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Back to Normal

Washington therapist focuses on the sacroiliac joint when treating back pain

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Sacroiliac Pain

Christopher Ford, MPT, is owner of ABC (Alternative Back Care) Physical Therapy, Tacoma, WA. He became a PT in 1995 and founded the practice in 2001. According to Ford, his clinic has achieved great success in treating patients with back pain by including the sacroiliac (SI) joint, as well as the lumbar facet joints. In many cases, these patients had tried several options that did not bring relief before coming to ABC Physical Therapy. *ADVANCE* spoke with Ford last month to discuss his philosophy and methods.

ADVANCE: What are some of the common conditions seen at your clinic?

Ford: We treat the entire back, particularly low-back and upper-back, as well as migraines. We see everything but that's our specialty and what we treat differently from other clinics.

ADVANCE: What percentage of your patients present with some type of SI joint dysfunction?

Ford: If it's a low-back issue, about 100 percent will present an SI joint dysfunction. And about 90 percent have an immediate positive response when this joint has been properly addressed. Which you won't learn in school, but that is my perspective on it.

ADVANCE: What symptoms will people typically experience when they have SI joint dysfunction?

Ford: Typically, they have good days and bad days or complain that "their back goes out." Bending, stooping, lifting, rolling in bed, getting in or out of the car, sitting to standing, long bouts of sitting, standing or walking will aggravate symptoms. The low-back should be considered a mechanical issue, so the more they move the more likely they will displace the SI joint and lumbar facet joints, and deliver pain/symptoms. Typical symptoms include burning, sharp, stabbing shocks and aching in the sacroiliac joint, groin or lumbar region. Sharp twinges at the SI joint complex with transitional motions is another common complaint. Symptoms travel into the buttocks and sciatica-type symptoms are typically caused from the sacroiliac and/or lumbar facets, as well.

ADVANCE: And you believe few PT professionals would agree that low-back pain and SI joint dysfunction are basically synonymous?

Ford: Yes, because I was taught what they were taught, so now I'm basically rewriting the book on how we look at back pain. I see the back as a collection of joints, if you look at cause and effect pain and symptom-wise. If I can take away pain every day or lower it by proper accurate alignment of these structures, then we have established a cause-effect relationship. But in school, they used to teach us the percentage of patients with an SI joint dysfunction is low, anywhere from 5 to 15 percent. Other studies cite higher percentages of 15 to 25 percent.

The SI joint is commonly considered something that only might be an issue and can be put on the back burner. Not just in the PT world but also in the medical world, where the causation of back pain is focused on bulging

discs, nerves and muscles. I rarely find that these structures are the source of their pain at all. This is consistently established by the cause-effect relationship demonstrated after proper alignment is attained. The difficulty with diagnosing SI joint dysfunction is that it is not identified in MRIs or X-rays, but easily identified with proper manual skills.

So the difference between me and many other therapists is my philosophy. I focus and treat the cause of low-back pain, not the symptoms. I look at the low-back as a series of joints, that when displaced, deliver the wide range of symptoms so prevalent with this condition. We can recreate these specific symptoms while mobilizing the individual joint segments, which again confirms this typical cause-effect phenomenon. Using my segmental leveling technique, we are able to reduce or resolve their symptoms, immediately after accurate alignment is attained.

In the physical therapy world, shoulders, knees, ankles, hands and wrists are all joints. Well, the success rate for shoulder-joint injuries is in the 90-95 percent range, wherever you go. That rate is very high because we treat it like a joint. Simply meaning, the difference between treating a dislocated shoulder and an SI joint is nothing, except that we don't walk on our hands.

There's a reason low-back pain in general has around a 30-35 percent success rate. And success doesn't even mean resolution of pain, just that the patient doesn't come back and the pain isn't bad enough to get it totally resolved. Nevertheless, the numbers are low and it's because we don't treat it like a joint. If you have a dislocated shoulder, the traditional treatment is to sling it. You immobilize the joint, let it heal and then introduce exercise slowly, steadily and safely. How do we traditionally treat low-back pain? By getting patients into exercises right away. So what we're trained to do is start exercises right away and continue to progress exercises without regarding the SI joint complex. In other words, exercising patients with unstable joints of the lumbosacral complex will only lead to pain, dysfunction and more importantly, continued instability.

Many of my patients complain that physical therapy was painful for this very reason. They're exercising with a joint that's out of place and standard exercises make it go out of place even more. It puts too much stress on the joint and we just have them push through the pain. That's counterproductive because the only way to properly allow a joint to heal and strengthen is to first immobilize it. During this period you must introduce exercises that respect the mechanics of the SI joint complex.

What I do differently is treat the back like a joint. So for at least the first two weeks, I don't work on muscles. Patients need to learn what they're doing on an hourly basis to displace that joint. So I teach them how the joint moves and how not to move it. Our focus is to maintain alignment by changing the way they sit and move. Those are two important tasks they must master.

The SI joint is very powerful. Those two joints, left and right, hold up our upper and lower half. It's a weight-bearing joint. This is the reason why a lot of patients will walk with a limp. When I examine them, I find that either the left or right SI joint is displaced. Because it's a weight-bearing joint, the first thing I do is determine how much weight they put on each leg by using two floor scales. It is typical to see patients unwittingly shift anywhere from 5-50 pounds less on their affected side. Patients with symptoms of sciatica or other symptoms frequently feel them more on their right or left side. So I say "back pain is not back pain, it's either left or right." That is, I find the SI joint plays a primary role with low-back pain and is a weight-bearing joint, just like the knee joint.

