



DIAGNOSIS

The Short Leg Dilemma Revisited

Douglas R. Briggs, DC, Dipl. Ac. (IAMA), DAAPM, EMT

I was told I have a short leg, is one of the most common statements made during my new patient consults. It seems almost universal. Heel lifts are sold over the counter at every pharmacy. Leg length inequity has become almost an expected finding - it is just noted and accepted, and I would argue that many of my colleagues still fail to recognize its significance or the possible causes. The mere finding of a short leg causes many doctors and therapists to default to a single treatment option - such as a heel lift.

As discussed in a previous [article](#), "The Short Leg Dilemma"¹ several years ago it is common to note a relative shortening of one leg to the other. We must be careful to responsibly evaluate our patients. Do not trivialize any relevant biomechanical findings - as they may often make the difference in defining the real problem. In today's health care realm, it is reasonable to expect that other physicians, insurance companies, and attorneys may all be looking over our records at some point in time. Therefore, it is critical that what is documented is both understandable and credible.

Validate Your Findings



If during the course of your examination you suspect that one of your patient's legs is shorter than the other, you must be able to validate that finding, and rule out other more serious possibilities. It is important to recognize the different causes of a shortened leg, and what that finding may mean to that particular patient. Often the treatment for a true short leg is a corrective lift or surgery, while a functional short leg may be effectively treated with conservative options. Clearly, the practitioner must be able to identify the different causes of the short leg finding - if you observe an imbalance and don't define its cause, your treatment will not be as effective, and the patient will not get the best care.

When a difference in leg length is suspected, the textbook protocol is to measure and compare the extremities. Anatomical length is measured from one fixed bony landmark to another. Leg length is measured from the lower ASIS to the top of the medial malleolus of the ankle, crossing the knee on the medial side (up to 1cm difference is considered anatomically within normal limits).

Unequal distances between these fixed points indicate that one lower extremity is shorter than the other. To determine where the discrepancy lies (tibia or femur), have the patient lie supine with his knees flexed to 90 degrees and his feet flat on the table. If one knee projects further anteriorly than the other the femur of that extremity is longer. If one knee appears higher than the other, the tibia of that extremity is longer. Femoral portion deficiency suggests congenital dislocation of the hip joint, while tibial deficiency suggests bony dysplasia. This finding is often referred to as *Allis' Sign* or *Saleazzi's Sign*.

Defining the Inequality

If there is any question of true leg length discrepancy, further radiographic evaluation is required to

define the inequity. The lower extremities should be viewed together on a single radiograph (both legs from above the hips to the below the feet), and then measure the bones to compare. Such findings warrant referral to an orthopedic specialist for further evaluation and management.

It must be determined that there is no true leg length discrepancy before you can test for an apparent discrepancy. Short leg syndrome may be characterized as arising from either structural, pathological, or functional etiologies. Functional causes refer to leg length differences not attributed to an anatomical deficiency – including foot pronation, adduction or flexion deformity of the hip secondary to muscular contraction, and pelvic and sacral subluxations.

The majority of apparent leg length discrepancy is due to pelvic torsion. Appropriate evaluation is necessary if you are going to document and treat the patient for a short leg syndrome or a related pelvic torsion. It should be obvious that unless all of the possible causes of leg length discrepancy are considered, a diagnosis will be reached either on historical dogma or ritual rather than applying the appropriate rules of differential diagnosis.

During inspection, pelvic obliquity manifests itself as unleveling across the ASIS or PSIS while the patient is standing. If this is noted, have the patient lie supine with his legs in as neutral a position as possible, and take a measurement for the umbilicus or xiphoid to the medial malleoli. An unequal measurement signifies an apparent leg length discrepancy, particularly if the true leg length measurements are equal. It should be noted that pelvic torsion will almost always produce a finding of an apparent short leg due to the eccentric position of the acetabulum to the sacroiliac joint.

The Biomechanical Root

During the course of an examination, several simple maneuvers may be used to define the biomechanical root of the shortened leg. These are collectively referred to as Derifield (deer – field) Maneuver. Have the patient lie prone on the table, and evaluate the relative leg length using the internal malleoli, calcaneus, or where the heel of the shoe joins the shoe as reference points (the base of the heel is not a good reference, as this may not be even due to shoe wear). The examiner will then ask the patient to turn their head to one side and then the other. With cervical rotation, the examiner may note that the leg discrepancy has now resolved or reversed, thus indicating that the leg imbalance is due to compensation for cervical dysfunction.

