

## ■ Sacroiliac Joint

An article by DonTigny entitled "Critical Analysis of the Sequence and Extent of the Result of the Pathological Failure of Self-Bracing of the Sacroiliac Joint"<sup>1</sup> clearly contributes to our understanding of the sacroiliac joint (SIJ). Articles in other journals and books demonstrate the interdisciplinary interest in the problem of pelvic joint pain and movement dysfunction.

Problems have been demonstrated with all older models of SIJ dysfunction as new research re-examines the nature of the sacroiliac joint in depth. It is time that we as a profession re-define what SIJ dysfunction is, specifically; what are the biomechanics of the structure, what are the postural and movement dysfunctions, what are the pain patterns, and how do we effectively evaluate and treat the SIJ. I will share some conclusions I have reached in evaluating this structure over the past 20 years.

I believe that Mr. DonTigny is correct in his finding that anterior ilial dysfunction is the most common movement dysfunction of the ilium. In contrast with the traditional mode of evaluation, I have been using additional landmarks for palpation and accessory motion testing<sup>2</sup> and I am convinced that anterior ilium is a tri-plane phenomenon. It rarely accompanies torsion of the sacrum about an oblique axis, but often accompnies pure sacral rotation about a vertical axis<sup>3</sup> and it sometimes accompanies a contralateral posterior ilium as has been noted by Cibulka et al<sup>4</sup>. After resolving the anterior/posterior ilium patterns a transverse plane pattern often emerges and should be addressed. This I refer to as a Type 1 Right Inflare/Left Outflare<sup>3</sup> in contrast to the infrequent traditional Inflare/Outflare<sup>3</sup>. The Outflare is noted by a posterior PSIS with restricted anterolateral accessory motion as tested in prone.

The expanded evaluation format has convinced me that sacral torsions are actually quite rare, sacral rotation about a vertical axis is quite common and unilateral flexion/extension of the sacrum<sup>3,5</sup> probably does not exist.

This approach has been shown to achieve significant pain relief in one visit, increase passive SLR, and have greater than 70% intertester agreement for the majority of palpation and passive motion tests<sup>7</sup>. Intertester agreement has been poor with most traditional tests<sup>8</sup>. Fluroscopy has demonstrated several of the passive accessory motion tests to evoke movement in the SIJ<sup>9</sup>.

It is an exciting time as so much new work is being done in this area. I believe that our profession will continue to evolve in its understanding of this complex problem. I thank Mr. DonTigny for his many contributions and this journal for allowing me to express these ideas.

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## REFERENCES

1. DonTigny RL. Critical analysis of the sequence and extent of the result of the pathological failure of self-bracing of the sacroiliac joint. *The Journal of Manual & Manipulative Therapy* 1999; 7(4):173-181.
2. Hesch J, Aisenbrey J, Guarino J. Manual Therapy Evaluation of the Pelvic Joints Using Palpatory and Articular Spring Tests. Presented at the First Interdisciiplinary World Congress on Low Back Pain and Its Relation to the