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7 Classification of Sacroiliac Joint Pathological Conditions in the AKA-Hakata Method

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There are three conditions which can be treated by the AKA-Hakata method (AKA-H), namely, joint dysfunction, simple arthritis, and complex arthritis. The diagnostic criteria for these conditions were clinically defined based on symptoms, physical findings, and responses after the AKA-H treatment.

7.1 Sacroiliac Joint Dysfunction

A joint dysfunction is said to be the condition in which intra-articular movements of the joint surfaces are impaired without any pathological changes in the joint. The joint surface could be locked just beyond the joint play in the joint dysfunction. Diagnostic criteria of joint dysfunction is shown in Table 7.1. Having no neurological deficits is a mandatory item in the criteria. A neurological examination must be carried out in all cases with pain and/or paresthesia. When pain, paresthesia, and muscular weakness are not consistent with dermatome, myotome, or the innervation of the peripheral nerve, they are considered to be originating from the joint. At the initial evaluation, two or more of the following are required: (1) mild SLR limitation comparing to sound side; (2) mild restriction in the truncal flexion; (3) pain with limitation in the truncal extension, and/or pain on the stretched side in truncal lateral bending; (4) pain in Fadirf or Fabere (ipsilateral or contralateral); (5) pain in the low back or lower extremities by SLR (ipsilateral or contralateral). The most important point is that physicians should feel and evaluate the decrease in the joint play of the sacroiliac joint with their hand. A definitive diagnosis of the joint dysfunction is made when the symptoms, including pain and/or paresthesia, decrease immediately after the initial treatment with AKA-H, and completely or nearly completely disappear within 3 weeks after one or two treatment sessions.

Table 7.1 Diagnostic criteria of the sacroiliac joint dysfunction

A.	No neurological deficits	
B.	Pain, paresthesia, and muscular weakness are not consistent with dermatome, myotome, or peripheral nerve innervation	
C.	At the initial evaluation, 2 or more of the following are required:	
	1	Mild SLR limitation comparing to sound side
	2	Mild restriction in truncal flexion (finger–floor distance, FFD)
	3	Pain with limitation in the truncal extension, and/or pain on the stretched side in truncal lateral bending
	4	Pain in Fadirf or Fabere (ipsilateral or contralateral)
	5	Pain in the low back or lower extremities by SLR (ipsilateral or contralateral)
D.	Decrease in the joint play of the sacroiliac joint	
E.	The symptoms, including pain and/or paresthesia, decrease immediately after the initial treatment with AKA-H, and completely or nearly completely disappear within 3 weeks after one or two treatment sessions	

7.2 Simple Sacroiliac Arthritis

Symptoms of simple arthritis are the same as in the joint dysfunction, except that the pain is much more intense in acute arthritis than in dysfunction. The symptoms and physical findings are similar to joint dysfunction. However, these are not relieved completely in the initial treatment. ROM in the truncal extension, flexion, Fadirf, and Fabere are not sufficient, particularly in the SLR angle. The diagnostic criteria of simple aseptic arthritis are shown in Table 7.2. Response to AKA-H improves remarkably within 2 months, and the symptoms completely disappear within 3 months.

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Table 7.2 Diagnostic criteria of the simple sacroiliac arthritis

A.	No neurological deficits	
B.	Pain, paresthesia, and muscular weakness are not consistent with dermatome, myotome, or peripheral nerve innervation	
C.	At the initial evaluation, 2 or more of the following are required:	
	1	Mild SLR limitation comparing to sound side
	2	Mild restriction in truncal flexion (finger–floor distance, FFD)
	3	Pain with limitation in the truncal extension, and/or pain on the stretched side in truncal lateral bending
	4	Pain in Fadirf or Fabere (ipsilateral or contralateral)
	5	Pain in the low back or lower extremities by SLR (ipsilateral or contralateral)
D.	Immediately partial improvement after the initial treatment with AKA-H, 2 or more of the following are required:	
	1	10°or more improvement of SLR
	2	Improvement of ROM and/or pain relief in truncal flexion, extension, lateral bending, Fadirf, or Fabere
	3	Decrease in pain and/or paresthesia
	4	Increase in muscle strength
	5	Improvement in mobility and ADL
E.	Decrease in the joint play of the sacroiliac joint	
F.	Response to AKA-H improves remarkably within 2 months, and the symptoms completely disappear within 3 months	

