

Pelvic Pain

Cause, Effect and Treatment

Based on clinical research and observations of 22,600 patients over a 22 year period

Pelvic Girdle

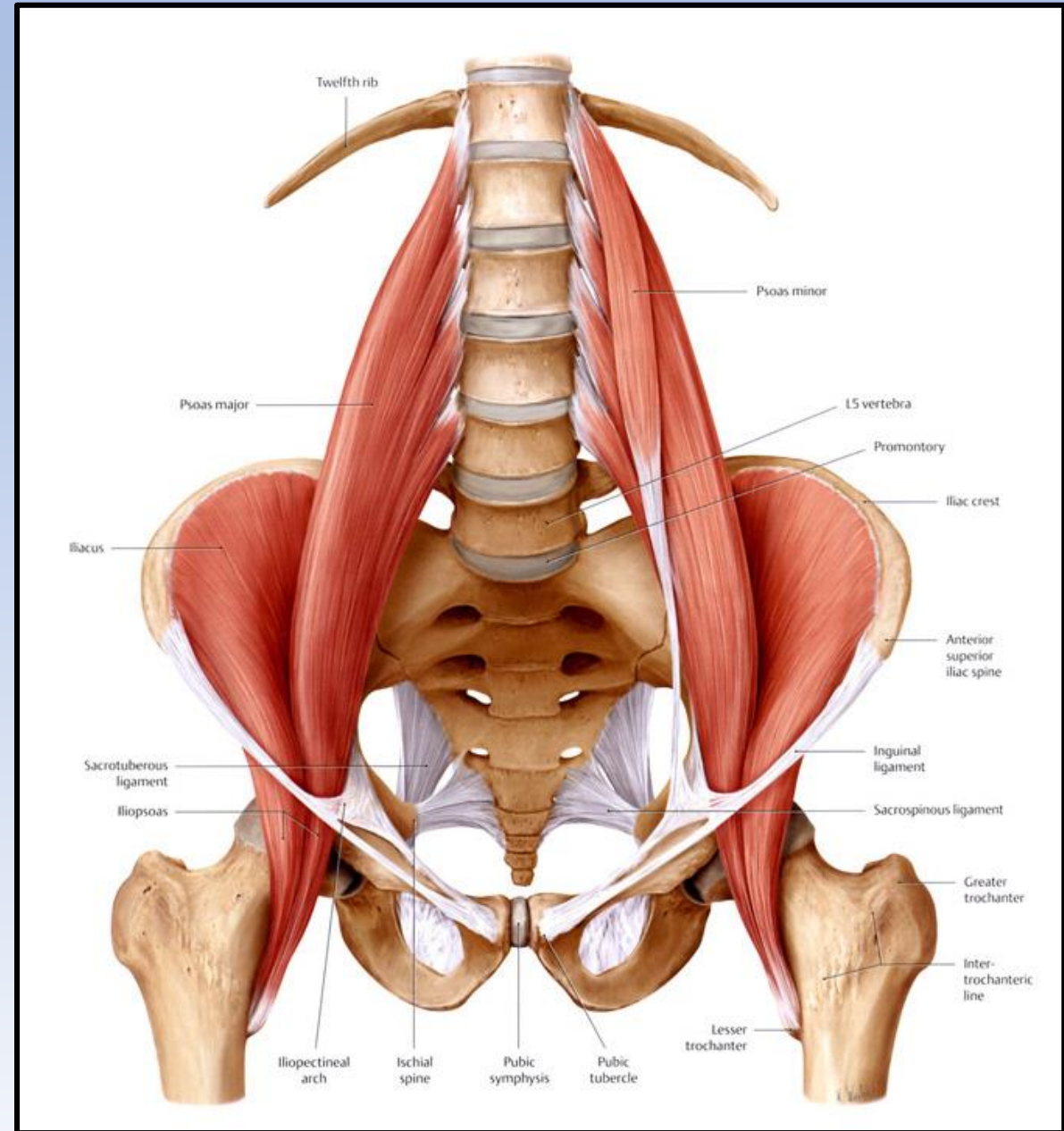
4 pelvic bones

Ilae, Sacrum, Coccyx

8 joints, 2 SIJ's, Symphysis Pubis,
Sacrococcygeal, 2 Iliolumbar, 2 Hip
Joints

The Sacroiliac joints are triplanar

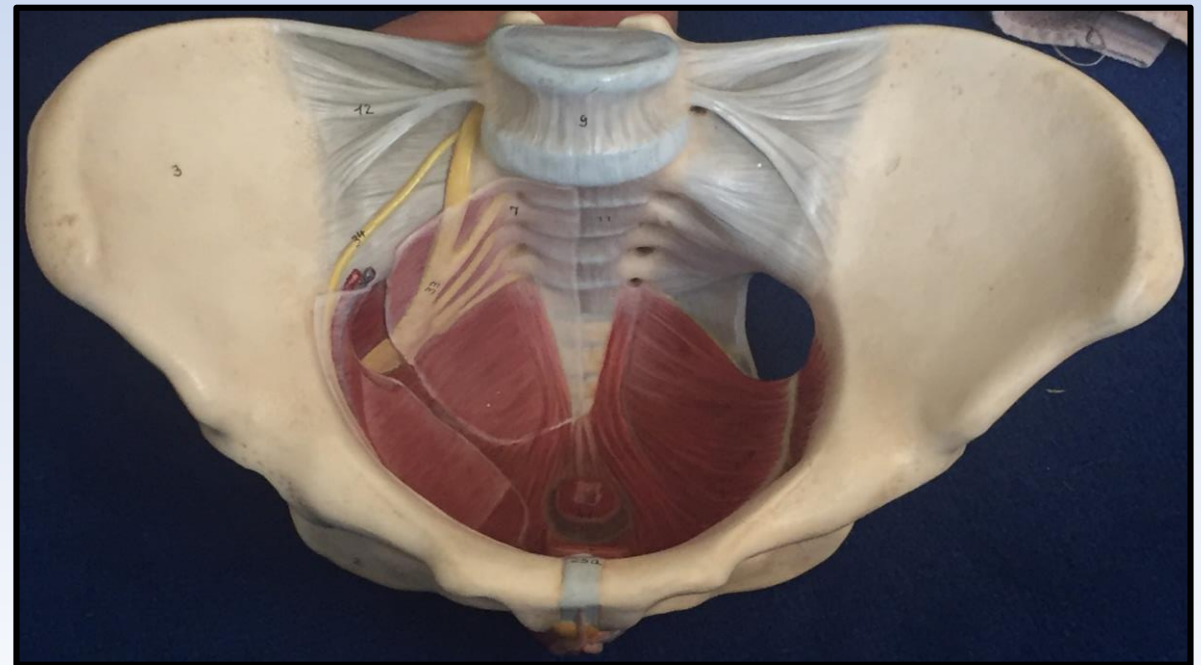
**In order to fully correct pelvic
position and biomechanics, all 8
joints need to be addressed**



Posterior pelvic pain

- Lumbopelvic pain (torsioned uterosacral ligaments, labour)
- Dysmenorrhea
- Ligamentous pain (iliolumbar/sacroiliac)
- Joint surface pain (teeth on teeth)
- Quadratus lumborum pain
- Sciatic pain (compression piriformis/obt. internus compression)
- Sciatic pain (lumbosacral plexus)
- Lumbopelvic pain (labour)

