

# SCIATICA AND SACRO-ILIAC JOINT SUBLUXATIONS IN WOMEN

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**Abstract:** a series of female patients of varying ages each suffering from sciatica is presented to determine a pattern of aetiology.

## INTRODUCTION

Sacro-iliac joint (SIJ) subluxations can be common causes of acute and chronic sciatica. They have often been overlooked and disregarded as insignificant injuries. Dr. C. S. Gonstead himself proved the importance of SIJ subluxations to the Chiropractic and clinical world and not only justified their existence but developed the most specific approach of detecting and adjusting the SIJ subluxation.

There are many definitions of the term subluxation in the Chiropractic context, but common to all concepts of subluxation are some form of kinesiologic dysfunction and some form of neurologic involvement. (1)

This case study presents the history, management, findings, diagnosis and treatment of eight women suffering from sciatica. The Gonstead pelvic x-ray analysis protocol was used to assess each patient which were then compared to the physical observations for each individual. All the women had been through two or more pregnancies and had not experienced sciatica until after their first pregnancy. Each patient had sort help from conventional medical approaches. This study demonstrates the significance of SIJ subluxations in women and the effectiveness of specific hands – on chiropractic when dealing with such cases.

## CASE HISTORIES

Case A was a 78 year old woman who presented with an acute exacerbation of a chronic lower back condition. She had never been to see a chiropractor before and had suffered with sciatica on and off for many years. The lower back pain was sharp and was located over both sacro-iliac joint regions. The acute episode began six months earlier over the left SIJ and only recently had been felt over the right SIJ. The sciatic pain had been present during the entire six months and was affecting the right thigh postero-laterally and the right calf. The sciatica was aggravated by walking and the patient needed to rest and raise her right leg up by five pm every day. The patient had already received cortisone injections with no success.

Case B was a 74 year old woman who had been suffering from severe lower back pain and left anterior thigh pain. The thigh pain was extreme and also very painful to touch. It had been present for five months but not worsening. Although the patient had been living on painkillers, the pain was daily and constant. Standing aggravated the pain and after five to ten

minutes of standing, she had to sit as the pain became too severe. Lying, sitting and walking also caused pain but were not as painful as standing. The patient also reported that the pain had been a chronic problem for many years and would come and go ever since going through child birth. This episode was the worst it had been.

Case C was a 70 year old woman with right sided lower back pain and leg pain. She had a very severely degenerated L4/5 disc and a degenerative spondylolisthesis at L3. The pain was located over the right SIJ and radiated down the right buttock and half way down the posterior thigh. The patient reported chronic episodes of lower back pain since being pregnant but this acute episode began a few days earlier after hearing a “cracking sound” in her back when lifting a box out of the car. The pain was instant, right sided and shooting down the buttock and thigh.

Case D was a 56 year old woman with right SIJ pain and radiating right gluteal, posterior thigh, calf and ankle pain. She was also suffering from bilateral foot numbness. The pain was acute and had never been this severe before. She had suffered the occasional lower back pain and sciatica after pregnancies but never this debilitating. This episode was brought about by twisting her right ankle four months previously.

Case E was a 53 year old woman with right sided lower back pain, hip pain and sciatic pain. She reported that the pain had been chronic since giving birth years ago and had been intermittent. This year the pain had been a lot worse and regularly remained constant for a couple of days at a time all year. The pain was located over the right SIJ and radiated to the right hip, down the posterior thigh all the way to the knee. The patient found it difficult to get into her car and had to use her hands to lift her right leg up and into the car. She found relief by sitting but the pain was aggravated by getting up off a chair. Pain was sometimes brought about by walking and the leg ached continuously whilst lying down.

Case F was a 50 year old woman with no previous history of lower back pain. She presented in acute pain which was located over the right SIJ and extended into the right gluteal region. The pain had been present for five weeks and was very severe and was constant whether sitting, lying, standing or walking. The patient had seen a chiropractor a couple of weeks earlier who applied traction and massaged her spine. She had also been seeing her general practitioner who had been performing acupuncture, giving her medication and also injections. All this treatment was unsuccessful. This patient could not sit for longer than a minute before trying to redirect her weight bearing and could not stand in the one place at all. She had the characteristic gait where she would place her right hand over the right buttock whilst standing and/or walking.

Case G was a 47 year old woman who had been suffering from chronic and intermittent left sided lower back pain and sciatica. The sciatic pain was located over the postero-lateral thigh and had been more constant recently. It had become sharper in nature and beginning to affect her gait. Relief was gained by lying down and walking tended to aggravate the pain. This patient had also been through four pregnancies.

Case H was a 36 year old woman who had presented with chronic lower back pain and left sided hip, groin and posterior thigh pain. She also experienced bilateral foot tingling. The pain had begun 13 years ago after her first pregnancy and subsequently had two more pregnancies. The pain was becoming more frequent and severe and would exacerbate every three months. She had been seeing a masseur/sports trainer who she described as “popping something in”. This however never addressed the issue. The patient walked with a limp and reported that the pain was always worse in the morning when getting out of bed.

## SUMMARY OF CLINICAL FINDINGS/ASSESSMENTS

PATIENT	INSTRUMENTATION	STATIC PALPATION	MOTION PALPATION	POSTURE
<b>CASE A</b>	.At the S2 level	Pain and edema over <b>superior</b> left SIJ region	Left SIJ restricted compared to right	Left foot pointing in, left gluteal muscles lower, narrower left gluteal muscles
<b>CASE B</b>	No reading	Pain and edema throughout <b>entire</b> left SIJ region	Left SIJ restricted compared to right	Left foot flare, left gluteal muscles lower
<b>CASE C</b>	No reading	Pain and edema over <b>superior</b> right SIJ region	Right SIJ restricted compared to left	Right foot flare and right gluteal musculature wider and lower than left
<b>CASE D</b>	At the S2 level	Pain and edema over <b>superior and inferior</b> right SIJ region	Right SIJ restricted compared to left	Right foot pointing in, right gluteals higher and narrower than left
<b>CASE E</b>	No reading	Pain and edema over <b>superior</b> right SIJ region	Right SIJ restricted compared to left	Right foot flared and right gluteals lower and wider than left
<b>CASE F</b>	No reading	Pain and edema over <b>inferior</b> right SIJ region	Right SIJ restricted compared to left	Right foot flared and right gluteals higher and wider than left
<b>CASE G</b>	At the S2 level	Pain and edema over <b>superior</b> left SIJ region	Left SIJ restricted compared to right	Left foot pointing in and left gluteals higher and narrower than right
<b>CASE H</b>	No reading	Pain and edema over left <b>inferior</b> SIJ region	Left SIJ restricted compared to right	Left foot flared and left gluteals higher and wider than right

## **RADIOGRAPHIC EXAMINATION**

Full spine radiographs were taken of each woman. Please refer to digital images.

