

Prone Hi-Lo Table Adjusting: Part 2. Pelvis

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In this article, we will explore the pelvis adjustment. It's often said that if you could only pick one table to use for adjusting, most would choose the knee chest table. While I would agree that the knee chest table is one of Dr. Gonstead's greatest innovations, I would have to choose the Gonstead Zenith Hy-Lo as my table of choice. Not only for its ease of function and patient comfort, but primarily for its diversity. Being able to adjust the pelvis while the patient is prone on the Hy-Lo sets this table apart.

Of course, adjusting the pelvis prone is not the preferred technique for the vast majority of cases. But, occasionally, we have patients that can't lie in the side posture position, or, do not respond the way we know they should with the pelvic bench adjustment. In these infrequent instances, it might be beneficial to set their pelvis prone.

In the previous article, I talked about stabilizing the opposite pelvis by using your opposite hand. This stabilizing hand does not thrust, but it does add some light pressure. I have found that the stabilizing hand serves to help "take up the slack" before the thrust and most importantly to limit the lateral motion that thrusting through the sacroiliac joint will create. Said another way, you want to stabilize the pelvis against the table so that the thrust only moves the ilium that you are adjusting.

I don't always use the counter stabilization technique though. Some cases, I will use the same single hand contact that we would use for a prone or lumbar adjustment. It depends upon the individual doctor and patient and type of pelvis subluxation that we are correcting. Trial and error are sometimes necessary to determine exactly how to set any subluxation. This is particularly true in these cases.

Let's start with the posterior-inferior (PI) ilium subluxation. The doctor's stance is on the contra-lateral side, facing 45 degrees towards the opposite PSIS (i.e., the "fencer's stance"). The doctor's contact is the thenar of the inferior hand with the hand pointing superiorly and laterally. The thenar contact is more comfortable for the doctor and the patient and eliminates any contact with the sacrum. The stabilizing hand can be either over the contact or stabilizing the opposite ilium.

To contact and stabilize the opposite ilium, try using your thenar contact at the inferior aspect of the ipsilateral sacroiliac joint.

Another point of contact could be your pisiform over the back of the acetabulum. The same contact if you were adjusting an AS ilium. The line of correction is the same as the side posture adjustment, P to A, I to S and through the joint plane.

If there is internal rotation (IN) of the ilium, then we make our contact more medial and add torque throughout our thrust (clockwise for the left side and counterclockwise for the right).

For a PIEX subluxation, the contact is on the inferior-lateral aspect of the PSIS. The thrust and torque is the same as it is for a side posture adjustment: P to A, lateral to medial, with torque throughout the thrust (counter-clockwise for the left side and clockwise for the right). When adjusting contra-laterally, either the thenar or the pisiform can be used as the doctor's contact. When setting this ipsilaterally, I prefer using my thenar.

When the EX component is involved or is the sole direction of subluxation, I feel that the side the doctor stands on will be dependent on the comfort, size, and flexibility of the doctor and the patient.

When the IN component is involved or is the only listing, I feel that, in the vast majority of the cases, you will want to be on the opposite side of your contact. This position provides an ideal line-of-correction. Again, experience and trial-and-error will facilitate your technique and allow a 'tailored' approach.

Finally, let's address the AS subluxation, with and without pelvic rotation. For an AS listing, I feel the doctor should stand on the contra-lateral side. In addition, the doctor's stance will be more superior and perpendicular to the table. This will permit a more accurate line of correction (S to I).

There are two contact points that I use on the patient when AS is part of the listing. The first is the most popular: over the acetabulum. This allows the best mechanical advantage to correct for the AS component. With the prone adjustment, I use the inferior hand's pisiform contact. The stabilization hand either covers the contact hand, or I would place my thenar contact on the ipsilateral PSIS.

The second contact point is less popular but can be especially effective when the IN or EX component is paired with the AS subluxation. That contact point is lateral to the most inferior point on the sacroiliac joint. This point is usually lateral to the space between the second and third sacral tubercle. By contacting the subluxated ilium here, the doctor has more influence on correcting the rotation of the ilium and can still correct for the AS subluxation.

When thrusting, your direction of torque stays the same as if you are setting the pelvis in side posture (for the left ilium: EX is counterclockwise and IN is clockwise). This contact point is very effective.

The science, art, and philosophy of the Gonstead System of Chiropractic is all about being specific. This specificity is what we believe separates the Gonstead practitioner from other types of chiropractors. Clearly, it's one of the many attributes that made Dr. Gonstead very

special indeed. Another characteristic of Dr. Gonstead's successful approach was to "think on his feet" and tailor or customize his adjustments. I hope this article contributes to your ability to provide a custom approach and helps you to help a patient even more effectively.

One of my favorite GMI instructors, Dr. Denny O'Hara, once said, "when you hit the target, the patient gets well, but when you hit the bull's-eye, the patient gets better faster than you ever expected". Here is your dart! Now, go find that bull's-eye!