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Lumbar, Sacroiliac and Hamstring Unified Dynamics

By Joseph D. Kurnik, DC

I have written about the relationship of lumbar dysfunction to sacroiliac dysfunction and the resultant stress to the hip and groin. The same relationship can occur with the hamstrings. Briefly stated, the following are observed:

1. Lumbosacral dysfunction. Usually L-5, S rotates P, spinous going right. This occurs due to the "seeking phenomenon." This phenomenon is the tendency of the left ilium to seek the PI mode of function. It can be observed in the seated, standing and ambulatory positions with motion palpation. It also is seen with L-5 rotation, C-1 rotation, and many other examples.
2. One or both ilia fixate in the AS mode. This means that the ilium does not rotate downward during flexion of the hip. This is a "counter-nutation" maneuver designed to protect the L/S region (described in previous articles of *DC*).
3. Strain of the hamstring muscles occurs due to over stretching during hip flexion. This happens because the ilium does not rotate inferiorly during hip flexion, causing over stretching of hamstrings.
4. Pain and/or discomfort may occur ultimately in the hamstrings, ischial bursa, and hip region.

The solution is initially and primarily chiropractic, as are groin and hip problems. Briefly stated, the following must be done:

1. Correct any lumbar dysfunction. Analysis is determined by motion palpation.
2. Ensure that sacroiliac motion is established through correct motion palpation. This is usually established with L-5/S-1 correction. If not, evaluate and adjust for an AS ilium fixation. This adjustment should occur, usually on the right side. It is rare to have to directly adjust the left ilium as an AS fixation.
3. Perform appropriate soft tissue techniques to the hamstrings and ischial region. I use these procedures:
 1. a DSR zone finder to locate primary regions of inflammation (procedure developed by Lyn Taylor

of Los Angeles;

2. electrostim to soften muscles hypertonus and adhesions;
3. myofascial massage to such muscles;
4. pulsed ultrasound over previously worked muscles;
5. microcurrent and cold pack over the ischial bursa regions, if sore.

As with hip and groin problems, the spinal and sacroiliac lesions and dysfunctions (including subluxation) are the primary concerns and usual origination of these problems. The use of soft tissue procedures without correction of subluxation and dysfunction, suggest a lack of understanding of these problems. Chiropractors are missing out on professional and nonprofessional sports and lay injury rehabilitation because they are too often using physical therapy protocols. They are often not distinguished from other professional groups in their choice of therapies. The reduction of the AS fixation is the primary goal.

The way to go about this is a sophisticated yet simple process. There is usually a lower lumbar fixation subluxation complex, followed by a unilateral or bilateral compensatory AS fixation. Correcting the lower lumbar fixation subluxation usually occurs first. The AS fixes may clear spontaneously, but not always. Sometimes a right sided AS correction must be done, but rarely on the left side.

We should be investigative chiropractors first. The relationship of lumbosacral dynamics to lower extremity disorders should be appreciated and acted upon. The chiropractor has this potential, but outsiders may act upon this opportunity first.

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