Osteopathic Diagnosis

Fundamental to osteopathy is the concept of Osteopathic Somatic Dysfunction (OSD) or what was traditionally referred to as the Osteopathic lesion. This would also correlate to the Chiropractic subluxation. All of these terms refer to a situation where a joint is restricted and is causing pain, asymmetry and tissue changes.

I have chosen to use the traditional term "lesion" without the qualification of the use of the word "Osteopathic" partly for brevity but also because I don't think any profession should claim ownership of these phenomena. I am also using it because with the rise of the use of the term Osteopathic Somatic Dysfunction there seems to have been a fall in the emphasis on sacroiliac joint manipulation. In this sense it is also a nod to the pioneers of Osteopathy who seem to have paid more attention to this area.

I think the neglect of this area has several reasons. One of these reasons is the difficulty in palpation and particularly manipulation of sacroiliac joints. Manipulating sacroiliac joints effectively, certainly from my own experience, can take many years to get up the steeper part of the learning curve. It is very easy to give up on manipulating sacroiliac joints and use other techniques instead or ignore the area altogether.

Another major reason is the perception that the pain and the joint restriction have to be in the same place. In many areas this is true but not in the pelvis.

The pelvis is a closed biomechanical system and as such, dysfunction of the whole can produce pain in either sacroiliac joint, the pubic symphysis or the muscles and other tissues associated with the pelvis. Pelvic dysfunction can then produce dysfunction and pain in the lumbar facet joints and the other structures and tissues in that region.

Pelvic torsion can also produce torsion through the lower limbs and hence are involved in a number of conditions of the knee.

The sacral base forms the foundations of the spine and as such dysfunction in the pelvis can be associated with dysfunction higher

up. In this sense the pelvis should be the first port of call when treating cervicogenic headaches.

Orthopaedic studies would indicate that lower back pain can be affected by anaesthetic injection in the sacroiliac joints in only 15-25% of cases. On this basis it is easy to discount sacroiliac joints as a major cause of pain. However, although they may not frequently be a direct source of pain they are frequently a direct cause of dysfunction. In this sense there may not be symptomatic lesions in the pelvis but there are invariably structural lesions in the pelvis.

Some people refer to primary and secondary lesions. In this respect, the pelvis is often the source of the primary lesion, even if it is not symptomatic in itself.

Accordingly, when it comes to treating lower back pain or pelvic pain, sacroiliac joints in their entirety as well as the lumbar facet joints should be palpated and assessed as a matter of course with every patient. The site of pain should be noted but should not influence the assessment. In my opinion, reducing a diagnosis to just sacroiliac joint dysfunction or lumbar facet joint dysfunction is excessive reductionism and incorrect as such. A collection of findings in the entire area is more general but in fact more accurate. At the same time, a treatment approach involving assessment of both sides of the pelvis and lumbar spine is both warranted and most effective.