

The Upper Thoracic Subluxation/ Fixation Complex as a Common Cause of a Category II Pelvic Fault

Timothy D. Francis, D.C., F.I.A.C.A., DIBAK, M.S., D.H.M

Abstract

A category II pelvic fault is an osseous subluxation of the ilium in relation to the sacrum. There are various structural, chemical, and emotional causes for this lesion. A common structural cause is an upper thoracic/rib head subluxation/fixation complex.

Introduction

The category II pelvic fault is a common structural finding with patients in a clinical setting. Many varied symptoms may be associated with this subluxation. Utilizing a two handed therapy localization (T.L.) to the sacroiliac joint involved and then cross therapy localizing to the upper thoracic/rib head area often will negate the positive category II findings. Osseous correction of the upper thoracic/rib head subluxation manually will then correct the category II.

Discussion

The category II pelvic fault was first described by Dr. DeJarnette (founder of sacro-occipital technique). It was later incorporated into applied kinesiology by Dr. George Goodheart. This is one of three pelvic category lesions first described by Dr. DeJarnette.

Category II is an osseous misalignment of the ilium to the sacrum. There are two basic types; a flexion malposition (PI-Gonstead terminology) and an extension malposition (AS-Gonstead terminology). The two subtypes are external (ex) and internal (in).

A flexion malposition involves disassociation of the upper portion of the sacroiliac joint (the amphiarthrotic section) with possible superficial edema. The upper sacral surface is concave while the corresponding iliac portion is convex. When the upper portion dissociates, the normal biomechanical listing is PIEX (Postero Inferior-External) following normal joint biomechanics. However if the joint is traumatized, then a PIIN (postero inferior and internal) is possible; going against normal sacro iliac biomechanics. Three dysfunctional muscles are commonly associated with a PI ilium; sartorius, gracilis, and the rectus femoris on the ipsilateral side. With a PI ilium flexion of the hip joint is easy while extension is difficult. This subluxation of the ilium corresponds to an ipsilateral short leg. Symptoms may be found anywhere in the body, in a structural, chemical, and emotional basis.

An extension malposition involves disassociation of the lower S/I joint (the diarthrotic section) with possible deep edema. Rarely pain may radiate into the ovaries or testicles. The lower portion of the sacral side is convex while the iliac portion is concave. Therefore when this portion is involved the ilia moves internal making the normal biomechanical listing ASIN (Gonstead terminology). If the S/I joint is traumatized then

the listing would be ASEX indicating abnormal joint biomechanics. Two common dyskinetic muscles are the gluteus maximus and/or the hamstrings ipsilaterally. With an AS ilium extension of the hip is easy while flexion is more difficult. An AS ilium corresponds to a long leg ipsilaterally. Symptoms may be found anywhere in the body on a structural, chemical, and or an emotional basis.

The two subtypes of a category II are ex and in. Ex is an external disassociation of the ilium in relation to the sacrum. The muscle association is an ipsilateral gluteus medius. IN is an internal disassociation with the ilium in relation to the sacrum and the muscles involved are the obliques.

Therapy localization involves a one handed contact to the S/I joint in question being careful to touch the entire joint. Traditionally the patient is in the supine position. Therapy localization may require the palm up or down position. However many times a category II is not revealed in this manner but is still present. Flexion of the cervical spine with or without rotation may often uncover a covert category II. Likewise, a weight bearing posture such as sitting or standing may be employed. Therapy localization to the S/I joint in a forward/backward gate position is also necessary sometimes. (As well as lateral flexion or rotation of the spine).

Once a category II has been identified, the S/I joint may be challenged on a rebound basis to determine the subluxation listing. The arm-fossa test (S.O.T.) may be utilized as well as medial or lateral knee tenderness. These procedures help to determine the osseous correction required.

Correction of the category II may be performed with a high velocity thrust with the patient in a side posture or prone utilizing a drop cable (Thompson). A non-high velocity protocol (S.O.T.) may be done with the patient supine laying on wedge shaped blocks. Proper correction may be verified if the therapy localization, challenge, leg length, knee tenderness, associated muscles and arm-fossa test are all negative post therapeutic effort.

As with any correction in the body, a question often asked by the practitioner and patient alike is; how long will that last? If after a category II correction have the patient run in place, run up and down stairs, chew, swallow, think a stressful thought, and or ingest a food substance and then recheck the category II findings, many times stressing the body will cause a recidivism of the pelvic fault.

Utilizing a two handed cross therapy localization, one hand on the sacroiliac joint, and one hand on the upper thoracic area often times this will negate positive therapy localization of the category II. This may involve a subluxation/fixation of the upper thoracic/rib head complex. One may also utilize a temporal tap procedure to determine if indeed this is the primary structural cause of the category II. It is this author's observation that well over half of the category II faults are in actuality due to this upper thoracic/rib head subluxation/fixation complex. After manual osseous correction of the subluxation/fixation area, recheck the category II and if negative then restress the patient structurally, chemically, and emotionally to determine if indeed the therapeutic attempt holds. In a vast majority of cases (assuming the osseous correction was performed properly) it does, demonstrating that this is where the cause originated.

Conclusion

A category II pelvic fault may be compensatory to other factors involved in the body on a structural, chemical, and emotional basis. A common structural cause is an upper thoracic/rib head subluxation/fixation complex which is easily demonstrated via a two handed therapy localization and temporal tap procedure. Proper manual osseous correction of this subluxation/fixation complex will ultimately correct the category II pelvic fault if this is the cause.

Resources

1. Francis, Timothy D., *Structural Corrections For Eyes Into Distortion Patterns*. Collected Papers of the Members of the I.C.A.K., Vol. I, Summer, (1990-91).
2. Ibid., *Spinal-Rib Subluxation Immune Syndrome Correlations*. Experimental Observations of the Members of the I.C.A.K., Vol. 1, (1999-2000).
3. Ibid., *Spinal Subluxation/Bilateral Muscle Syndrome Correlations*. Experimental Observations of the Members of the I.C.A.K., Vol. 1, (2000-2001).
4. Goodheart, George J., *You'll Be Better, The Story of Applied Kinesiology*. AK Printing; Geneva, Ohio.
5. Kapandji, I.A., *The Physiology of the Joints, Vol. Three*. Churchill Livingstone; London 1974.
6. Walther, David. *Appled Kinesiology: Synopsis*, Systems, D.C., Pueblo, Co. (1988).