

McKinnen Technique

The McKinnen technique is simple in theory but subtle in execution. As with other techniques it requires good tissue tension sense to be effective.

There are 2 positions for this technique. Both positions involve the patient being treated side-lying with the patient's leg closest to the couch flexed to 60 degrees.

In the first position the upper leg is flexed to approximately 30 or 40 degrees so the knee of the upper leg drops behind the lower leg and induces some pelvic side bending away from the lordosis. The practitioner applies a downward compressive force through the upper sacroiliac joint with their proximal forearm contacting the space between the iliac crest and greater trochanter.

The application of force is more comfortable for the patient with a folded towel placed over the area. Stress through the practitioner's shoulder can be reduced by holding the applicator arm next to the practitioner's torso and applying downward pressure with the abdomen.

The objective of the technique is to approximate the joint surfaces at the point of lesion. Small amounts of pelvic side bending are used to alter the focus of the applicator's force. The technique is most effective when the force is perpendicular to the surface of the joint at the point of lesion. The tissue tension sense is one of maximal compression without shear or other vectors.

The second position also involves the lower leg being flexed to 60 degrees but this time with the upper leg flexed to 70-80 degrees so the upper knee lies superior to the lower knee. The upper foot may be tucked behind the lower calf. This position induces some pelvic side-bending into the lordosis.

Downward compression is applied in a similar manner as before.

Reverse McKinnen

The standard McKinnen technique involves compressing the ilium on the sacrum. I have found that using a similar manoeuvre but

compressing the sacrum on the Ilium is just also effective. I would recommend using the conventional version first and if this does not free up the joint to use what I will refer to as the “Reverse McKinnen”.

The Reverse McKinnen targets the joint closest to the couch as opposed to the one upper most. The procedure is much the same as the regular McKinnen except the patient needs to be rotated further toward the practitioner. The distal forearm as applicator is placed on the sacrum. Due to the necessity to contact the sacrum at an angle it is not possible to induce pure compression with the arm alone. However applying pressure from an opposing angle with the abdomen through the Ilium and greater trochanter will counter any induced shear and increase overall control.

In a similar manner small changes in pelvic side-bending can be induced with both the forearm and abdomen to achieve optimal perpendicular compression. The technique involves using both positions outlined previously.

The McKinnen technique is very safe and can be used when manipulation is contra-indicated. It would appear to be more effective for lesions in the S2 and S2/3 region than in the S1 complex.

The McKinnen technique can be modified to affect the S1 complex by abducting the hip. The practitioner’s arm that is usually used as an applicator is used to abduct the hip and the other arm is used to apply compression through the joint. As the hip is abducted a sense of accumulation of compression and joint surface proximation should become apparent. If the hip is abducted too much the sense of compression will diminish. Fine tuning of innominate rotation can be induced with hip flexion as well as with the applicator. Pelvic side bending and other micro vectors can be induced with the applicator as with the standard technique.