Pelvic Assessment

Although assessing the pelvis as a whole is not going to change the treatment approach, attaining a level and balanced pelvis (at least sitting) after treatment and ideally between treatments is an indicator of success.

However the most important indicator of success (ie. symptom resolution) is joint clearance during treatment and lesion progression between treatments but we will come on to that later.

A thorough assessment of the pelvis should involve visual and palpatory assessment standing, sitting and supine and involve the relative positions of the Posterior Superior Iliac Spine and Anterior Superior Iliac Spines and Iliac crests.

It should also involve the assessment of leg length. However this is not generally necessary at consultation unless there is a glaring difference. If after a few treatments the symptoms have not resolved this may be necessary to determine if there is a true leg length discrepancy or some other pelvic anomaly.

When the patient is standing kneel down so your eyes are at the same level as the pelvis. Place your thumbs under the PSISs. Try to keep them horizontal and flat against the skin. Palpate the area with a broad contact. Make a mental note of their relative position. Then using the second ray of each hand assess the level of the iliac crests. Make a note of your findings.

Now with the patient seated repeat the same procedure.

To make a fuller assessment we can of course check the ASISs standing or supine but for the moment this is generally sufficient.

The pelvis may be level but more often than not there will be some degree of torsion or tilt. Generally the pelvis will appear torsioned when the PSISs are not level and where the lower PSIS is accompanied by a higher Iliac crest and the higher PSIS is accompanied by a lower Iliac crest.

This may seem counterintuitive but, due to the shape of the Ilium, as it rotates posteriorly the PSIS drops but the anterior aspect of

the Ilium rises. Conversely as the PSIS rises the anterior aspect of the Iliac crest drops. The most common torsion is a posteriorised left innominate and an anteriorised right innominate. If both the PSIS and the Iliac crest are lower on one side the pelvis is generally tilted to that side.

At the end of each treatment the pelvis should be level at least when sitting. If it is not level standing as well we may consider a true leg length discrepancy.

If after a few sessions the pelvis and lumbar spine are clear but symptoms have not resolved, a more thorough assessment of the pelvis sitting and standing as well as leg length assessment should be undertaken.

Once the pelvis is clear true leg length is more easily determined.

With the patient lying supine get the patient to raise their bottom and wiggle from side to side. Once they are lying flat again check to see that the ASISs are level.

Make sure the body and legs are straight and now check the relative position of their Medial Malleoli. I find this is more accurately assessed by eye than with a tape. As my thumbs are 2cm wide it is relatively easy to determine if there is a significant leg length discrepancy. A difference of 1.5cm or ¾ of my thumb width may benefit from a heel lift as a correction.