A Lazy Osteopaths Approach to Sacral Dysfunctions
Sacral Dysfunction

• This approach is based on the work of Fred Mitchell, Sr as taught and understood by Ed Stiles.

• We start with assumptions - that you have a working understanding of Mitchell’s pelvic axis system and that you can diagnose the sacrum based on that model.
If we look at the ten sacral diagnoses from the standpoint of the axes, they fall into three groups:

- Those that occur around the middle transverse axis - bilaterally flexed, bilaterally extended, left sacral flexion, right sacral extension, left sacral extension and right sacral flexion.

- Those that occur around the left oblique - L/L and R/L torsions

- Those that occur around the right oblique - R/R and L/R torsions
Sacral Dysfunction

• That leaves three treatment set-ups if we could just treat the axes…

• And only flexed or extended dysfunctions at those axes (and luckily all of the named sacral dysfunctions fall into one of these categories).
Sacral Dysfunction

• To do that we need to be spot on about finding and engaging the needed axes.

• To understand that...more anatomy...
The MTA is deep to the PSIS

This axis will be our primary focus!
When we perform our seated bend test with the patient’s legs together, we are not being specific to any one axis.

This is the place to begin...
In the seated bend test, each thumb is placed on the patient's PSIS and the patient is asked to bend forward.
This is a positive test on the left
And, if the left ILA is inferior and posterior

And, if the sacrum is rotated right

If you have a left positive bend test

You have a left sacral flexion (unilateral sacral flexion on the left)
This occurs around the Middle Transverse Axis (MTA)
Treatment

• To treat this the easy way, we need to localize the body/pelvis to the middle transverse axis.

• This can be done by abducting/adducting each leg until it localizes on the MTA with the patient seated.
Abduct/adduct one leg at a time until you feel the motion localize on the MTA (deep to the PSIS)

As long as the patient does not move their legs, they stay positioned on the axis

Localizing both legs as shown here places the patient on the MTA on both sides.
Treatment

• Now that you are localized on the MTA, simply have the patient bend forward (another seated forward bend test) - without moving their legs!

• This movement will take the sacrum posterior on both sides of the MTA - making this a direct treatment for a left sacral flexion and an indirect one for a right sacral extension.
The bend test has now become the treatment.

If you want the patient to be more involved in the treatment, have them take a deep breath and blow it out while bent over.
Treatment

- Now have the patient sit back up and bring their legs back toward the midline (taking them off the MTA).

- Then recheck your seated bend test.
Principles

• We just treated dysfunctions on the MTA by aligning the sacrum within the innominates on the axis that these dysfunctions occur around and having the patient bend forward.

• These dysfunctions include six of the ten named sacral dysfunctions - bilateral flexion, bilateral extension, left sacral flexion, right sacral extension, left sacral extension and right sacral flexion.

• Indicates  Direct treatment  Indirect treatment
Principles

• Since this is a principle based approach, having the patient extend over the MTA should give the same outcome by nutating the sacrum rather than counternutating it with the bend test.

• You patient needs to be flexible enough to be able to extend over the MTA to make this approach viable.
Oblique Axis Dysfunctions
Left Oblique Axis Dysfunctions
Left Axis Dysfunctions

- On the left oblique axis, there are two dysfunctions
- The more common left on left sacral torsion and less common right on left sacral torsion.
- To treat, we need to create the left oblique axis.
And the left ILA is inferior and posterior.

If the sacrum is rotated left:

You have a left on left sacral torsion.

You have a right on left sacral torsion.

If the sacrum is rotated right:

And the right ILA is inferior and posterior.
Abduct/adduct the left leg until you feel the MTA convert to the left oblique axis

As long as the patient does not move their legs, they stay positioned on the axis

Due to the configuration of the SIJ, the left leg will not create the left oblique axis in every patient (in some it will be the right leg) - please palpate each patient individually!
Treatment

• Now that you are localized on the left oblique axis (LOA), simply have the patient bend forward (another seated forward bend test) - without moving their legs!

