

**SACRAL TORSION ABOUT AN OBLIQUE AXIS:
A NEW APPROACH TO AN OLD PROBLEM**
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INTRODUCTION

This chapter is an in-depth exploration of sacral torsion and of sacroiliac joint dysfunction. It presents a model of nomenclature, of evaluation, and of treatment that is much more user-friendly than the traditional model. For those who do not want to dig deeply into the historical and theoretical reading, but do wish to learn the clinical application, you will find the latter part of the chapter that starts with TORSION EVALUATION will suffice. There are some videos on the topic which you can find by searching for “Jerry Hesch,” “sacral torsion” on www.YouTube.com. I believe the videos will be very helpful.

Manual therapy applied to the sacroiliac joint (SIJ) encompasses a variety of types of movement dysfunctions, and may include a variety of pain presentations. In this chapter, SIJ dysfunction (SIJD) will be defined thus: Sacroiliac joint dysfunction is a movement dysfunction in which movement within the SIJ, or going through the SIJ, is altered, possibly causing pelvic posture to be altered and provoking proximal or distal pain. The pain may be intrinsic to the SIJ, or extrinsic, such as from sacroiliac ligaments and other proximal soft tissue. Due to the proximity of the lumbar and sacral nerve supply, pain patterns can be unclear. True SIJ pain is not always clearly demarcated. Furthermore, the SIJ and lumbar spine are inextricably linked and therefore I deny distinct and separate SIJD without lumbar segmental involvement. In contradistinction to much of the general literature, asymmetry is not a necessary prerequisite for the definition of SIJD, as symmetrical and treatable hypomobilities and hypermobilities do exist. A frequently reported sacral movement dysfunction is named “sacral torsion about an oblique axis,” which is also known as “sacral torsion,” or simply as a “torsion.”^{1,2} Torsions do meet the above definition of SIJD, and are the focus of this chapter. I also include my method of evaluation and treatment for sacral torsions. My work is a distinct departure from the traditional evaluation and treatment paradigm, and is therefore referred to as the *Hesch Method*.

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TORSION THEORY

A sacral torsion is a pattern of traumatic, symptomatic, sacral asymmetry with altered movement in the joint. It is described in many works on osteopathic-based biomechanics of the SIJ, including Fryette,³ Greenman,⁴ Mitchell Sr.,⁵ Mitchell Jr., Moran and Pruzzo,⁶ Mitchell, Galen, and Mitchell-Kaia,⁷ Richard.⁸ It is also described in some physical therapy texts.^{9,10} Many typical works on manual medicine, manual therapy, and muscle energy technique (MET) address SIJD and torsion. In the SIJ, torsion is a type of dysfunction in which the sacrum is described as becoming stuck while moving within the ilia about the left or right physiologic oblique axes,^{11,12} (See Fig. 1.) Therefore, torsion can also appropriately be referenced as a sacral “fixation.” There are a total of four types of torsion: Left on Left, Right on Right, Right on Left, and Left on

Right, oftentimes abbreviated as L on L, R on R, R on L, L on R. The nomenclature will be addressed in detail later in the chapter.

Torsion might be an un-physiological dysfunction

Perhaps appearing counterintuitive and somewhat paradoxical, the sacrum can actually go further into the direction of fixation. However, it cannot move back to physiological neutral or beyond it into the opposite direction without a corrective maneuver. This phenomenon is explained as obeying the *Rule of Physiological Motion* (dysfunction). The rule defines physiological motions as those motions which are normal based on the design of the structure. For example, the knee primarily flexes and extends during gait and is *physiological*. A lateral blow to the knee induces a valgus movement which is *un-physiological*. In spite of the fact that torsions obey this rule, I believe that they are not a normative physiological motion, such as part of the gait cycle, per osteopathic theory as described by Greenman,¹³ and perhaps all works on the subject. Rather, it takes a large passive, extrinsic force in addition to vulnerable positioning to induce torsional movements and fixations. For example, activities such as lifting a heavy object with the spine in full flexion, rotation, and side bending.



Figure 1. The left and right oblique axes of the sacrum. The left oblique axis originates above the left side of the sacrum, whereas the right oblique axis originates above the right side of the sacrum.

Torsion theory is often absent in movement science textbooks

It is noteworthy that the concept of torsions is either trivialized without justification, or completely omitted, in several traditional works and in contemporary works on manual therapy, including physical therapy and sports medicine literature.^{14,15,16,17,18,19,20,21,22,23} These works do address the general concept of SIJD. A few manual medicine practitioners, such as JF Bourdillon, MD²⁴ and K Lewitt, MD, DSc,²⁵ do not endorse a torsion model. Also, a remarkably detailed textbook on joints; *Joint Structure & Function: A Comprehensive Analysis*, briefly covers the SIJ in less than four pages, but avoids sacral torsions.²⁶ Another thorough textbook, *Kinesiology of the Musculoskeletal System: Foundations for Physical Rehabilitation*, also limits explanation of sacral motion to nutation and counter nutation.²⁷ The topic of sacral motion is limited to only a single page. Both of these textbooks hold a very prominent location in my library, and if published clinical studies existed that showed the utility of treatment for torsion, I

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