The lumbopelvic listings derived from the radiographs utilising Gonstead pelvic analysis techniques and biomechanical listing system were as follows:

Case A:	P-R, L.PIEX
Case B:	L5PLI-M, P-L, R.ASEX
Case C:	L5PRI-M, R.PIIN
Case D:	L5PLI-M, R.ASEX
Case E:	L5 Spondy, R.PIIN
Case F:	BP, R.ASIN
Case G:	S2 Post, L.ASEX
Case H:	BP, S2 Post, L.ASIN

## **CHIROPRACTIC DIAGNOSIS**

Following full Gonstead Chiropractic examinations and spinographic findings, the initial diagnoses made for the above cases were:

- Case A – L.PIEX subluxation
- Case B – P-L subluxation
- Case C - R.PIIN subluxation
- Case D – R.ASEX subluxation
- Case E – R.PIIN subluxation
- Case F – R.ASIN subluxation
- Case G – L.ASEX subluxation
- Case H – L.ASIN subluxation

## **TREATMENT and RESULTS**

Each patient was adjusted on the pelvic bench in the side posture. A single audible was heard with all the adjustments.

Patient A had her L.PIEX adjusted four times over a four week period. The patient reported improvement after each adjustment and after the fourth reported that all her pain, including her sciatica had subsided.

Patient B had her P-L adjusted with a push move and the left side up. It was adjusted on five occasions over a three week period after which her left anterior thigh pain and back pain subsided.

Patient C had her R. PIIN adjusted three times in the one week after which her right sided sciatica completely eased. It was adjusted with a pull move on each occasion.

Patient D had her R. ASEX adjusted four times over a two week period. This was adjusted as a pull move on each occasion. Her sciatic pain and foot numbness eased after this period of time.

Patient E had her R.PIIN adjusted with a push move three times in the first week and settled immediately afterwards.

Patient F had her R.ASIN adjusted seven times over a four week period. Her acute sciatica began subsiding after the second week and was completely resolved after the fourth week.

Patient G had her L.ASEX four times with a push move over a three week period. Not only did her sciatic pain disappear in that time but her bowel movements returned after the first adjustment as well.

Patient H had her L.ASIN adjusted seven times over a six week period after which her chronic sciatic and hip pain fully subsided.

It is important to note that each patient was advised to go for a 10 minute walk after the adjustments and to apply ice over the SIJ for 15 minutes every hour for two days when possible.

## **DISCUSSION**

This case study has demonstrated the effectiveness of specific chiropractic adjustments on sacro-iliac joint subluxations.

This case study has not revealed anything ground breaking for the competent chiropractor but is presented in support the Gonstead approach of specific sacro-iliac joint analysis and adjusting. It has presented a variety of different cases which help substantiate the importance of the SIJ and its analysis and correction. Where many chiropractors adjust the SIJ with no specific listing and where the medical profession overlooks the SIJ, Gonstead Chiropractors are able to accurately detect and adjust this potential cause of the patient's sciatic pain.

Many patients are sadly misdiagnosed with disc prolapses when presenting to their medical doctors with sciatic pain. They are led on a diagnostic merry-go-round with no options other than physical therapy, anti-inflammatories and eventually surgery. Many unfortunately slip through our system and undergo costly surgery only to remain in pain afterwards and often worse. We all see these patients and we all help them, however getting our hands on them before the surgery provides a much better result for the patient.

On the other hand, these patients also present to other chiropractors who fail to either recognize the SIJ subluxation and/or fail to correctly list it and therefore adjust it. These patients improve slowly, do not improve at all or get worse.

The sacro-iliac joint allows an independent movement of the ilia and sacrum. It is this movement that Plaugher (2) states that distinguishes humans from other animals and allows them to walk upright. The SIJ in males are built for strength and have extra intra-articular tubercles (ridges), whereas the female SIJ is designed more for mobility and parturition. (2).

The SIJ can present with many signs and symptoms that requires a specific and careful analysis. SIJ pain may be characterized by lower back pain and localized tenderness over the joint, referring through to the buttocks, groin and trochanteric region. Plaugher (2) also states that a SIJ subluxation may also cause thigh pain, leg pain and also foot pain. This pain is often referred and directly related to the severity of the nerve root inflammation. Plaugher (2) also writes that research has shown that mechanical tissue distortion, such as that caused by a subluxation, can activate the peripheral nociceptive system. He describes these mechanical changes giving rise to stabbing, bursting, vice-like sensations caused by the activation of interstitial and perivascular nociceptive receptors.

Cox (3) has written that sciatic pain can originate from many different subluxation locations. He states that the SIJ may cause posterior gluteal and thigh pain and groin pain, especially when an ASIN or IN is involved. However, Gonstead (4) always stressed to accept the subluxation where it is found and not be influenced by symptoms at any stage. This therefore explains the diversity of symptoms that can be caused by SIJ subluxations.