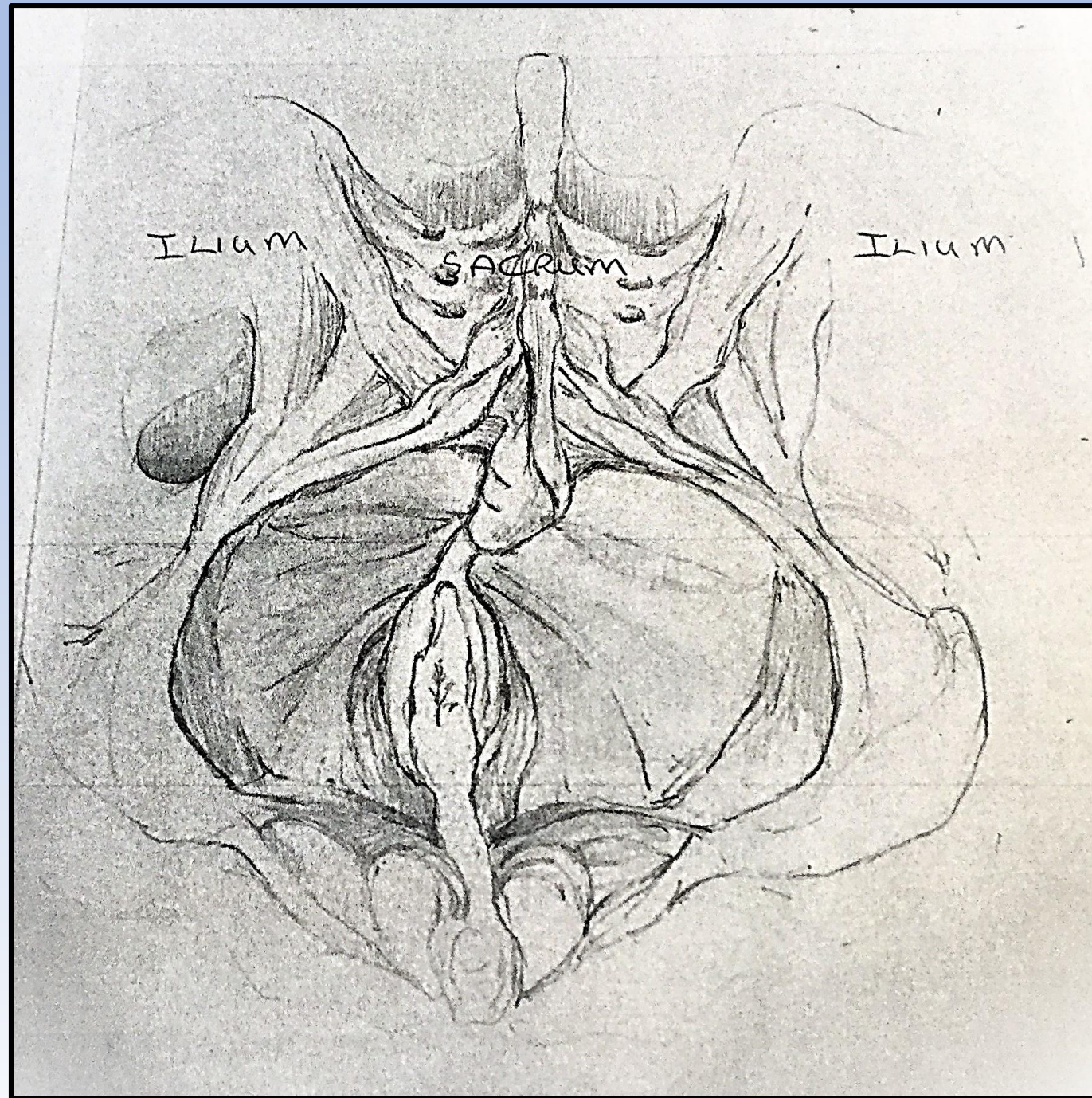
- Dyspareunia (Asymmetrical pelvic floor)



Pelvic Floor Asymmetry
caused by left side flexed
and rotated sacrum and
coccyx and low left ilium.

Shortens and torsions left
pelvic floor muscle.

