DISC TECHNIQUE: AN ADJUSTING PROCEDURE FOR ANY LUMBAR DISCOGENIC SYNDROME

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ABSTRACT

The intent of this article is to provide a format for chiropractors to learn a Sacro-Occipital Technique (SOT) adjusting procedure (known as Disc Technique) for treating patients with lumbar discogenic syndromes. Disc Technique along with the 'Step Out Toe Out' procedure (SOTO) are central to the SOT Category III protocol. Other SOT Category III procedures will be discussed so that Disc Technique can be understood in its context. Disc Technique requires only a stool or an armless chair, a willing patient and your thumb. (*J Chiropr Med* 2003;2:142-144)

KEY WORDS: MeSH: Chiropractic. Non-MeSH: Sacro-Occipital Technique; Discogenic Syndromes

INTRODUCTION

Disc Technique, (1,2) as developed by M.B. DeJarnette D.C founder and developer of SOT, along with the 'Step Out Toe Out' procedure (SOTO) is central to the Category III adjusting protocol (Figure 2).

SOT treats all patients within a 3-category system.

- Category I: Is designed to deal with the Primary Cranial Sacral Respiratory Mechanism (PCSRM). The PCSR is a system of functional support for the central nervous system. (1-3)
- Category II: Is designed to deal with systemic weight-bearing problems expressed through the weight-bearing portion of the sacroiliac joint. (1-3)
- Category III: Is designed to address lumbopelvic problems primarily discogenic in nature. (1-5)
- Selecting the category most in need is based on a series of indicator tests and SOT principles (Figure 1).

DISCUSSION

While a patient's symptoms do not necessarily define the category, sciatic problems (referred pain into the right or left buttocks/lower extremity) usually are consistent with Category III findings (called Indicators).

Category III Indicators are as follows:

1. In a standing plumbline analysis with the eyes closed there is limited movement, a possible antalgic lean, and a possible lateral spinal curvature. There may be no lean or curvature especially in cases of severe disc damage (herniation). (1,2,4)
2. In a standing position the first rib and first thoracic articulation is negative for unilateral tenderness, swelling and/or lack of movement on forward head flexion. Lack of movement may be present bilaterally. (1,2)
3. There must be a leg-length differential in the prone position. (1,4)
4. The "Step Out Toe Out" (SOTO) test should have some finding consistent with the patients symptoms. The SOTO maneuver is made to determine the causative factor in sciatic pain (Table 1). At the same time, it has the therapeutic effect of correcting the distortions of the pelvis and supporting the lumbar spine. (1-3) The SOTO maneuver is accomplished by grasping the knee of the prone patient with 1 hand, and the ankle with the other. Abduct the patient's leg slowly until the hip on that side begins to elevate from the table and/or resistance is met, then externally rotate and dorsiflex the foot making sure that the foot is at the same level as the pelvis (Figure 2). Unilateral restriction and/or provocation of pain is an indication of the need for block placement. The

THREE CLINICALLY DEFINABLE BUT INTERRELATED CATEGORIES

Figure 1. Three categories inter-related.

TABLE 1
SOTO ANALYSIS

	SYMPTOMS	SOTO NO BLOCKS	DIAGNOSIS	SOTO ON BLOCKS	PROGNOSIS
1	POSSIBLE HIP PAIN OR NO PAIN	LIMITED SOTO ABILITY UNILATERALLY POSSIBLE HIP PAIN	TROCHANTERIC	IMPROVES ON BLKS WITH REPEATED SOTO	GOOD, SHOULD IMPROVE STEADILY
2	POSSIBLE HIP PAIN AND/OR SCIATIC PAIN	LIMITED SOTO ABILITY UNILATERALLY POSSIBLE PAIN SCIATIC AND/OR HIP	PIRIFORMIS	IMPROVES ON BLKS WITH REPEATED SOTO	GOOD, SHOULD IMPROVE STEADILY
3	SCIATIC PAIN OR JUST LUMBAR, LUMBOSACRAL PAIN. LEAN ON OPPOSITE SIDE OF SCIATIC IF PRESENT	POSSIBLE PAIN ON SOTO (AS PER SYMPTOMS)	LUMBAR SUBLUXATION INFERIOR TILT OR BODY ROTATION TO SIDE OPPOSITE SCIATICA	USUALLY IMPROVES SOMETIMES NO CHANGE IN SOTO UNTIL AFTER LUMBAR ADJUSTMENT	GOOD, SHOULD IMPROVE STEADILY
4	LUMBOSACRAL AND/OR SCIATIC PAIN SAME SIDE AS LEAN	PAIN ON SOTO (AS PER SYMPTOMS)	NERVE ROOT COMPRESSION FRAGMENTED DISC OR HERNIATED DISC	PAIN WORSE OR SAME WITH REPEATED SOTO	GUARDED, IMPROVEMENT SLOW IN MOST CASES
5	SCIATIC PAIN BUTT AND LEG (+ CALF) NO LEAN	PAIN (AS PER SYMPTOMS) OR NO PAIN ON SOTO. COULD HAVE CALF PAIN	NUCLEUS HERNIATION	NO CHANGE	GUARDED, IMPROVEMENT SLOW IN MOST CASES.

