Addendum
Gonstead Chiropractic Science and Art

Chapter 2

Please note that in normal human ambulation, the ilium moves alternately through PIEX and ASIN configurations. ASEX and PIIN misalignments are considered abnormal and should be scrutinized carefully. Also, be aware that a non-subluxated pelvis may present on the radiograph with a misalignment. This misalignment may present on subsequent radiographs with a listing completely different form the original. This can happen because the pelvis is moveable and may appear in any configuration depending on what position the patient's pelvis is in when movement is halted.

A PI ilium slips down the articulation, an EX further down. An AS slides up and articulation, while an IN slides further up the articulation. This information will be important in determining torque in the adjustment of the innominate.

The side of lumbar body rotation is listed for consistency only. To ascertain which ilium is subluxated use criteria other than radiographic. A probable ratio of ilium subluxations is: 95% (or Most of the ilium subluxations) are on the side of the lowest lumbar body rotation, 4% are on the opposite side of lowest lumbar body rotation, and approximately 1% is bilateral ilium subluxations.

As stated above, it is possible for both ilia to become subluxated at the same time. This can occur with any combination of misalignment. For example: ASEX-PIIN or PIEX-ASIN. A bilateral subluxation such as this can occur with any structural presentation of the spinal column. A common exception to this is the IN-EX, which usually presents with little or no sacral rotation.

Chapter 3

When a bilateral ilium subluxation exists, the 5:2 ratio used to determine the actual difference is no longer valid. The compensatory mechanism of the unsubluxated ilium no longer exists; therefore, there is no consistent ratio to determine the actual difference.

A posterior sacrum at the sacroiliac articulation will also lower the femur head height in a 5:2 ratio. It could, but only if the sacrum is not malformed.

Chapter 4

For a 4-6 mm sacrum to be considered significant, body rotation of the 3 lumbars above must be to the same side. Please note that scoliosis is not a factor, nor is ilium misalignment (except as noted on page 43).

The coccyx may, in rare occasions, have a listing of posterior. This is usually due to direct trauma during parturition or excessive bearing down during defecation.

Chapter 9

There is no PS only listing for the condyle. It will always have another component due to the shape of the condyles. (Lateral masses of atlas)

Chapter 10

This chapter is beyond the scope of this paper. The reader is directed to the Gonstead Clinical radiography department for the appropriate information.

Chapter 11

Although the exact mechanisms by which skin temperature changes are produced by subluxation are unknown, current theories suggest that they are due to changes in subcutaneous blood vascularity. The control mechanism for this is believed to be the recurrent meningeal nerve. There are assuredly many other pathways by which thermoregulation may be altered.

Research has demonstrated that there is no correlation between the peak of deflection and the side of the open or closed wedge. One exception to this is to the side of the rotated sacrum, which will produce a break on the side of rotation 90% of the time.

Also, acuteness and chronicity cannot be determined by determined by instrumentation as either the open or the closed wedge may be producing nerve pressure.

Chapter 12

Anterior rotation of the atlas will produce a low mastoid on that side upon visualization. Conversely, anterior rotation of the occiput will produce a high mastoid on that side. These rules assume that the rotated structure has a level foundation.

Chapter 13

Torque for combination listings favor the EX or IN component. The EX behaves like a PI, therefore torque for an ASEX would be towards the head of the table or superior. The torque for a PIIN would be towards the foot of the table because the IN behaves like an AS. (Or, when contacting the PIIN with the contact hand fingers pointing up to some degree, the fingers of the contact hand move IN towards the spine of the patient, the hand moving in a clockwise torque.)

PI, AS, or combination listings can be adjusted on both the Hi-lo and the knee-chest table. Similar listing are performed the same on each table. Therefore all descriptions apply to both tables.

All combination listings require the Dr. to stand on the side of the EX, or opposite the side of the IN. If there are no EX or IN components then the Dr. stands on the side of the AS component or opposite the side of the PI. The Dr. is in a fencer type position with their right hand contacting the right structure and their left hand contacting the left structure. PI listings are contacted with the pisiform and AS listing are contacted with the heel of the hand. The pisiform or thenar eminence may be used as contact points for stabilization. (I believe that this is the way Dr. Bovee teaches this, but, Dr. Gonstead and the Seminar have always said that you always stand on the EX side, but: You make both the contact and the stabilization contact with your thenars. E.g. PIEX Right Ilium subluxation; I stand on the right side of the table, fencer stance. I place my right thenar on the lateral border of the PSIS and I place my left thenar on the medial border of the ischial spine. I apply pressure to the left ilium on the ischial spine slightly raising the right ilium off the table, at this point I hold my contact and pressure on the left ilium and offer a thrust with my right thenar in a I to S and lateral to medial direction. Always use a thenar contact for both the stabilization and the contact.)

To make the contacts, the Dr. must contact the side opposite subluxation first, in al

appropriate manner to its misalignment. All slack should be removed from this structure with a stabilizing pressure. The contact hand is then placed on the patient. The corrections is then made with the same line of drive as with a pull or push move. No torque is needed for prone moves. (There is a slight torque given with the thenar during the thrust; PIEX superior-ward thenar gives a clockwise torque. ASIN inferior-ward, thenar gives a counterclockwise torque. PIIN superior-ward, thenar moves up with a slight counterclockwise torque. ASEX, inferior-ward, thenar moves down with a slight counterclockwise torque.)

Bilateral ilium subuxations are corrected one side at a time on the same visit. The side opposite the last lumbar body rotation should be adjusted first; the side of body rotation is then adjusted. EX-IN and IN-EX subluxations are to be done as listed in the chapters.

Chapter 14

The sacrum may be adjusted on the Hi-lo table. The Dr. stands opposite the involved side of the joint and makes a single hand contact. The inferior hand is used with a pisiform contact. The thrust is the same as a push move.

I should be noted that adjusting a spondylolisthesis on the knee chest table is done as a last resort only. The table of choice is the pelvic bench followed by the Hi-lo.

Individual sacral segments may also be adjusted. The correction is identical to a base posterior correction.

A posterior coccyx is made with no tissue pull and with a P to A thrust.

Chapter 18

An AI atlas may only be done on the knee chest table or in a like manner on the Hi-lo. A PS condyle may also be adjusted on the knee chest table or in a like manner on the hi-lo the setup look just like an atlas except the supramastoid groove is contacted and the line of drive is the same as it would be in the chair.