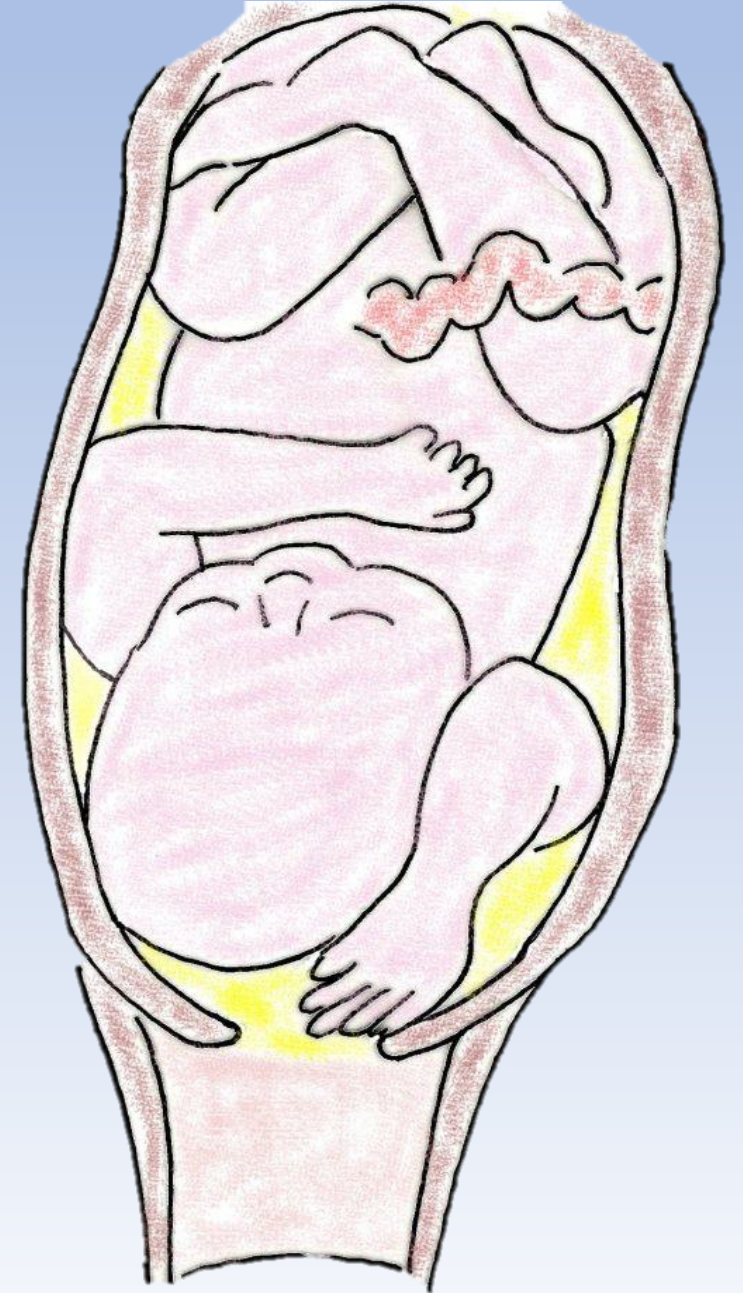
Lengthens, stretches and
torsions right pelvic floor
muscles.



Causes

Wide and varied

- Foetus in utero position
- Any significant trauma (e.g. falling of horse; down stairs)
- Whiplash
- Fractures
- Falls on buttocks
- Sporting injuries
- Abdominal and pelvic surgery
- Pelvic infections



Common Pelvic Positions

Sacral restrictions

Iliac bilateral downslips (88%)

Iliac bilateral upslips (9%)

Iliac bilateral upslip/downslip (3%)