## **CONCLUSION**

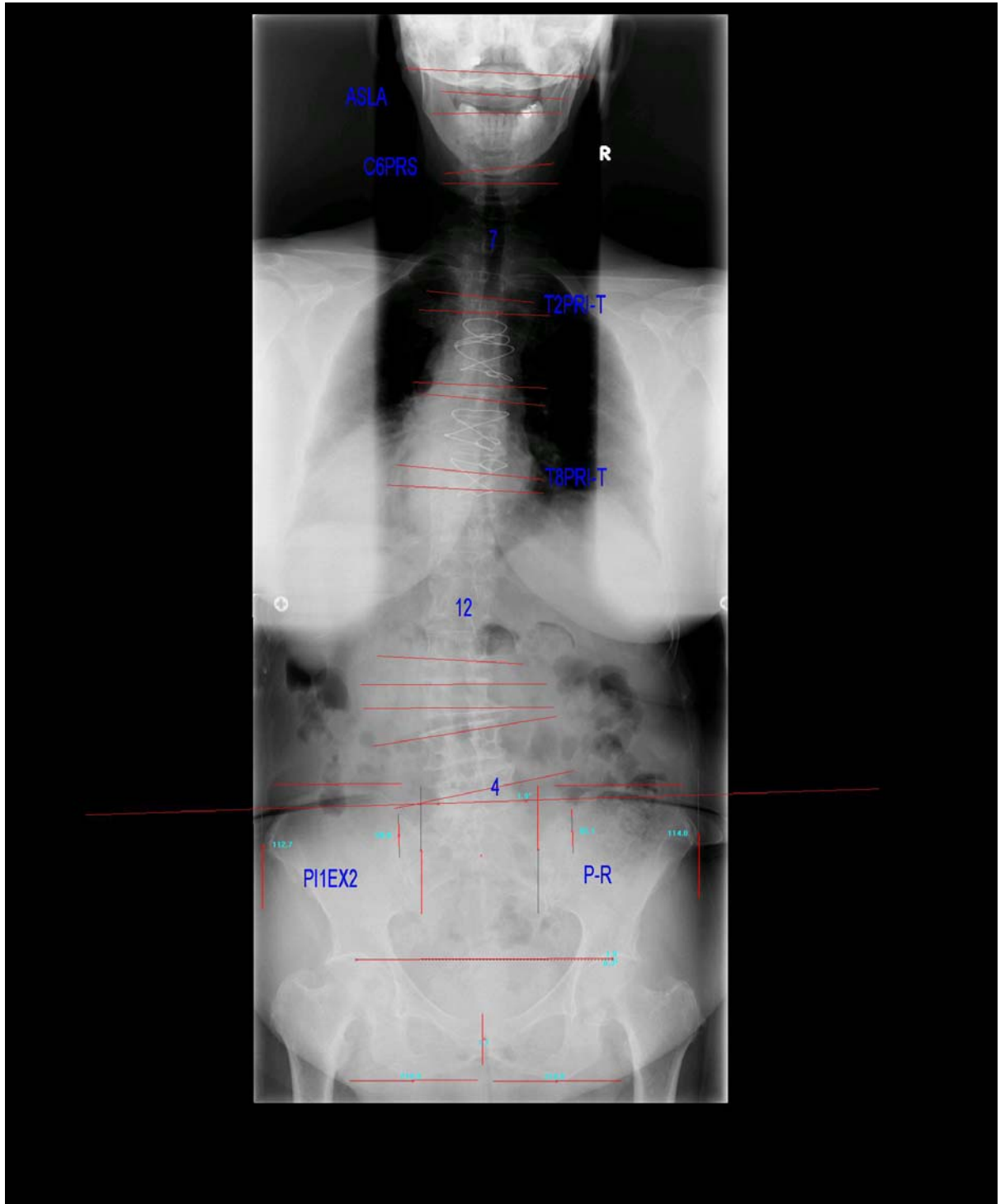
Considering that vertebral and SIJ subluxations directly or indirectly cause nerve irritation and therefore affect the ability of the neural impulse to reach its target, whether afferent or efferent, it could be concluded that SIJ subluxations could potentially cause quite severe symptoms. It is commonly known that pregnancy can destabilize the pelvis and lead to problems both during and after the term. Although this is well established, many chiropractors do not specifically adjust the SIJ; they manipulate it simply as a “SIJ” rather than with a specific line of correction as described by the Gonstead adjusting technique.

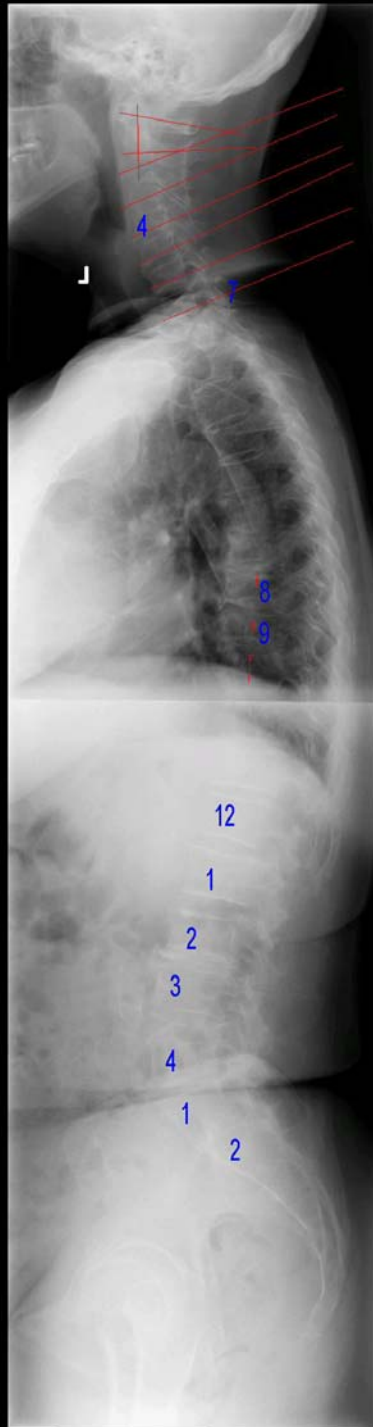
Specifically adjusting these sites that contribute to nerve dysfunction will therefore increase the ability of the patient to function normally and prevent unnecessary and costly surgery.

