

The Thoracic Spine and Associated Disorders and Treatment

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My previous articles have referred for the most part to the relationship of the lumbar spine and sacroiliac functioning. The middle (and especially the lower) thoracic spine also may influence SI joint functioning.

There are a few situations involving the mid and lower thoracic regions which can be looked at in relation to SI joint functioning:

1. thoracic extension fixations (dysfunctions); and
2. thoracic round back disorders

In the case of thoracic extension dysfunctions, which may include rotation and lateral bending dysfunctional elements, compensation for such extension restrictions will occur in sacral areas, but especially in the lower lumbar spine. Lower lumbar compensation will be in the form of increased extension. Increased extension will cause increased posterior disc and facet compression. This can lead to increased sacral counter-nutation and AS ilium fixation dysfunctions. The same principle applies to upper lumbar extension restrictions. The result of this can be low back pain, hip pain/disorders, groin strain/discomfort, and various knee complaints. Correction of the thoracic and upper lumbar extension fixations can result in partial or complete release of the AS ilium fixations.

This concept especially holds true with congenitally or acquired thoracic round back disorders (hyperkyphotic thoracic spines). You can see this also with hyperkyphotic scoliosis. Kyphosis may extend into the upper lumbar spine, causing increased lumbar lordosis and lumbar facet compression. Within this hyperkyphosis, you can find specific extension restrictions. The existence of extension restrictions increases the rigidity of the thoracic region, as well as the lumbar extension compensation and posterior compartment compression. Correction of this type of situation can be twofold:

1. adjustment of the thoracic and upper lumbar extension fixations to reduce the AS compensatory fixations;
2. use of a device, such as Health Bridges, to increase the extension of the thoracic and upper lumbar regions. These are wooden arcs in three different degrees of angulation. For more specific point extension stretching, a towel may be rolled up and lied upon in the supine position, changing the towel position every few minutes. These methods can be used on any thoracic/upper lumbar spine needing more extension flexibility.

The positions for adjusting the thoracic and upper lumbar dysfunctions are:

1. Prone. This works well in many cases, but has limitations. It can create problems for some patients, such as when adjusting the upper thoracic region, and the lower thoracic/upper lumbar regions.

2. Supine adjusting. This works well for many doctors and patients. There are some problems with this position, as follows:
 1. Some low back pain patients cannot recline in the supine position.
 2. Some doctors develop low back pain with the frequent bending forward.

3. Wall adjusting. This technique is like supine adjusting, except against the wall. It works well when it can be done. It is difficult if the doctor is small.

4. Incline adjusting. This is the use of a bench table with an incline attachment. It is a standard adjusting bench with a headpiece and an adjustable bench top. The caudal end of the table can be raised to any angle up to about 45-50 degrees. The patient sits and straddles the table and leans back against the raised backboard (as opposed to standing or lying supine). The patient is adjusted as in the supine type of adjusting. There are several benefits here:
 1. The doctor does not have to bend very much.
 2. The patient does not have to lie supine and may sit.
 3. It is easier to adjust upper lumbar extension fixations. On some individuals, I can adjust down to L-3 and L-4 levels. This allows lumbar adjusting without twisting and permits direct extension correction.

I use this incline table much of the time, but I mix up the above adjusting positions based upon the problem and build of the patient. The incline table is like oxygen. You don't always need it, but it can save the day. Other tables are similar and pre-date this table, such as the Pettibon style tables. The incline table I prefer uses a caudal incline, and the Pettibon-style uses a cephalic inclination. This table style also is narrower, allowing for easier straddling in the seated position. This table style also has a narrowed head region for use in performing supine and prone adjusting.

The styles of adjusting and table styles are important considerations for allowing greater variability of adjusting and for increasing your success. The Pettibon table style must work well for these doctors who use them, as other styles work well for other doctors.

Whatever method and equipment works well to achieve the correction of extension problems in the thoracic and upper lumbar regions is the best for you. If you monitor the SI joints before and after adjusting, you can evaluate your effectiveness in releasing tension and stress in the low back and hip regions.

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