- Left down/right up

Based on 22,600 patients



Green = sacral base
and PSIS before
treatment
Black = after
treatment

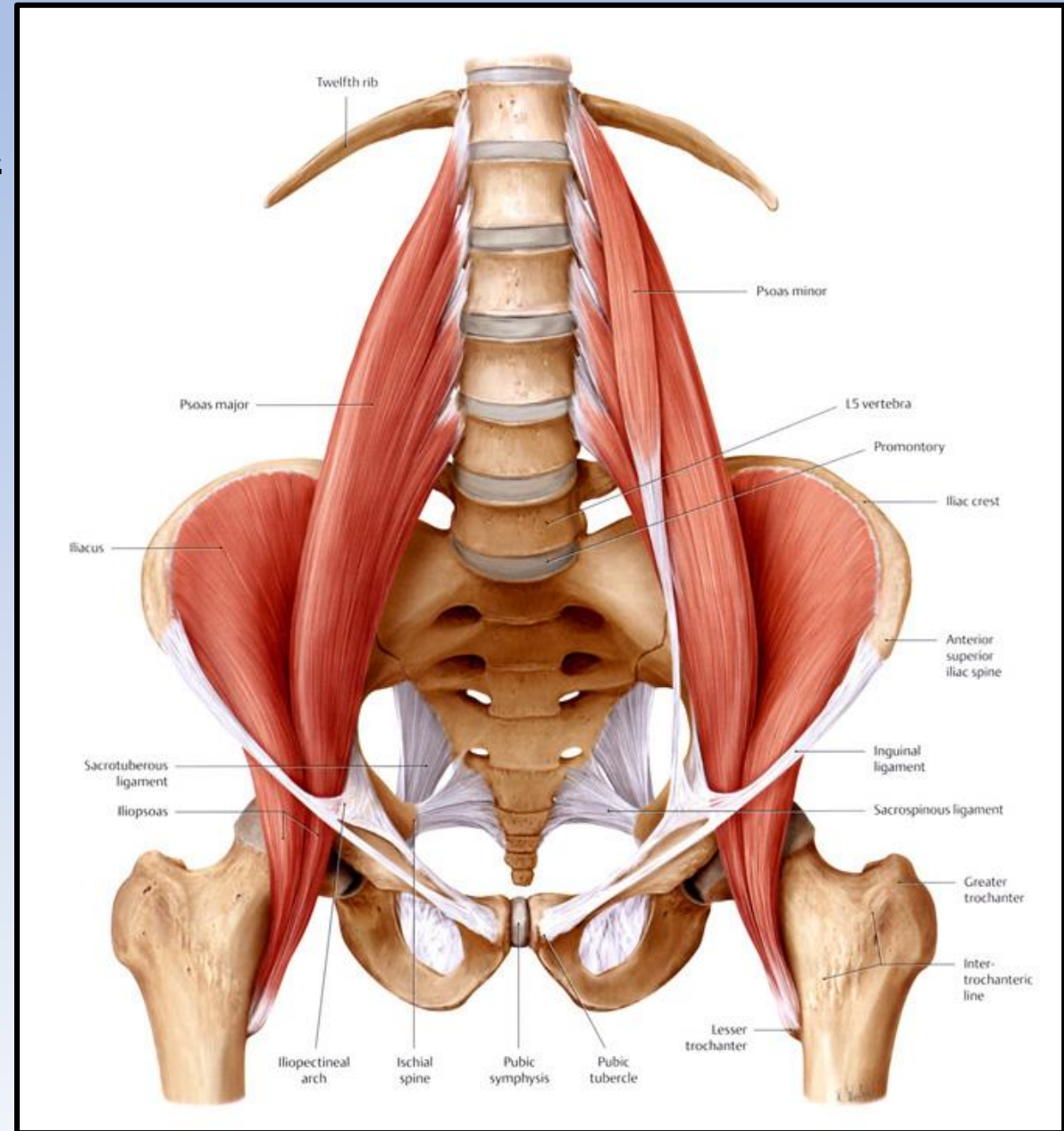
This joint excursion is
only possible due to
the 3D SIJS

Autonomic nervous system activation and reaction due to unravelling of sacral plexus