## **REFERENCES**

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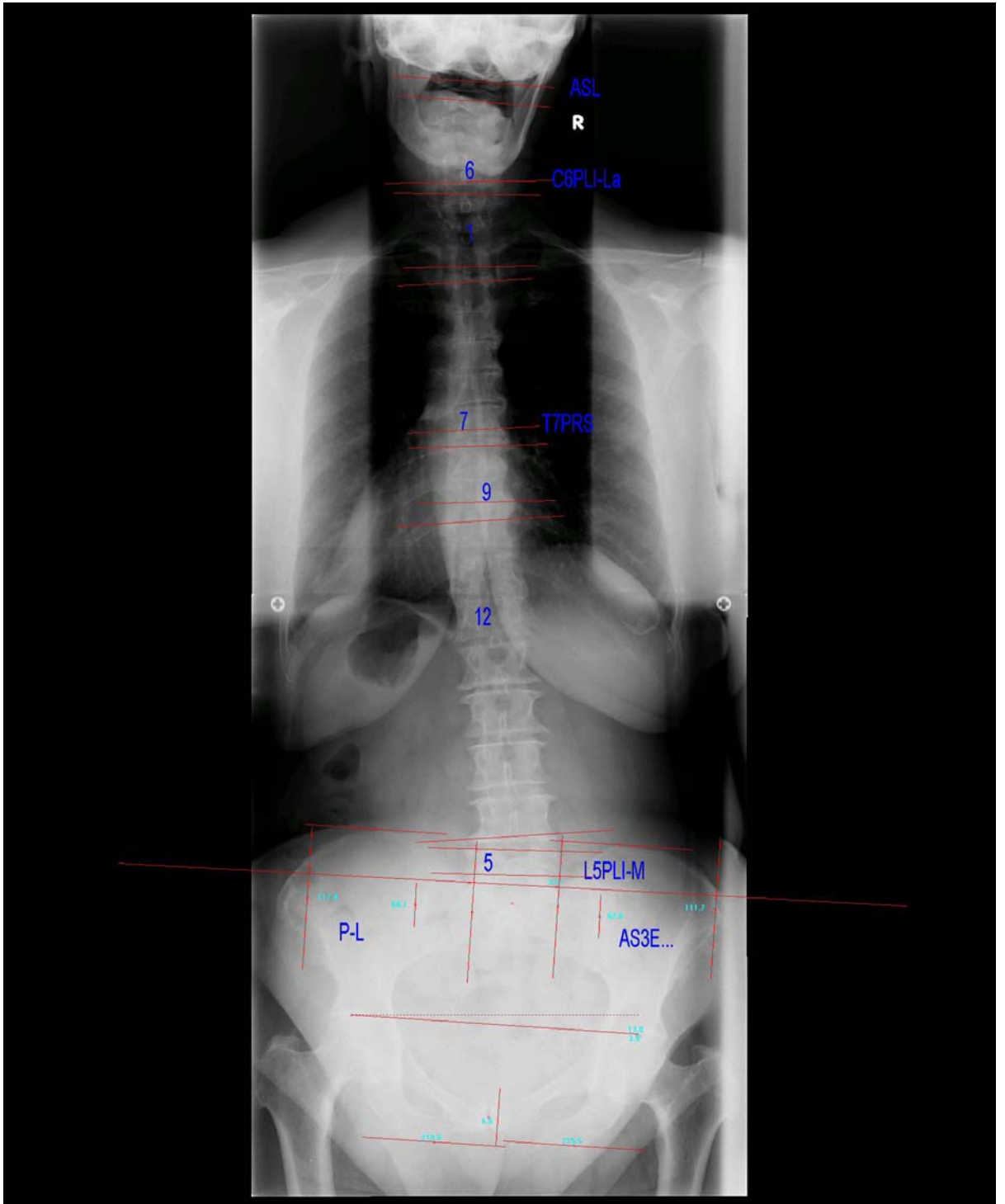
CASE A.

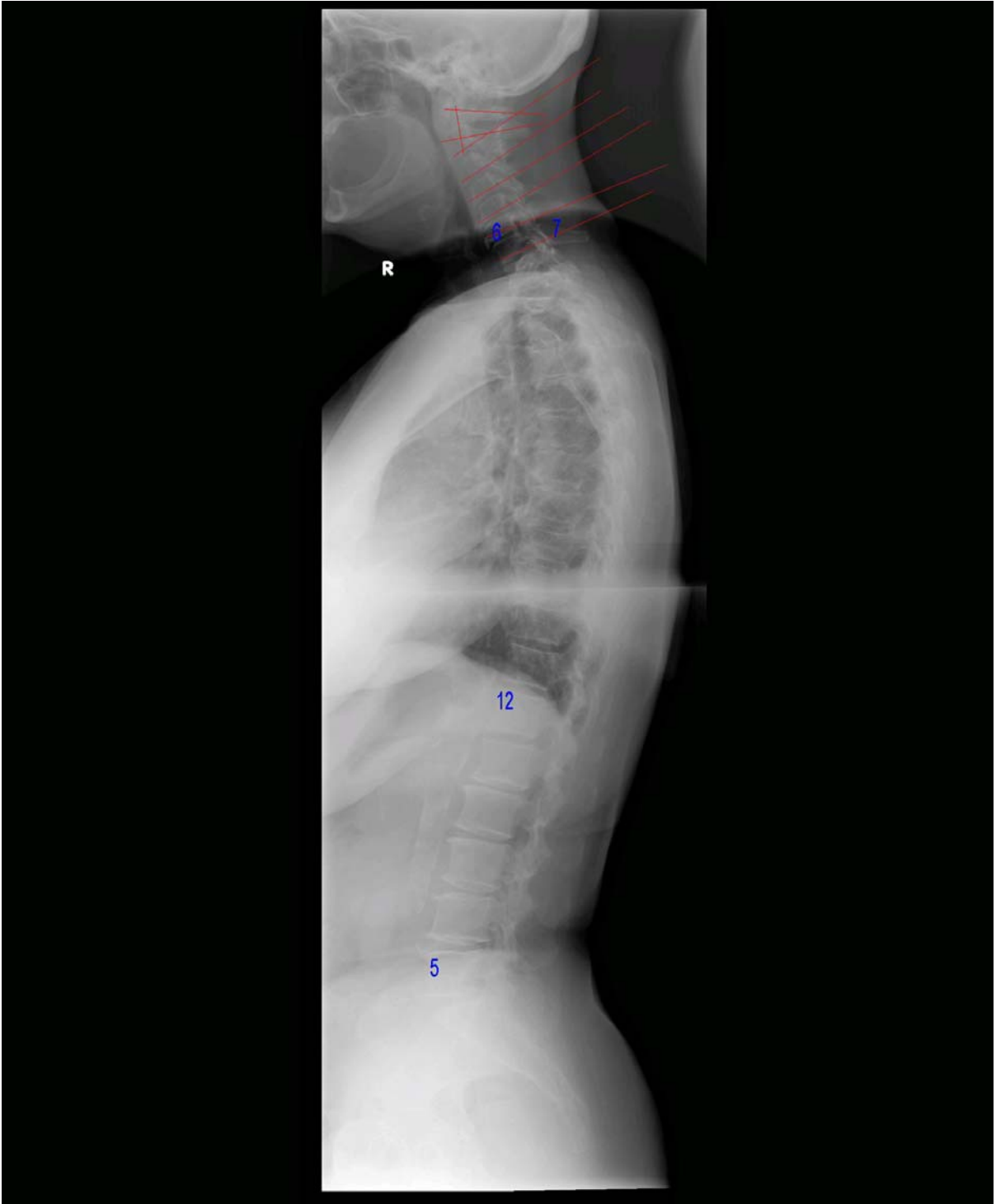






CASE B.