I've learned a lot about how to treat backs by listening to my patients. Because they really know more about their backs than their doctors. So patients are accurate when they say, "My back went out on me." They just haven't been validated because whoever they're telling that to can't make sense of it the way my philosophy does. When they have sharp twinges in the back, that's like if they sprained an ankle. Ligaments are torn, and when you re-sprain it that's how ligaments react. It's a sharp, painful stab.

They teach us in school that's probably a nerve pinch. But it's actually the SI joint slipping out of place. It's a moving joint anyway so it rotates when we walk. As a rotating joint, to fix it we have to stabilize it. Because

the SI joint is at the center of gravity, forces transfer through the joint complex during all transitional movements. Just about any motion can aggravate it, from brushing your teeth to sneezing.

This is the most difficult joint to immobilize due to these mechanical factors.

So the same way you would sling and immobilize a shoulder until the joint gets strong enough to handle exercise, I do for the low back. I put the SI belt on, which has the same function as a weightlifting belt. When bodybuilders do 400-pound squats, they have these belts on and they're very tight. It's not for hernias, but for compression.

The SI joint is shaped like a wedge, similar to the keystone of a brick archway. Structure and function always go together. That means the function of the sacrum is to create adequate vertical strength to hold our upper half from falling through our lower half. So when weightlifters put their weightlifting belts on to lift hundreds of pounds, they're going to have 200 pounds on each SI joint. When you compress that wedge, you can basically hold up the world.

I'm just borrowing their techniques when I want to teach patients how to move through space, do work or home activities, get in and out of the car, etc. I teach them how a bodybuilder does their squats, dead lifts or stooping activities (i.e. moving purely in the hip joint itself). Bodybuilders also keep the lumbar spine straight and immobile. The neutral position of the lumbar spine is a slight lordosis. The bodybuilder keeps his back arched with the belt on, successfully securing the SI joint, during the squat. The patient will attain the same mechanics with similar motions of sit-to-stand or in-and-out of the car, etc.

So what I'm teaching them mechanically is to shift the torque out of the SI joint area and into the hip where it needs to be. Because that's the best joint in the body and the gluteus maximus is the strongest muscle. So the human power center is in the hip. Theoretically and in practice, if I can teach patients how to bend, get in and out of the car or pick up a dollar bill so that all their motion is in the hip joint, that's what immobilizes the sacroiliac joint.

And the only way to heal any joint in the body that's been sprained or displaced is immobilization. So in a nutshell I focus on that the first two weeks, maybe three weeks, rather than deliver any exercise at all to them, since most exercises will put the joint out anyway. Just like when you body-build, you want to get your mechanics down first and then put more weight on later.

ADVANCE: After that initial two or three weeks when you're just trying to stabilize patients and teach proper body mechanics, what exercises do you advocate?

Ford: Those that mimic or reinforce the basics mechanics to learn. Basically a lot of squat-type and stooping exercises with the focus on hip-hinging. Along the way, we do basic core exercises, teaching them how to maintain their lumbar stability. But we don't do exercises such as having them lie on their back and raise their legs from the mat table because it puts too much torque on the SI joint. We do more isometric-type exercises that eliminate or minimize twisting and side-bending. We also emphasize strengthening, using a theraband cord and simple sit-to-stands off a chair. So we're creating resistance and making the lumbar spine contract. We get the same exercise to core muscle groups that is needed but in more planar motions. We avoid rotation and twisting until the joint starts to heal and scar down.

ADVANCE: For a typical patient with SI dysfunction, how long does an entire treatment regimen last at your clinic?

Ford: Depending on the severity, typically six to eight weeks. The other thing about this clinic is we don't get the easy back patients. We get the ones who have failed with traditional physical therapy or chiropractic, shots, surgery, etc. Which makes it very difficult for our population to attain adequate stability. Those patients usually need around eight weeks. There is a lot to learn and it takes time for them to do it right and become pain-free. Even a year after patients leave this clinic, I expect the SI joint to move out again, because it moves out on normal backs. But they will be able to recognize it and fix it right away, then get back to work and lead their normal lives.

ADVANCE: How would you characterize your general success rate with SI joint patients?

Ford: It's very high. I would guess at least the 75-80 percent range. For a good portion of the patients who have not had much luck here, it's because they didn't come back for the second visit, didn't follow the plan of care or didn't believe in it. A lot of this rehab philosophy is put upon them. I can realign the back and get them to zero, but can they maintain that? It's dependent on their ability to comply. And when they're having a hard time, it's usually a compliance issue, not that they're lazy. They may not be able to control their environment to maintain alignment/stability. It might be a carpenter who has to work. So I'm changing his mechanics but he's working all day. Some patients also can't take time out to adequately provide maintenance to their low-back pain. That lengthens the time of rehabilitation and is an impediment to progress. So there are many little barriers that patients have to overcome. The greatest success comes from those patients who understand the plan of care and diligently practice and utilize all the strategies and techniques given to them. *Brian W. Ferrie is managing editor of ADVANCE and can be reached at bferrie@advanceweb.com.*

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