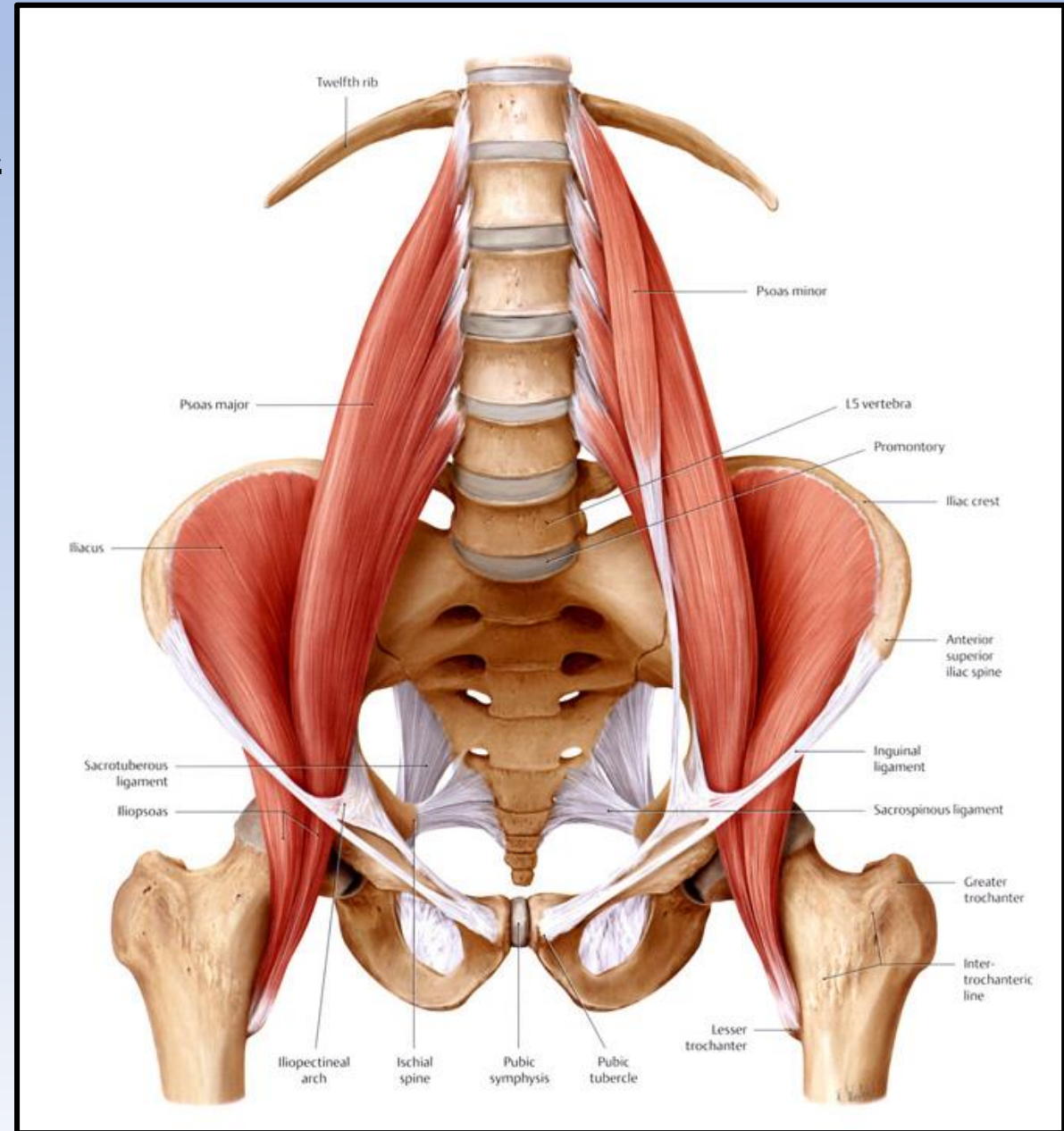
Symptoms/pelvic pain

- Sacral torsion
 - Alters tensions in sacroiliac ligaments and uterosacral ligaments
 - Lumbosacral pain
 - Dysmenorrhea
 - Braxton Hicks
 - Protracted and painful first stage labour
- Neural symptoms
 - Sacral plexus distortion
 - Sciatica
 - S-2,3,4-disruption/pudendal nerve supply to pubic floor