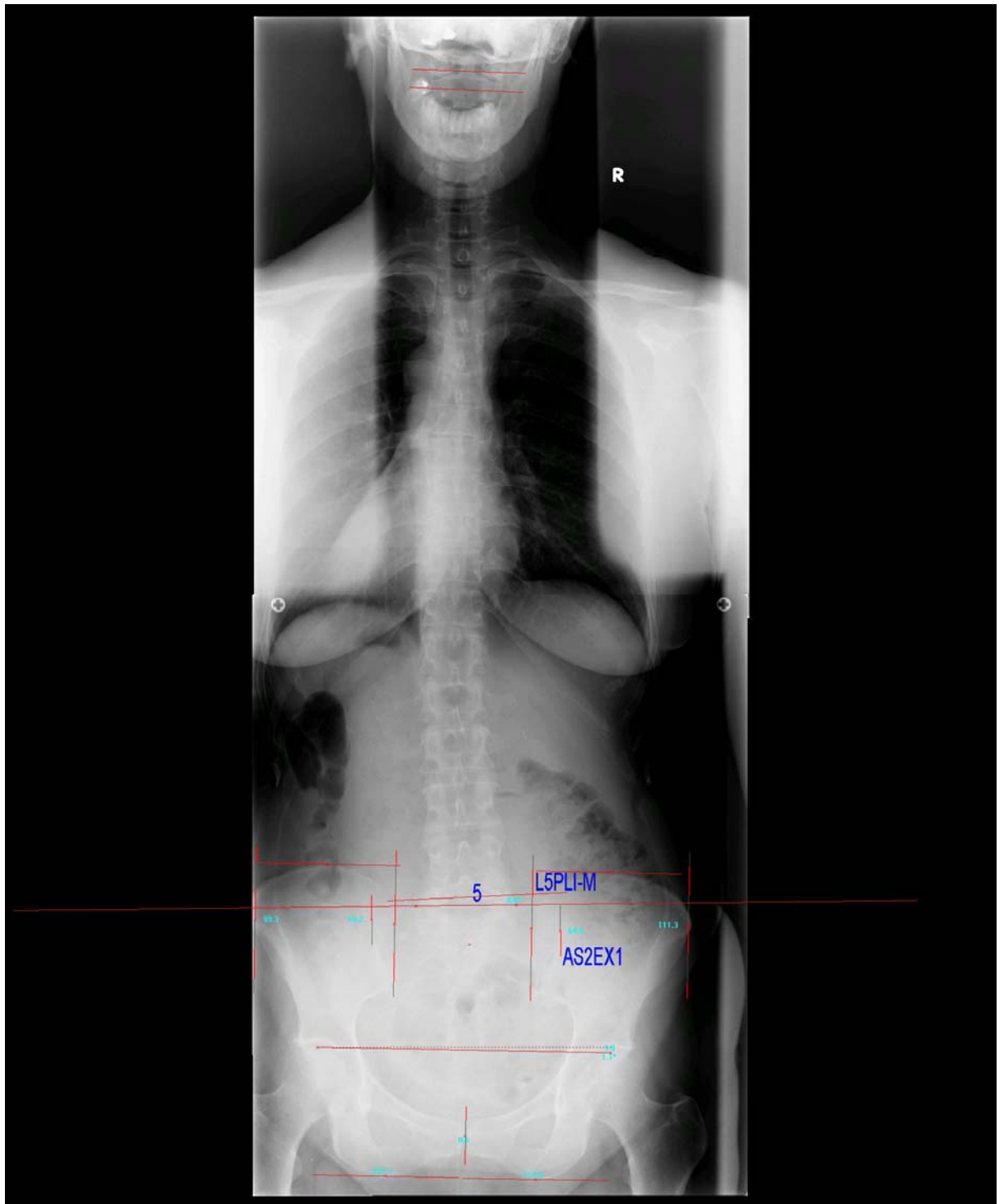


CASE C.

