decisions based on knowledge have to be made. If there is a left sided AS fixation, there is a lumbar problem predominant. Correct it first and then repalpate. Correct the right AS only if it is still fixated, and with significant right L/S pain, hip and/or groin discomfort.

If an AS fixation exists long enough, gluteal and hip flexors will become strained. Correction of the lumbar and AS fixations may correct the groin discomfort/hip discomfort automatically. If left uncorrected, secondary problems such as gluteal and hip flexor strain may become independent problems, requiring specific nonadjustive therapy. The lower lumbar extensors may also become strained. It may require soft tissue therapy. I have found that in diagnosing and treating soft tissue injuries, the procedures of Lyn Paul Taylor are the most exacting and efficient. They primarily involve diagnosis and treatment of gluteal and lumbar extensor muscles and anterior/medial thigh muscles. An instrument for locating areas of inflammation is utilized. The general procedure for diagnosis will be outlined in Part II.

Part II

Evaluation and Treatment of Inflammatory Disorders

The inflammatory process which occurs following too much soft tissue stress is basically a chemical process designed to promote healing. Basically, the stressed tissues are provoked into producing three classes of chemicals including; 1) bradykinins, 2) histamine and, 3) prostaglandins. These chemicals produce the symptoms of sensitivity, swelling, and pain; also promoting the ongoing production of each other. Together, this all constitutes the initial stage of the healing process. It only becomes a problem if the aggregate of these chemicals is allowed to build up and remain in the affected region. This is usually prevented by the release of enzymes, carried by the blood, which are supposed to break these chemicals down soon after their production.

If capillary activity in the involved region is less than optimal (such as with aging or inactivity), these chemicals may build up and become a source of chronic inflammatory conditions, due to their mutually cross-fostering nature. This is especially true if sustained levels of prostaglandins (an organic acid) have caused the body to react to the constant "burning" by inundating the region with collagen (in the form of collagen fibrils), which further restricts capillary activity, augmenting the effects of histamine. These collagen fibrils may further complicate matters by forming adhesions between tissues (fascial) layers, preventing them from sliding past one another and causing them to "catch." This produces a source of ongoing irritation and inflammation and further fosters the chronic evolution of such injuries. This was a general condensation or overview of the inflammatory process and its beginnings.

A peculiar physiological mechanism causes blood to be "shunted" from the surface (skin) to be concentrated around the deeper inflamed tissues. This, in effect, increases the resistance of the skin to the passage of an electrical current. A monitor can be utilized to measure such resistance, if in the proper range. It can thus show the practitioner which areas are inflamed, which often differ from the site of pain. For example, look at groin and hip pain. The groin may hurt, but it is not necessarily inflamed. Areas of inflammation show in the gluteals, hip flexor muscles, and other regions; but not the tendinous regions of the groin.

In my practice, I utilize a specially designed and modified OHM meter which may be used for a differential skin resistance survey.

Such instruments must be able to measure resistance levels in the micro-OHM range, though the resistance may be measured in forms of how much current gets from one electrode to the other, as microamperees or mamps. In other words, you simply measure the amount of current passing from one probe to another. The more the resistance, the less current passes, and the more inflammation present.

The treatment of inflammation should be based on, 1) increasing circulation in the involved tissues; 2) stopping the production of inflammatory chemicals; and 3) decreasing the potential of ongoing soft tissue stress.

Increasing circulation in the involved tissues may be accomplished through the use of electrical stimulation (wide-pulsed, low frequency) to provoke intermittent muscle contractions, massage and vibration. This can drive out noxious chemicals and soften the underlying tissues. Aerobic exercise may also be helpful if no tendinitis or nerve impingement is present.

The interception of inflammatory chemical production may be accomplished through the use of ultra high frequency sound to drive effective anti-inflammatory chemicals into inflamed areas (phonophoresis). These chemicals include preparations containing various types of substances having an anti-inflammatory action (e.g., Ibuprophen). Some doctors use more natural herbal or other preparations, but the molecular size of the constituents must be able to pass through the skin to be effective.

Decreasing the potential for on-going stress may be accomplished by:

1. Reduction of any adhesion formations which may be present through a combination of medium frequency electrical stimulation and soft tissue manipulation.
2. Lengthening any tight musculature through the use of intermittent low frequency electrical stimulation, followed by brief mechanical vibration of the tight muscles' antagonists, with a five minute rest with the tight musculature continually on stretch.
3. Vertebral or joint manipulation.
4. The toning or strengthening of involved musculature through isometric or isotonic exercise (the latter performed only if there is no tendinitis or nerve impingement present).

In conclusion, efficient resolution of any soft tissue injury will depend on an accurate evaluation, coupled with appropriate treatment. This approach has given me a path and direction to follow when presented with soft tissue inflammatory lesions which have not responded to spinal or extra-spinal adjusting. As I practice, I become more efficient and effective. Masters of this type of treatment often clear out difficult cases within a week or less.

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