7.3 Complex Sacroiliac Arthritis

Symptoms of complex arthritis are also the same as in joint dysfunction, but the pain in this condition is peculiar, as shown in Table 7.3, and usually more severe than in dysfunction. Complex arthritis is differentiated from simple arthritis because of its peculiar pain, accompanying autonomic dysfunction, and repeated recurrences. In complex arthritis, the main site of the involvement is the sacroiliac joint, complicated with multiple arthritis and dysfunction of the spinal facet joints, the costal joints, and extremity joints. The pain in this arthritis is partially responsive to AKA-H in the first treatment session, although in a few cases, it was not responsive at all. With monthly or biweekly AKA-H treatment sessions, the pain becomes fairly well responsive in about 2 or 3 months and can disappear completely in 3 months. However, accessory movement of the sacroiliac joint might not become normal even if the symptoms decrease. Moreover, the pain of complex arthritis could be aggravated by rough treatment or by sessions which are too frequent. The autonomic symptoms in this arthritis include hyperhidrosis, cold-feeling, edema, muscular atrophy, bony atrophy, deformed nails, nausea, blurred vision, tinnitus, etc. Because of these autonomic symptoms, this arthritis may be considered an incomplete reflex sympathetic dystrophy (RSD).

Table 7.3 Diagnostic criteria of chronic complex sacroiliac arthritis (RSD type)

A.	No neurological deficits
B.	Pain, paresthesia, and muscular weakness are not consistent with dermatome, myotome, or peripheral nerve innervation
C.	3 or more of the signs and symptoms described in 1–3 below
D.	1 or more of the response to AKA-H described in 4
E.	Decrease in the joint play in the sacroiliac joint and other joints
F.	No improvement for more than 2 months, ore repeated recurrence in more than 3 months
	1. Pain and tenderness (a) Rest pain: increase or decrease with exercise (b) Marked pain lasting more than 1 month (c) Pain upon rolling over lasting more than 1 month (d) Pain attack (e) Fluctuation of intensity of pain (f) Broad painful area (g) Severe pain on initiating motion (h) Marked paresthesia (i) Hypesthesia (j) Multiple tenderness areas in trunk (k) Chest oppressive feeling (l) Weakness of limb or part of limb
	2. Autonomic symptoms and signs (a) Hyperhidrosis or circumscribed hypohidrosis (b) Cold or hot feeling, subjectively and/or objectively (c) Mild edema in extremities (d) Mild effusion in joints (e) Muscular atrophy (f) Bony atrophy (g) Deformity or discoloration of nail (h) Discoloration of skin (i) Nausea and/or vomiting (j) Blurred vision, dizziness (k) Tinnitus
	3. Restriction of ROM: painful or painless (a) Marked restriction of truncal flexion (FFD), and/or extension (b) Restriction of FFD without limited SLR (c) Marked restriction of SLR (d) Marked restriction of Fabere (e) Lumbar scoliosis (f) Limited neck ROM
	4. Response in the AKA-H treatment (a) Tenderness to AKA-H (b) Pain increases with too forceful AKA-H (c) Pain increases with frequent AKA-H treatment (d) Location of pain and paresthesia changes immediately after AKA-H (e) AKA-H to multiple joints is required (f) Unawareness of changes of symptoms and signs immediately after AKA-H (g) Recurrence of pain or paresthesia within 1 month (h) Recurrence of limited ROM within 1 month