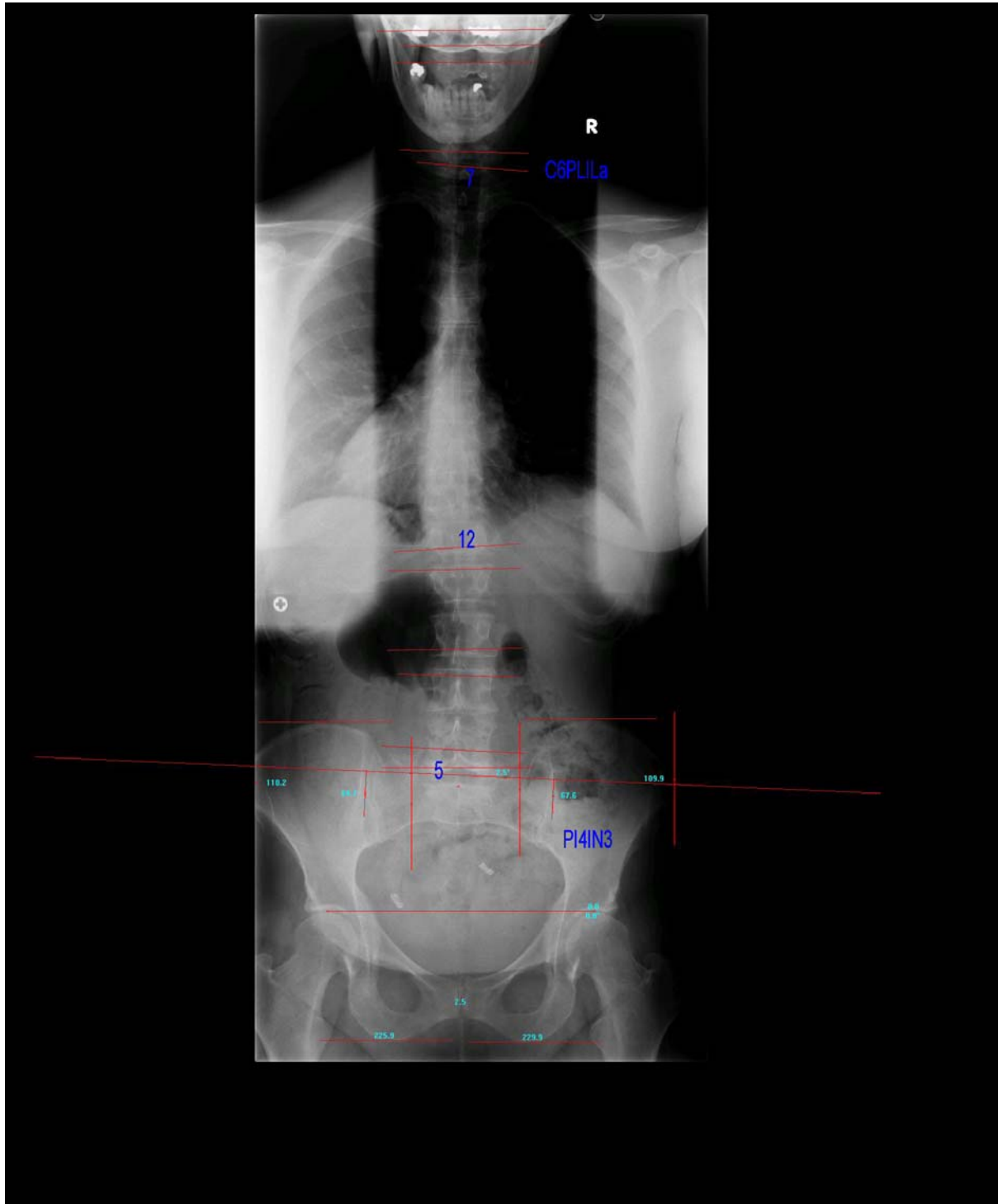


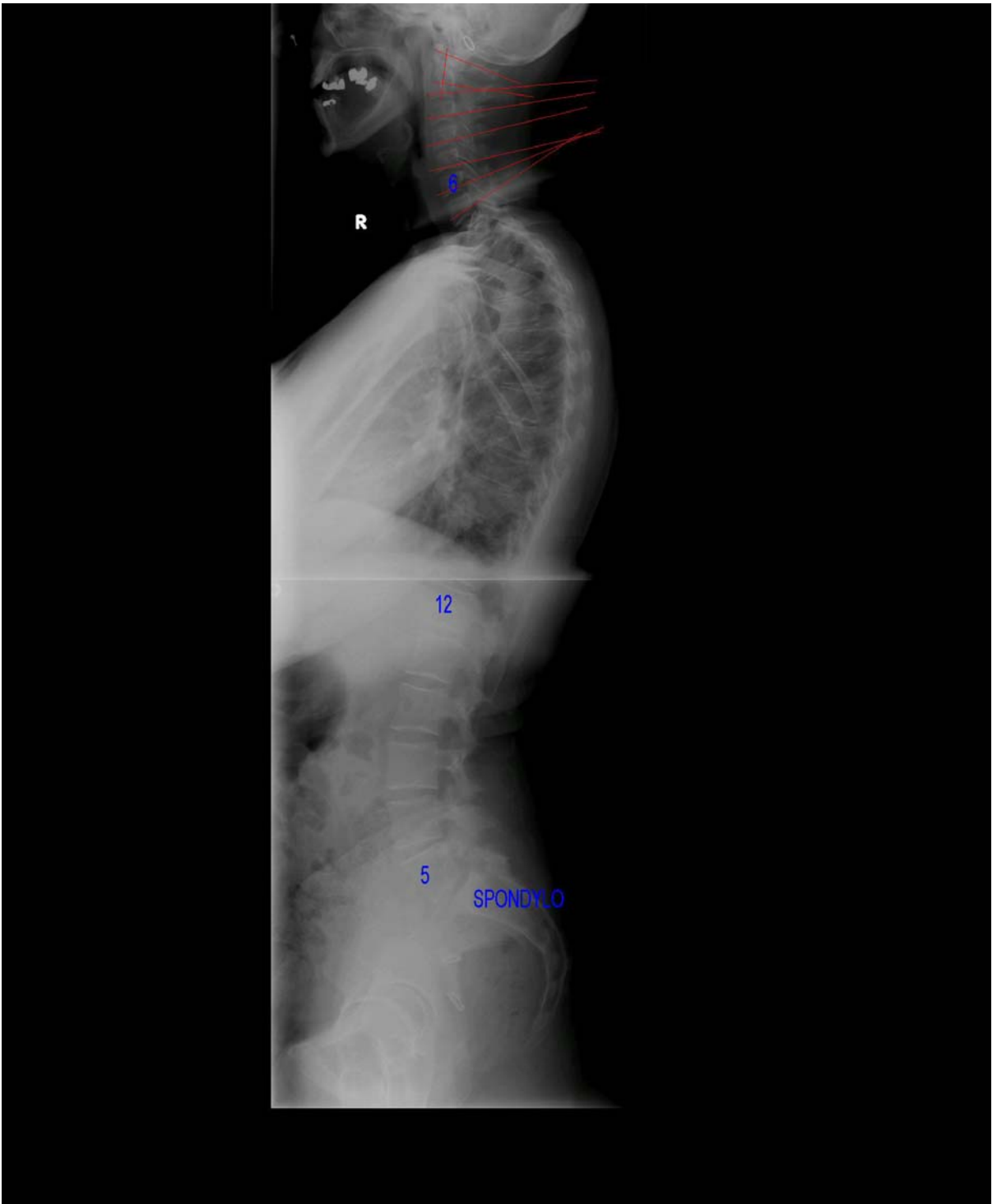


**CASE D.**

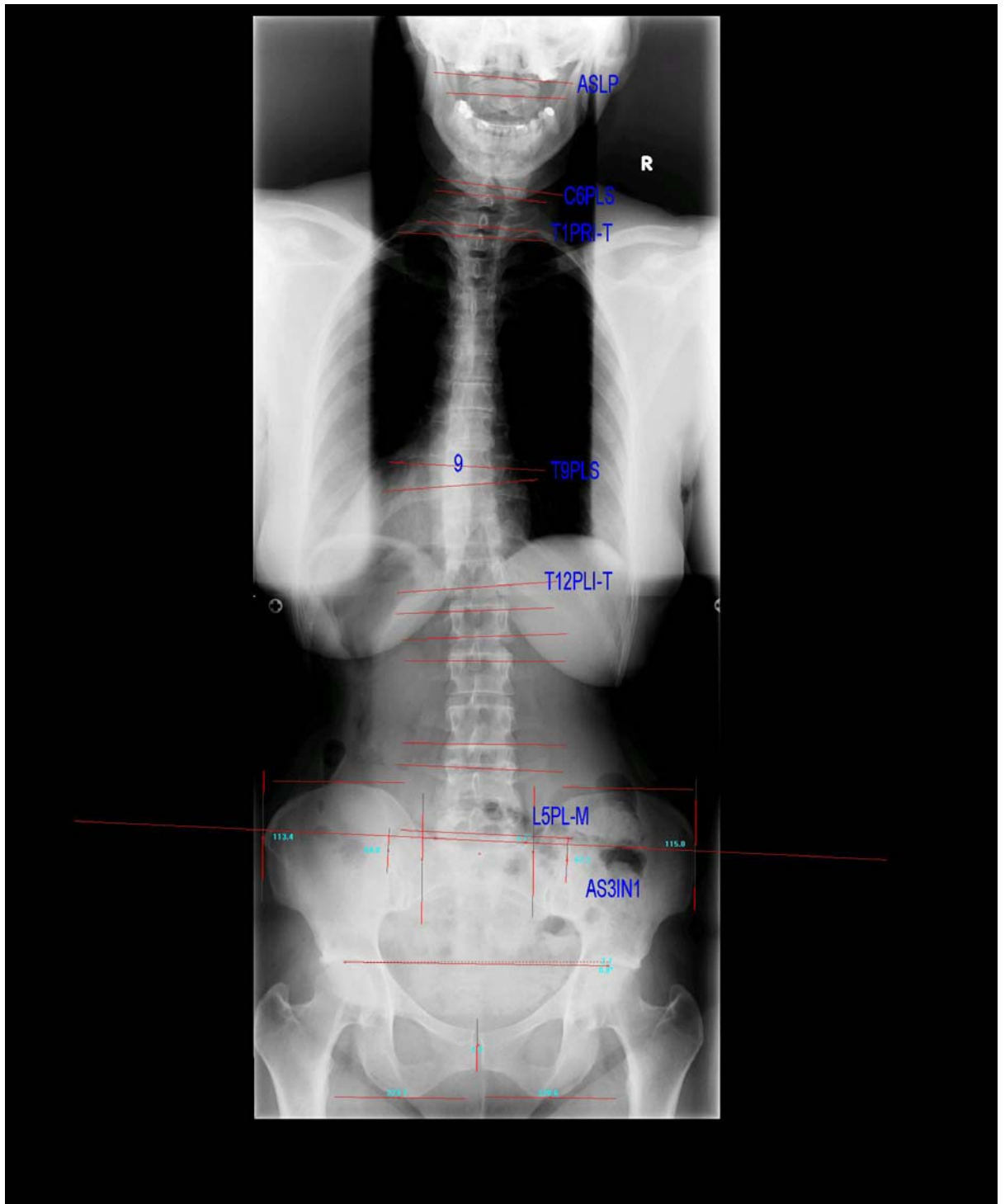


CASE E.