• This movement will take the sacrum posterior on both sides of the LOA (the sacrum is still counternutating) - making this a direct treatment for a left on left sacral torsion and an indirect one for a right on left sacral torsion.
Treatment

• Have the patient sit back up and return their legs to the middle and then recheck your findings.
Right Oblique Axis Dysfunctions
Right Axis Dysfunctions

- On the right oblique axis, there are two dysfunctions
- The more common left on right sacral torsion and less common right on right sacral torsion.
- To treat, we need to create the right oblique axis.
You have a left on right sacral torsion

If the sacrum is rotated left

And the right ILA is inferior and posterior

You have a right on right sacral torsion

If the sacrum is rotated right

And the left ILA is inferior and posterior
Abduct/adduct the right leg until you feel the MTA convert to the right oblique axis.

As long as the patient does not move their legs, they stay positioned on the axis.

Due to the configuration of the SIJ, the right leg will not create the right oblique axis in every patient (in some it will be the left leg) - please palpate each patient individually!
Treatment

• Now that you are localized on the right oblique axis (ROA), simply have the patient bend forward (another seated forward bend test) - without moving their legs!

• This movement will take the sacrum posterior on both sides of the ROA (the sacrum is still counternutating) - making this a direct treatment for a right on right sacral torsion and an indirect one for a left on right sacral torsion.
Treatment

- Have the patient sit back up and return their legs to the middle and then recheck your findings.
Alternate Approach to the MTA

Thanks to Micha Sale, PT and honorary osteopath for pointing this out
Alternate Approach to the MTA

• From the standpoint of the axes, when the patient's legs are together and they are seated, no axis is localized.

• When we begin to abduct and adduct, we can localize an axis. This usually occurs one side at a time (to make it easy for the operator's brain to follow).
Alternate Approach to the MTA

- When we localize an axis by abducting/adducting, first we move close to it (we feel the tissues start to move under our monitoring finger(s)), then we localize it (the tissues only under our fingers move), then the axis itself engages (the tissues under our fingers move AND the axis moves). This occurs with slow abduction/adduction and fine tuning of the patients position.
Alternate Approach to the MTA

• With the MTA, if we engage the axis and then go slightly past it (typically with more abduction), the MTA converts into an oblique (because the innominate begins to rotate).
Alternate Approach to the MTA

- We can use this information to get VERY precise about localizing to the MTA *without* converting it into an oblique axis to treat only one side of the SIJ (we treat the restricted side).
If you have a left positive bend test

And, if the sacrum is rotated right

And, if the left ILA is inferior and posterior

You have a left sacral flexion (unilateral sacral flexion on the left)

This occurs around the Middle Transverse Axis (MTA)
In our example, the left side has the dysfunction and is the side we wish to treat - we will set the SIJ up to be able to move on the MTA here.

While the right side has no dysfunction and thus requires no treatment - so we will relatively lock out this side.
Abduct/adduct the left leg until you feel the MTA engage - if you feel it covent to an oblique axis you went too far

As long as the patient does not move their legs, they stay positioned on the axis.
By NOT moving the right leg, we keep the right SIJ from being localized to any axis - effectively locking its motion and preventing change in this location (the right SIJ in this example)
Alternate Approach to the MTA

- We have localized the left SIJ to the MTA and locked the right SIJ (by not moving the leg).

- Now when the patient bends forward only the left SIJ moves on an axis - which corrects the dysfunction in this example.

- Recheck with both legs together after treating.
Superior Transverse Axis
The STA is one finger width above the PSIS

This axis will be our primary focus!
Superior Transverse Axis

- The superior transverse axis is located one finger width above the PSIS.

- It is the axis around which the cranial motion occurs in the pelvis.
Superior Transverse Axis

• Because our approach is principle based, if we use the legs to localize to the STA, we can use the bend test to treat pelvic dysfunctions that effect the cranium.
Inferior Transverse Axis
The ITA is one finger width below the PSIS

This axis will be our primary focus!
Inferior Transverse Axis

- The superior transverse axis is located one finger width below the PSIS.
- It is the axis around which the innominates rotate during the walking cycle.
Inferior Transverse Axis

- Because our approach is principle based, if we use the legs to localize to the ITA, we can use the bend test to treat innominate dysfunction (rotations).

- For the moment, let’s assume that true gait dysfunctions require a different treatment.