The examiner may palpate the contralateral cervical spine for taut and tender fibers, and will often find C5 rotated posterior on that side. This finding is referred to as a *Derifield Cervical Syndrome* (for example, if turning the head to the left causes the legs to be equal, then you could note a positive left Cervical Syndrome). The patient is then asked to return their head to midline / neutral. The knees are flexed to 90 degrees relative to the table and the examiner notes any changes in the short leg relative to the long. There are three possible findings at this time:

1. Short leg stays short—if there is an anatomical shortness in the tibia, and there are no pelvic involvements, the pivot points remain constant and the short leg will remain short.
2. Short leg gets shorter—if there is sacral involvement, the muscles of the thigh will tend to shorten the leg in appearance as it is flexed.
3. Short leg gets longer—when the ilium drops posterior and inferior, it pulls the femur up, thus bringing the knee on that side further up the table. When the short leg is flexed to 90 degrees, it reaches the highest point on the arc traveled by the foot. However, since the long legs pivot point is the knee, it is further down the table, and it reaches its highest peak in the arc before

the other side; it is actually going down the arc formed by the motion when it is "taken an equal distance." With the above in mind, we can see how a posterior-inferior ilium may cause a short leg to cross over and become longer. However, this does not mean that every time this test is positive, the patient has a PI ilium, you still have to pursue additional examination to document a subluxation.

While the patient is in this position, it is also advantageous to drop the heels to the buttocks to see if one leg falls further than the other. When noted, the heel which falls further indicates posterior rotation of the sacrum on that side. This finding is noted as a positive Webster's Sign.

The practical problem with the above information is that the one finding quickly becomes the deciding factor in a diagnosis. Many practitioners have defined algorithms connecting specific examination findings to specific manipulative procedures. Clinical pearls are a fantastic tool when applied with understanding, but the practitioner must always keep the big picture in mind as he follows through the course of the examination. What is outlined in a textbook is great foundation, but most patients have never read the textbook.

As professional members of the health care community, we are obligated to keep the big picture in mind. There are many other causes for the finding of a short leg, and we are responsible to define what is going on with that patient at that time. Beyond joint imbalance and dysfunction, there are possible traumatic and pathologic causes as well. Slipped femoral capital epiphysis (SFCE) is a serious orthopedic condition requiring radiographic evaluation and orthopedic surgical assessment.

Scoliosis may cause torsion in the spine and cause pelvic imbalance. Soft tissue congestion or adhesion may also contribute to both pelvic torsion and leg length inequity. Sometimes the problem may be traced to a patient sitting on a fat wallet. If the short leg is caused by factors such as these, the issue won't be corrected with any type of acupuncture care, the best chiropractic adjustment, or the newest type of heel lift on the market - you can bet the patient will back with the same pain very soon.

The Lesson in This

When a patient presents with a short leg, I need to think a little bit. The initial finding of short leg is an indicator of imbalance requiring further evaluation. First, I must rule out anatomic or pathologic causes, especially in the patient with lower back pain. Then I may consider musculoskeletal causes. While there are many ways to evaluate a short leg, none of them is adequate to fully assess all the possible causes. Derifield is a great test, and may indicate the root problem, but it will not always tell me what is going on in the spine and pelvis.

Other testing is reasonable and necessary. As my instructor in diagnosis taught - you should have at least three positive orthopedic indicators before confirming a musculoskeletal diagnosis. Basing a diagnosis or treatment plan on the finding of one screening maneuver is below the standard of care for any practitioner. There is no quick shortcut in a good examination. If you find a leg length discrepancy, take the time to fully evaluate the patient so that your diagnosis is correct, your treatment will be much more appropriate, and your patient will thank you for your quality care.

Reference

1. Briggs D. The Short Leg Dilemma. *Acupuncture Today*, Oct 2015.

Resources

- Seidel HM, Ball JW, et al. *Mosby's Guide to Physical Examination, 2nd ed.* St. Louis, Missouri: Mosby, 1991.
- Hoppenfeld S. *Physical Examination of the Spine and Extremities.* San Mateo, CA: Appleton & Lange, 1976.
- Evans RC. *Illustrated Essentials in Orthopedic Physical Assessment.* St. Louis, Missouri: Mosby, 1994.
- Innes K. Leg Length Discrepancy, Its Causes, and Its Importance. *Dynamic Chiropractic*, Oct 1996.
- Bovee ML. *The Essentials of the Orthopedic & Neurological Examination.* Davenport, IA: Palmer College, 1977.
- Kurnik JD. Lets Get Something Straight! *Dynamic Chiropractic*, May 2003.
- Cooperstein R. Derifield and Me. *Dynamic Chiropractic*, June 2003.
- Yochum TR, Barry MS. Short Leg Syndrome: a Hidden Cause. *Success Express*; Vol 18, No. 4.
- Laws S, Franklin DJ. *The Receptor-Tonus Technique.* Quincy, Ill: Holistic Health Enhancement.

APRIL 2019