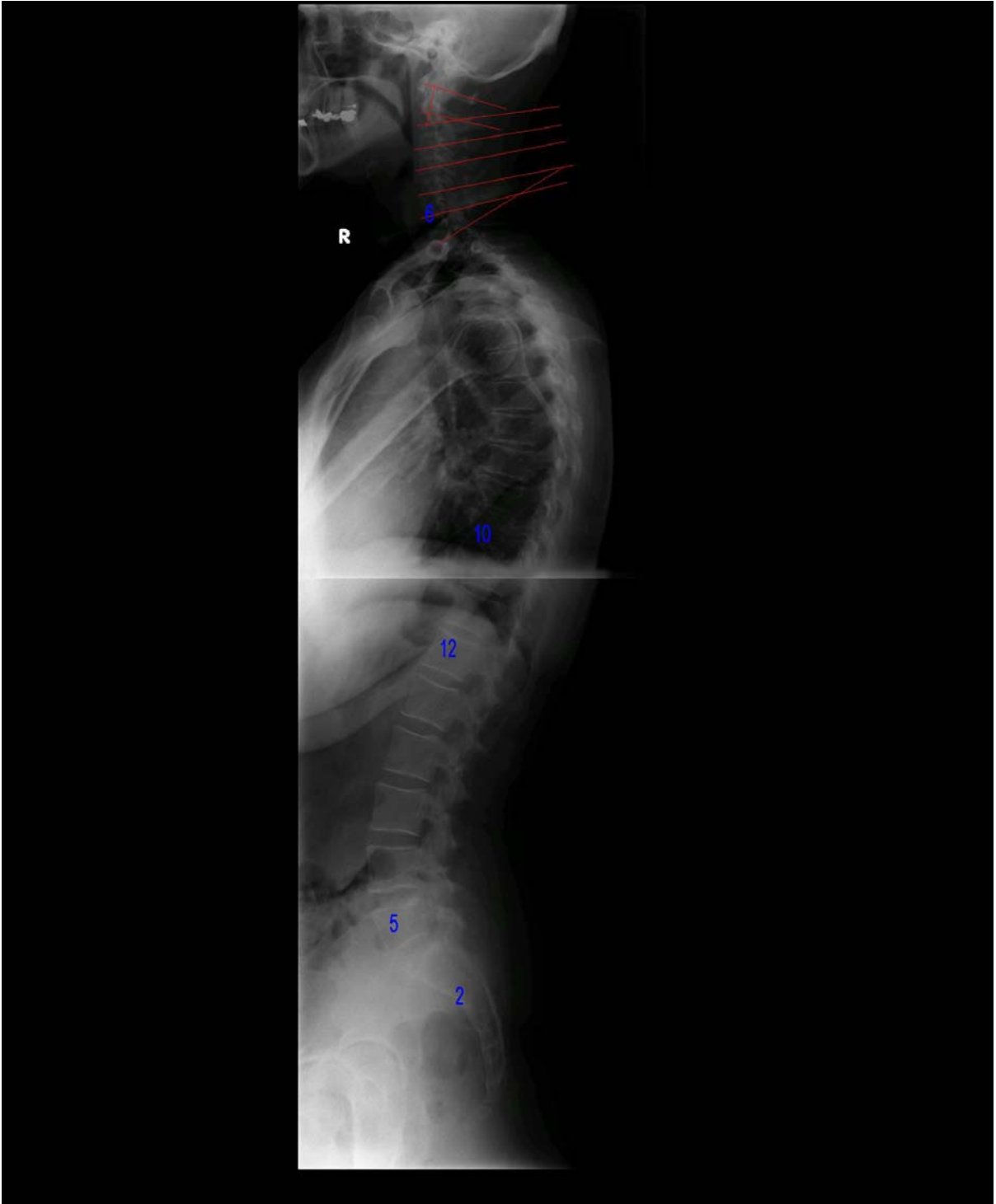




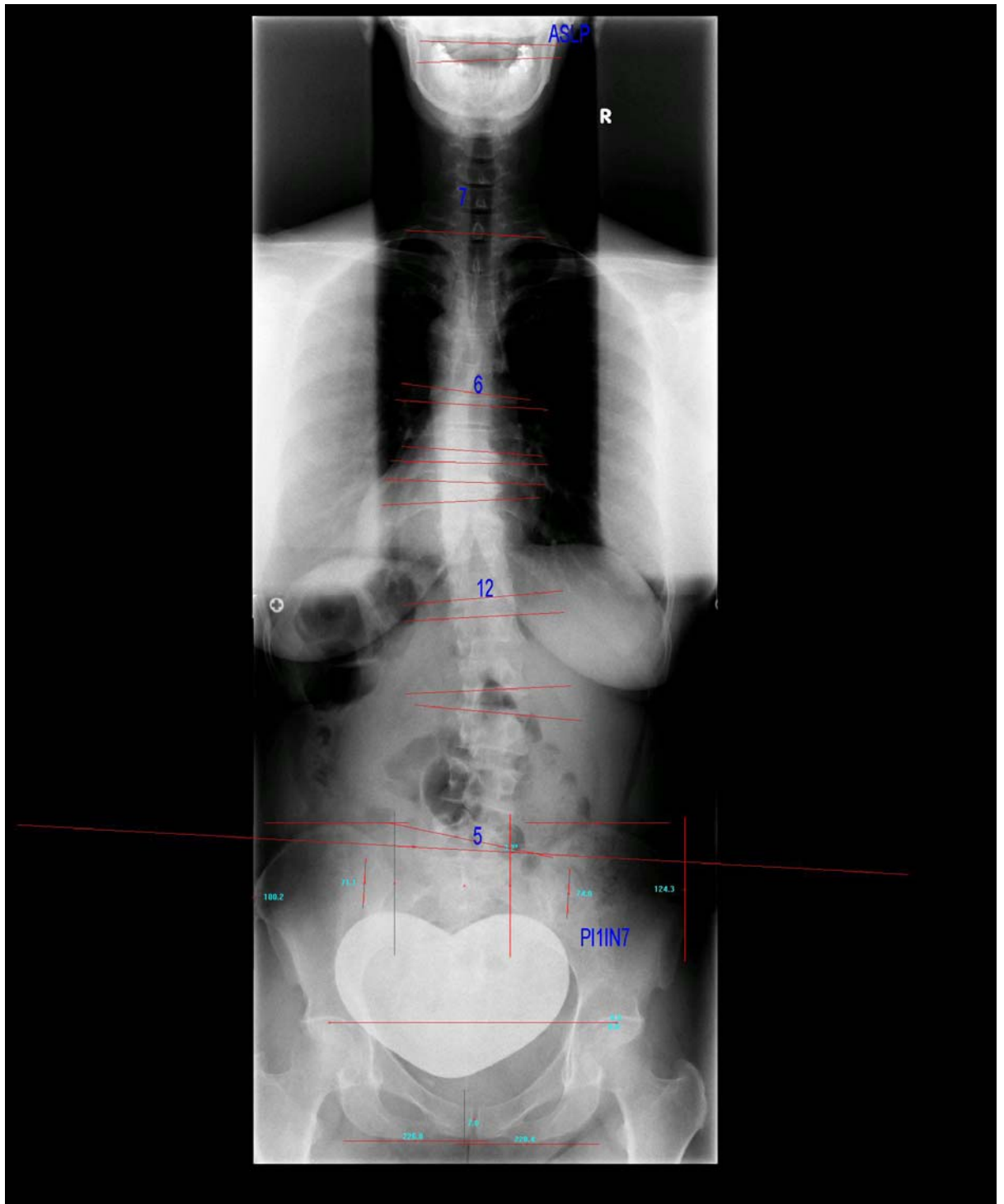
