TECHNIQUE TOOLBOX

# Pelvic subluxation

Correcting sacroiliac rotation around the long axis BY PAUL HUNTER

In my third year of practice my dear late mother asked me if I regretted not becoming a medical doctor. I told her, "No, mom, I will help more people with their health over my career than I would being a MD."

Now in my 25th year as a DC I know that more than ever.

When I was 20 years old I broke my neck in a diving accident. I spent four days on the couch in a tremendous amount of pain. Our family didn't go to chiropractors at the time, but I had heard about them and sought help from a doctor in Winnipeg where I lived.

X-rays showed a compression fracture of C5, and Dr. Gus Lodewyks told me to go to the hospital immediately. He also said to return to his office the next week if I was not hospitalized. More X-rays, a rigid cervical brace, and a consult with an orthopaedic surgeon came next.

After some adjustments that relieved me of most of my pain, I attended the surgeon again. He was furious I was seeing a chiropractor and flabbergasted that I was so improved. "If you want to die or be paralyzed, keep on with the chiropractor," he said.

I was to have a spinal arthrodesis (spinal fusion) of C5-C6. I returned to Lodewyks, my chiropractor, who explained my fracture was stable and did not require surgery. My decision to stay on with chiropractic care and reject surgery was a pivotal one that changed my life forever. (You can read more about my story on my website: fillupyourtoolbox.com)

After getting well and seeing all the people I referred to chiropractic get better, I decided I wanted to be a DC.

Lodewyks became my mentor and took me to my first Gonstead seminar in Mt. Horeb, Wis. He coached me to adjust his neck *a la* cervical chair on the evening of my first seminar. After a couple of hours of trying, I made his lower neck move. I was thrilled and went on to study more Gonstead and many other techniques while at Palmer College.

By the end of my first year there, I was holding workshops at my apartment teaching other students how to do palpation exams, cervical chair adjustments and side posture adjustments.

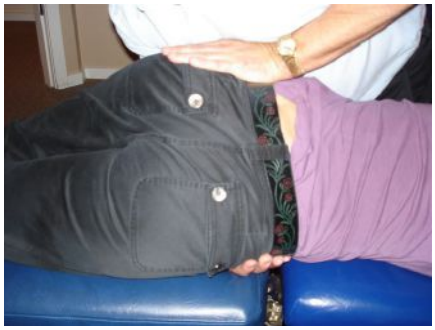
## Knowledge sharing

The skills and techniques we have learned become part of our repertoire, our technique toolbox. If Lodewyks did not have his technique I would have been out of luck and would have succumbed to surgery. My life would have been vastly different.

My practice became busy early on and I noticed I started solving problems in the adjusting room with techniques and protocols that were a synthesis of all the approaches I had learned, plus some innovations that I developed myself.

I have been teaching "Fill Up Your Toolbox Chiropractic Technique Seminars" for nine years now and, by and large, it has been very well-received by the 100 or so chiropractors who have attended. I would like to share some of these techniques in the hope that readers might learn something from my experiences.

Somewhere in the '90s I was scratching my head wondering what to do next with a patient's difficult acute low back. The adjustments I tried were not effective. It struck me that the pelvis was rotated around the long axis. I decided to try something I had never done before – and it worked.



Set-up for adjusting pelvic long axis rotation with listings ASEX left side and PIIN right side. The doctor's dominant hand reaches under the pelvis.

The following is a description of an adjustment that helps to correct sacroiliac rotation around the long axis. It is best used after you have done the usual initial corrections to lumbar and/or sacroiliac joints yet there is still a degree of dysfunction.

The pelvis can be considered to be like a ring that can misalign on the sacrum rotating around the long axis. It is a unique procedure that I have used daily for the last 10 years. This adjustment is easy to master and will be a useful tool in the chiropractor's repertoire for the correction of the pelvic subluxation complex.

## Presentation

After adjustment of the low back, sacroiliac joints, thoracic area and/or ribs, there still remains sacroiliac joint restriction. Active prone leg extension is weaker or compromised on one or both sides. Motion palpation of the sacroiliac joints using passive prone leg extension detects hypomobility on one or both sides.

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