

# The Thoracolumbar Regional Fixations and Regional Lumbosacral Pain

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These fixations are primarily fixes which resist posterior to anterior motion when tested seated and prone. They also tend to resist distraction when tested prone on a flexion-distraction table. They are in the region of T-10, T-11, T-12, and L-1 levels. They also can have rotation and lateral flexion components to their dysfunction. I believe, however, that the absence of proper extension is the main factor in the creation of L/S discomfort. It can come from two sources relative to thoracolumbar fixes.

Fixation complex(es) can cause hyper extension at the L/S junction. This type of fixation is caused by too much flexion, such as being seated at a computer and slumping. It can be a soft couch which causes slumping and prolonged forward bending. Ultimately, a single or multiple flexion deformity develops in which one or several segments become fixed in flexion, resisting extension. So that one does not walk around bent forward, the body compensates by overextending at the L/S junction. This creates a "facet syndrome" type disorder. It is corrected by adjusting the thoracolumbar fixes P to A.

I usually perform the procedure with the patient supine on a flat bench or on an incline bench. I have designed a special table to fulfill this purpose. You may incorporate some flexion traction at L-5 and L-4, as needed. Electrotherapy and cold packs at the L/S junction are helpful.

The second way in which thoracolumbar fixes may create L/S pain is through the cluneal nerve referral. The cluneal nerves derive from T-12, L-1, or L-2 and may cause L/S pain with thoracolumbar dysfunction. Correction of the thoracolumbar fixations is a step in the correction of L/S pain. The correction will most probably be in the form of extension restrictions.

Hypermobility also can exist at the thoracolumbar junction or just below it. This can be a source of local or referred pain. This is a touchy and interesting subject and requires its own discussion. It will not be elaborated upon here, except to say that you can make a serious error if you do not motion palpate in the seated and prone positions.

In the application of modalities to the L/S region, I would like to make recommendations. Placing most L/S pain-suffering patients in the prone position to administer a modality can lead to increased pain when trying to get up. You can place a pillow under the stomach to assist, and it will work for some people. The use of pelvic blocks in a prone position can greatly reduce post-therapy pain. Place the left block under the left femur head and the right block under the right ASIS. Administer therapy in this position.

Other positions of therapy can be in the side position and seated. In the side position, place a pillow between the knees, which should be flexed superiorward. Some patients such as those with facet syndrome type disorders, can easily tolerate seated therapy. The therapies I am referring to are electrotherapies, ultrasound, and massage.

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