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Posterior-Anterior Glide of the Femoral Head in the Acetabulum: A Cadaver Study

Dear Editor-in-Chief,

I would like to express my appreciation to the authors of the above study. In doing so I also want to express the same to all who contribute through publication. As a former manual therapy clinician and a manual therapy educator, I find the study to be very relevant. In November I was teaching a seminar on the sacroiliac joint, pelvis, and lumbar spine. I demonstrated how a client can present with a significant reduction of hip extension with concomitant positive tests for sacroiliac joint dysfunction. This includes altered pelvic landmarks in standing and a positive March Test, and a positive Standing Flexion Test; yet the crux of the problem is the hip. I made the comment that this pattern presents as though the head of the femur were stuck in flexion and posterior glide, yet I could not envision the hip as having much posterior glide available, based on my understanding of the joint. However, anterior glide passive motion testing revealed hypomobility, in addition to the loss of active and passive hip extension. A generalization can be made stating that the shaft of the femur is a bowed structure in the sagittal plane, and isconvex anteriorly. In supine a client with a purported "posterior glide fixation" will present with the hip in some degree of flexion, such that the greatest portion of the femur appears to more anterior than the contralateral femur, except at the most superior portion. The correction involves anterior glide and gentle stretch into extension, typically with the client in prone, with the knee flexed. This treatment is often very effective in a short period of time, typically 2-3 minutes. The standing pelvic landmarks are then much improved and the standing sacroiliac motion screening tests are typically rendered negative; hence, they were previously false positive.

This study is relevant because manual therapists evaluate anterior and posterior glide of the femur, and alteration of those accessory motions, along with reduced hip extension, can be associated with false positive sacroiliac screening tests. Recent studies have suggested that these standing sacroiliac motion tests do not actually provoke any significant motion *within* the sacroiliac joints, and other structures are implicated.^{1 2} Perhaps this is simply a pattern of

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"In times of profound change, the learners inherit the earth, while the learned find themselves beautifully equipped to handle a world that no longer exists".Author Unknown

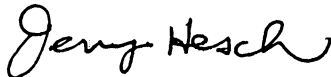
maintained shortening of the hip flexors, and treatment via anterior glide of the hip may be unnecessary. I look forward to evaluating this possibility.

The authors dedicated more than a full page to the section titled: *Limitations of Study and Recommendations for Future Research*. I believe that they did an excellent job of utilizing objective thinking in this section and it may be very useful for future studies. I was surprised at the degree of excursion of the femoral head with distraction in loose pack position. I believe that there are clinical ramifications worthy of further study.

I was also surprised at the amount of force utilized in the study (up to 356 Newtons). I have described up to 176 Newtons for spring testing the ilium, and lesser forces at the sacrum, ischium and symphysis pubis.³ If further study on hip mobilization is performed on living subjects, I believe that pilot testing will reveal that much smaller forces are necessary, in order to avoid pain provocation.

Again, I believe that the research and the article were very well executed, and are very relevant to manual therapists. Thank you.

Sincerely Yours,



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