blocks are placed according to the short/long leg. The block on the short-leg side is placed under the acetabulum, pointing oblique down to the other side. The block on the longer leg is placed under the ASIS also facing oblique downward to the other side (Figure 3). Keeping in mind that the SOTO without blocks is a diagnostic test. With the blocks in place, SOTO is both an adjustment and further defines the diagnosis (a working diagnosis). The SOTO adjustment is done after the acetabular adjustment as the patient is lying prone on the blocks, every 2 minutes (3 times maximum), or until relief and/or motion is improved (usually in 1 application). As SOTO is re-applied, note the changes in the response both subjectively (level of pain intensity) and objectively (movement of femoral head within the acetabular cavity) to make an accurate diagnosis and prognosis. (Table 1) (1,2,4)

Figure 2. SOTO procedure on blocks.

5. Possible unilateral psoas muscle contraction on the side of spinal lean or spinal curvature. Tested by tractioning the patients arms superiorly, with the patient in a supine position, looking for a unilateral ribcage and shoulder girdle restriction. (1-4)

Often, Category III patients have tenderness on palpation of the inferior lumbar spinous process along with limitation of the Straight Leg Raise Test bilaterally (hamstring tightness) or with sciatica pain unilaterally (side of involvement).

The Category III Adjusting Procedure is as follows:

1. Acetabular adjusting procedure prone if indicated. Goading the greater trochanter while rotating the patients lower leg. Done on the side of greater resistance on external rotation on the foot in the prone position. (Figure 4)

Figure 3. Category 3 blocking position for a right short leg.

Figure 4. Acetabular adjustment.

2. The Category III Blocking procedure along with the SOTO Technique for further defining the problem and its outcome along with further correction. (Figures 1,3, Table 1) (1,2,4)
3. The Psoas muscle technique if indicated. The psoas muscle is adjusted (with the patient in the supine position) on the contracted side by goading the abdominal tissues while bringing the bent knee on the involved side toward the midline. (1,2,4)
4. Disc Technique. (1,2) (Figures 5,6)

Disc Technique is done with the patient sitting approximately 2 feet from the wall, facing the wall. They place their toes up against the bottom of the wall. The doctor makes contact with his or her thumb at the inferior tip of the spinous process of lumbar 5. The patient then goes into flexion of the lumbar spine (Figure 5), pulling the abdomen in while arching the spine back (from lordosis to kyphosis). The doctor maintains a holding pressure in the superior direction on the spinous process of Lumbar 5.

The patient then moves into extension of the lumbar spine (Figure 6); pushing the abdomen out while arch-

Figure 5. Disc technique (flexion).

Figure 6. Disc technique (extension).

ing the spine in (From kyphosis to lordosis). The Doctor maintains a holding pressure in the anterior direction on the spinous process.

Do not hold the thumb in the superior direction on extension; make sure it is directly pointing anteriorward. Repeat this process approximately 3 times, while at each lumbar vertebrae. (1,2)

CONCLUSION

As the patient moves into flexion, the interspinous spacing should increase. As the patient moves into extension, the interspinous spacing should decrease. (1,2) Limitation of interspinous spacing on lumbar flexion can indicate a possible compressed spinal area, that needs to be addressed with further disc technique. Improvement of interspinous spacing in flexion of the lumbar spine along with anterior movement on extension is ultimately what is desired. Restoration of what is considered normal movement of the lumbar spine (flexion and extension) (6) in conjunction with improvement of the SOTO findings, in my opinion, is usually consistent with improvement of the patients symptoms. I have found these techniques to be significantly effective in treating lumbar discogenic syndromes, but at the same time I realize further research and study is needed.

REFERENCES

1. DeJarnette MB. Sacro-occipital technique. Nebraska City, NE: Self Published; 1984
2. SORSI. Sacro occipital technique, Participant Guide. Sedan, KS
3. Getzoff IH. Sacro-occipital technique categories. A system method of chiropractic technique. Chiropr Technique 1999;11:62-65
4. Getzoff IH. The Step Out - Toe Out Procedure. A therapeutic and diagnostic procedure. Chiropr Technique 1998;10:118-20
5. Getzoff IH. The iliofemoral joint (hip joint). SOT analysis and adjustment. Sacro-Occipital Research Society International Technical Report 1990;2:71
6. Cailliet R. Low back pain syndrome, 2nd edition. Philadelphia, PA; FA Davis; 1968. p. 20-4