Prone Hi-Lo Table Adjusting: Part 1. Sacrum

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The Zenith Hy-Lo table, built to Dr. Gonstead's specifications, is perhaps the greatest "workhorse" that the chiropractic profession has or will ever see. Its effectiveness and versatility are demonstrated by its presence in many the offices and schools throughout the world.

Many associate this table with thoracic adjustments. Gonstead doctors utilize this table predominantly from T1 to L5. Fewer of us use it for sacral and pelvic subluxation correction. Of course, these subluxations respond very well on the pelvic bench so why should we utilize the Hy-Lo table for them at all? How and why to adjust the sacrum and pelvis, prone on the Hy-Lo table, is the focus of this two-part article.

The sacrum has four basic subluxations: 1) sacral base posterior, 2) L5 spondylolisthesis, 3) posterior sacral tubercle, and 4) rotated sacrum.

The sacral base posterior, in my opinion, should rarely ever be adjusted on the Hy-Lo table. If the patient can lie in the side posture position, this is where the patient is best served. I can only think of two exceptions to this rule. The first instance is that of a geriatric patient with advanced disc degeneration at L5 and S1.The second, the patient who cannot lie in side posture. If you must adjust this prone, make certain that your contact is as high on the sacrum as possible, that the pelvic section of the table is as high as it can be comfortably positioned, and that your thrust is slightly inferior to superior in an arcing line of correction. The doctor should stand perpendicular to the table and use his/her inferior hand.

The "sibling" to the base posterior is the fifth lumbar spondylolisthesis. Unlike the B.P., the prone position may be the best place to perform this adjustment. The adjustment is similar to the B.P. except that the line of correction is a superior to inferior arc. This is a very important point. Not enough S to I will be painful and could exacerbate the condition. I feel that the inferior hand should be your first choice, but the superior hand can be used effectively. A very steep sacral base angle may be an indicator for using the superior hand.

Posterior sacral tubercles also respond well to prone adjustments. Although anyone can be adjusted for this in the prone position, I feel the best candidates are those under about fifteen and those older than sixty. Line of correction is similar to a base posterior, except, I feel, the line of correction should have less of an arc: the thrust is straighter, more P to A.

The last sacral subluxation, the rotated sacrum, is certainly almost always adjusted in the side posture position. On occasion, we have a patient who is unable to lie on his or her side. In these unique cases, the doctor stands at a 45-degree angle to the table, and one of two techniques can be utilized.

For the first, I use my inferior hand and contact the opposite side of the sacrum using my pisiform. The exact vertical placement of your pisiform will depend on your motion palpation and instrumentation findings. You want to have your fingers pointing superiorly with your pinky running medial to the ilium. You do not want to cross over the sacro-iliac joint and contact the ilium. As with almost all adjustments, you want your contact as close to the joint as possible. Line of correction is the same as a side posture adjustment, P to A and medial to lateral, through the joint plane. With your superior hand, you can either place it on your contact hand or stabilize the opposite pelvis by placing the palm of your hand lateral to the PSIS, pointing superior and lateral at a 45-degree angle. This hand should not thrust but instead limit the motion induced by your contact hand during the thrust. I find this stabilization to be very effective when adjusting the SI joints prone.

The second technique I use, is to contact the rotated sacrum on the same side that I am standing on and use my thenar (proximal first metacarpal) contact of my inferior hand. Placement of your contact is most effective
when you ulnar deviate and slightly extend your wrist, so that your thenar contact protrudes slightly into the sacrum. Anatomically, the sacrum is anterior to the ilium, so your contact has to protrude anteriorly to make contact. In addition, you want to protrude your contact as lateral as possible so that you contact as close to the joint as possible. Your thumb should border the ilium and point superiorly. Line of correction is P to A and medial to lateral, and thus requires the doctor to place his upper body over the patient more, in order to accurately deliver a thrust through the joint plane line.

With all of these and other adjustments, it is critical to: #1) adjust the correct segment and listing, #2) have the proper patient and doctor contact, and #3) execute an accurate line of correction. If an audible release is not achieved after one to three attempts, it is not advisable to thrust until you do. The audible release is not crucial with these or any adjusting. If you follow these three critical points, the patient will respond favorably every time. I hope this helps you, your patient and the chiropractic cause! In the next issue I will expand into the pelvis and ways to adjust it prone.

In good health!