OSTEOPATHIC VISCERAL TREATMENT OF FEMALE PELVIS

Objectives:

Review anatomy of the female pelvis

Discuss indications for osteopathic manipulation using visceral techniques

Discuss contra-indications for osteopathic treatment using visceral techniques

Discuss treatment of somatic dysfunction related to pelvic pain in females

ANATOMY

Physiologic motion of the sacrum is tantamount to maintaining structural and organic health in the female pelvis. This workshop will focus on the treatment of structures connected to the sacrum and influenced by its motion.

Coccyx – the coccygeal ligament has a direct effect on the dural tube. The motion of the coccyx may be influenced by sacral motion as well as indirectly by attachments of anterior/posterior longitudinal ligaments; dentate ligaments at C2 and S2. Almost all soft tissues of the pelvis attach to the coccyx. The sacrococcygeal articulation can contribute to lumbosacral dysfunctions.

Dysfunctions of coccyx: if coccyx moves closer to pubic symphysis, muscles of bladder and rectum approximate, which in turn may influence incontinence. Libido problems may also occur. If the coccyx is fixed anteriorly, pelvic prolapse may occur; if coccyx is restricted – sacrotuberous ligaments cannot stretch. Reciprocally, iliolumbar ligaments become taut when they should be relaxed. Fixed coccyx also can restrict kidney motion and the entire body (check this in depressed people).

Sacrococcygeal dysfunctions = painful sitting, decreased libido, cystitis, and incontinence.

Bladder – moves in sync with sacrum and uterus – posterosuperiorly with inhalation, and anteroinferiorly with exhalation. Most functional problems of the bladder are related to a ptosis which modifies functions of the sphincters. In vesical ptosis, the ureteral ostia close, causing urine to be retained in the ureters. UTI may result from urinary stasis. The pubovesical muscle sends some fibers onto the median and medial umbilical ligaments and anterior vagina. Closure of the urinary sphincter is assisted by pubovesical muscle and the trigone. The rectovesical muscle, located behind the sphincter and pubovesical muscle, helps to open the urethra. The other muscles of the pelvic floor that influence sphincter motion are: deep perineal transverse muscle, levator ani, and coccygeus.
Urethrovesical collapse affects bladder emptying. This collapse may occur after delivery of large baby (vacuum used for delivery), large episiotomy, advanced age, abdominal ptosis, chronic constipation, anteverted uterus.

**Indications for manipulation:**

Mechanical problems of the bladder – UTI from ureterovesical reflux, urinary stasis (rule out urethral strictures, severe infections, structural problems of urinary tract)

Incontinence – may be due to uterine malpositioning; patients report need to urinate during intercourse.

Dyspareunia – linked to bladder problems

(It is easiest to palpate a full bladder, but the patient will express need to urinate during treatment!)

**Contraindications** – acute UTI’s are not contraindications because there is no risk of peritoneal irritation by manipulating the bladder. Rule out structural defects of urinary tract first, if indicated, by cystoscopy, imaging, or urologist.

IUD in place

Pregnancy

**Uterus** – more supported than suspended in pelvis by ligaments. Broad ligament joins uterus to the pelvic floor (ovarian, round, inferior = cardinal ligament). Round ligament stretches from body of uterus to labia majora. Utero-sacral ligaments keep cervix from colliding into pubes. In menopause (or after age 50), uterine retroversion with retroflexion occurs. The cervix then rests upon the rectum as the pelvic bowl has tilted. Additionally, the small intestine lies on the bladder, further pushing it downward. During this time in a woman’s life, left uterine lateral flexion happens due to lateral fixation of left uterosacral ligament; or problems with cecum or sigmoid (diverticulitis?). Prolapse of the uterus may be the result of gravity, large episiotomy or instrument delivery.

**Indications for manipulation:**

Mechanical trauma (OB instrument delivery)

Postpartum cystocele (from prolonged vigorous pushing)

Infections – resulting in reproductive dysfunction secondary to tissue damage and adhesion formation
Pelvic stasis – ligamentous laxity, aging, decreasing weight, hormone disorders, sedentary living. Poor circulation (congestion) may cause lower abdominal pain, dysmenorrhea, hemorrhoids, varicose veins

Increased intra-pelvic pressure – leukorrhea, polyuria, cystitis, low back pain. Also – constipation, overeating, tight clothing aggravate these symptoms. Elevation of the abdomen may offer relief (NOT a girdle)

Secondary dyspareunia – occurring postpartum, or after a fall. May also be due to fluid congestion, vasomotor problems, or trauma to sacrococcygeal area.

**Manipulation:** *best time to treat* – just after end of menstrual period. NO TAMMOM should be in place during treatment. Treat abdominal organs (kidneys and intestines) first. *Patient should have an empty bladder.*

**Contraindications:** IUD in place, pregnancy, bleeding and infection problems of uterus or bladder.

**Post-treatment:** inform patient that following intravaginal treatment, there may be a pink vaginal discharge for a few days. While treating patient, check the posterior cervix for yeast.

Other areas to investigate for somatic dysfunction relating to pelvic pain:

Lumbosacral area – for women who have urogenital complaints

Pelvic diaphragm – ischio-rectal fossa

Reflex knee pain – provoked by irritation of genitocrural nerves from problems of motion restriction inside the pelvis

Upper cervical and cranial base – hormone and pituitary problems