CASE F.

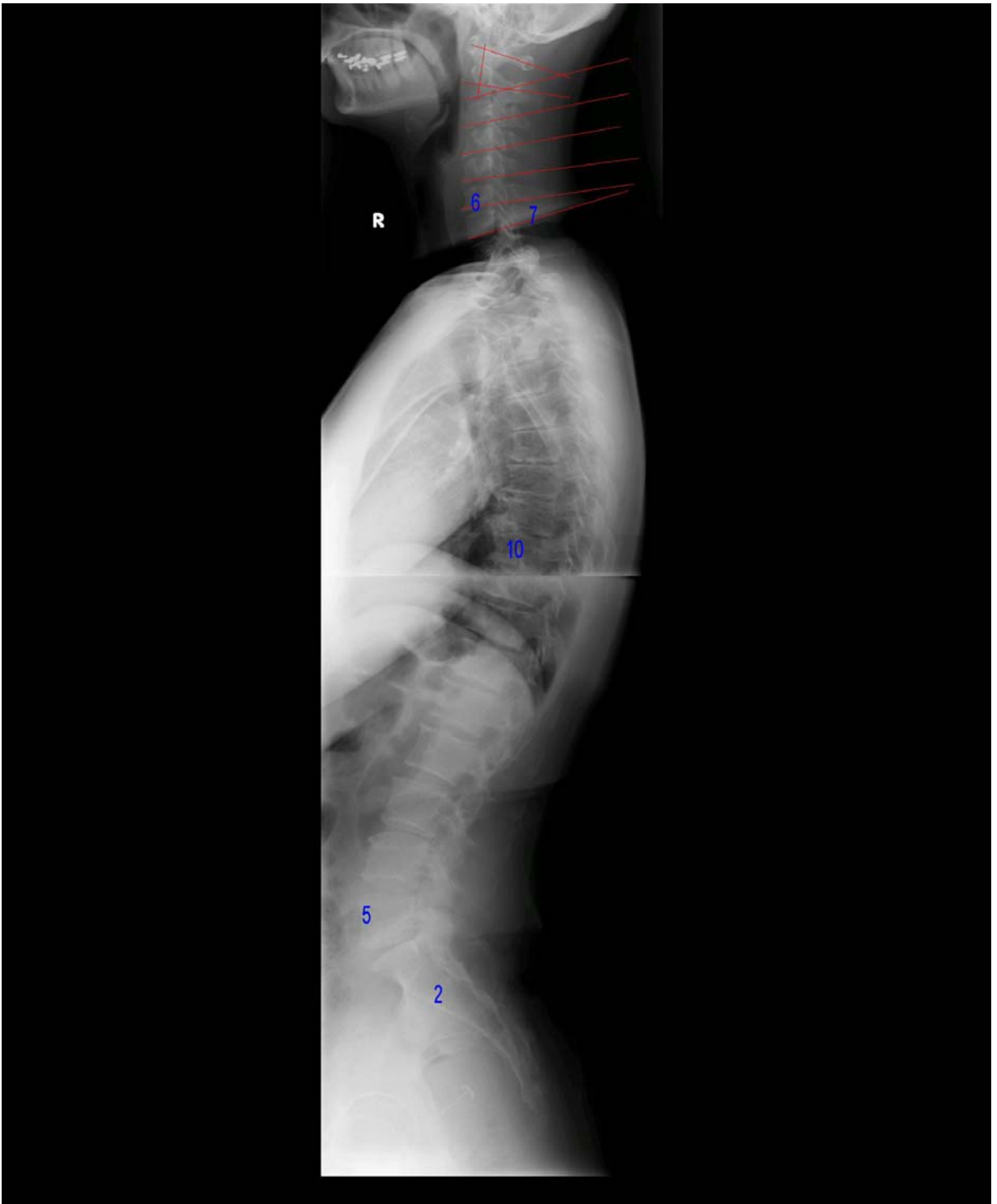






CASE G.





**CASE H.**