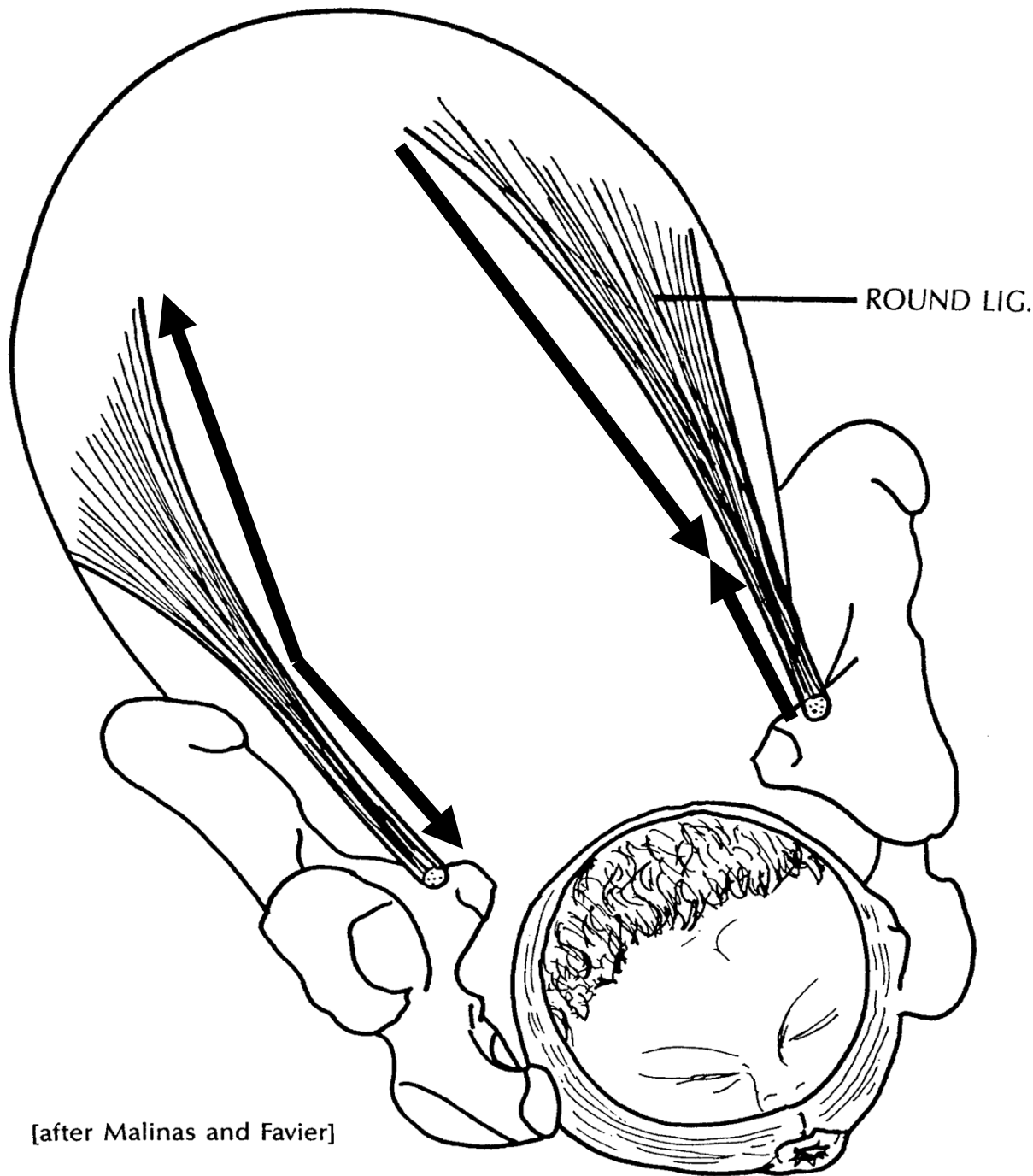


Symptoms/pelvic pain

- Pubic Symphysis asymmetry
 - Joint pain/↓ROM
 - Pubovesical ligament distortion
 - Pubourethral ligament distortion
 - Groin pain and obturator membrane tension
 - Shortened lateral hip rotators
 - Hip joint compression/pain/↓ROM
- Bladder symptoms
 - Frequency, urge and irritability
 - In combination with stress incontinence
- Increased psoas tensions



Asymmetrical round ligaments



[after Malinas and Favier]

- The shortened ligament will pull the uterus into side bend and flexion
 - Results in uterine torsion and increased ligamentous drag
 - Produces a solid, heavy uterus/abdomen
 - Braxton Hicks
 - Protracted, painful first stage labour
- This can be addressed at 38 weeks by a gentle recoil
 - This lengthens the ligaments and softens and lightens the uterus

Treatment

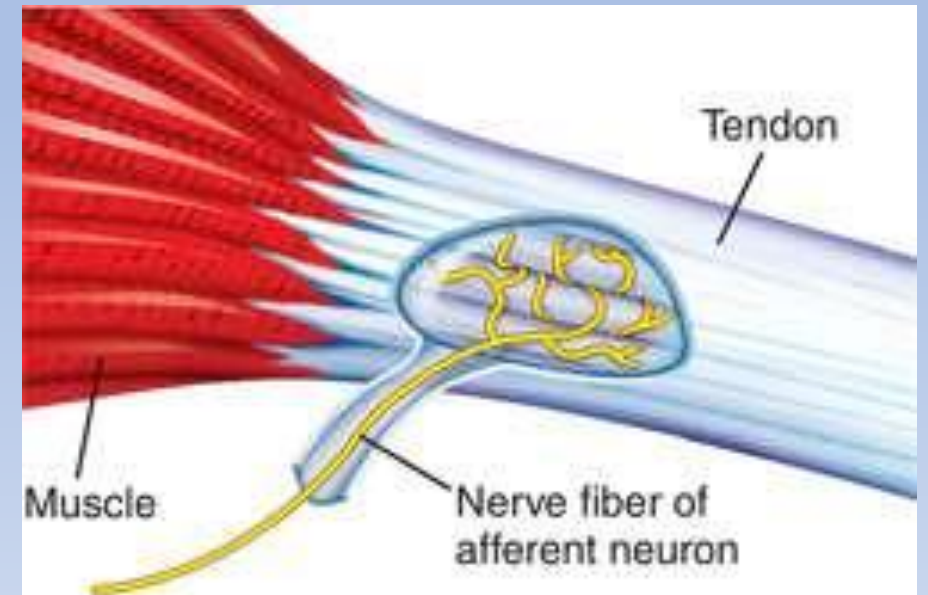
Aims:

- Normalising the spatial and biomechanical position of the joint system
- Decreasing tension in the stretched ligaments and softening and lengthening the shortened ligaments.
- Normalising muscle position and orientation
- Unravelling the neural system

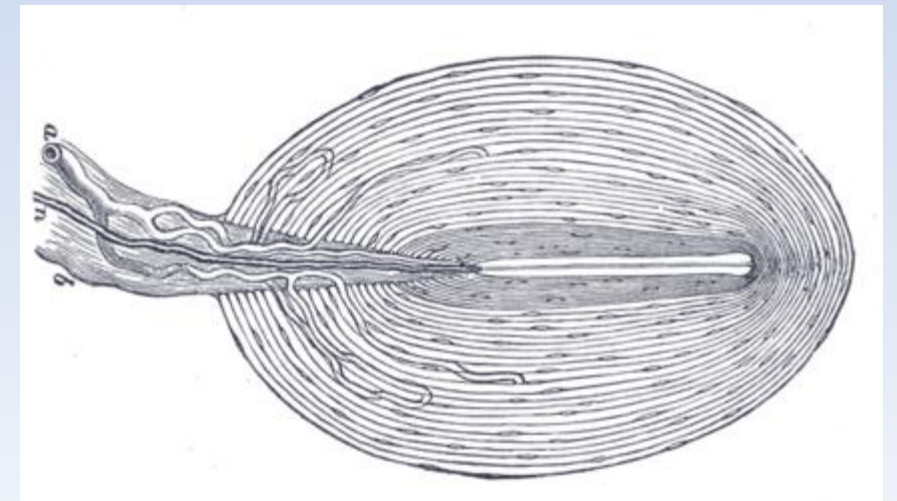
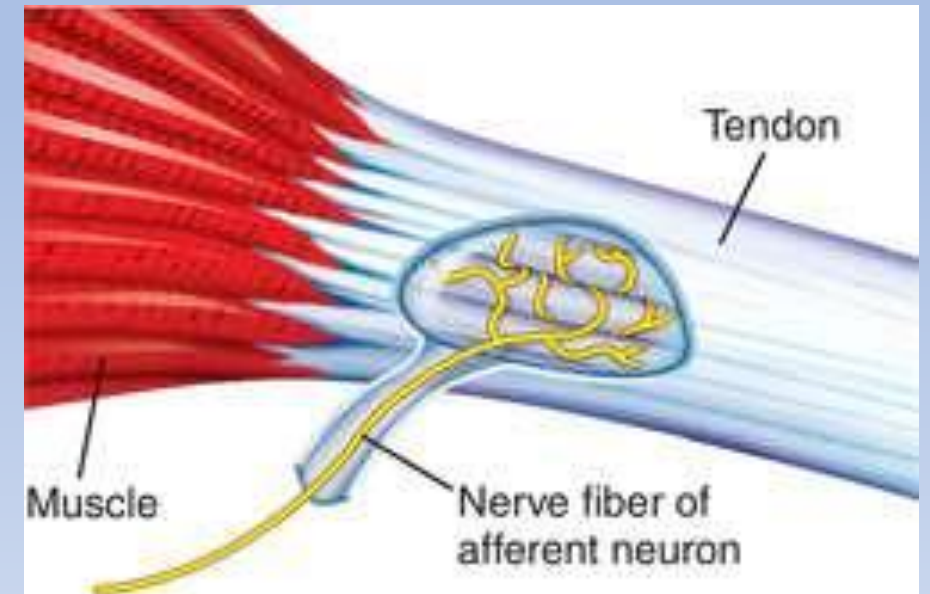
Techniques

- Recoil techniques are aimed at changing the tension within the ligamentous stocking of the pelvic girdle, both internally and externally.
- The mechanoreceptors are situated within the joint surfaces, capsules, ligaments and tendons
- Activated by vibration and rapid movement
- These mechanoreceptor cells are golgi, rufinni and paccini cells

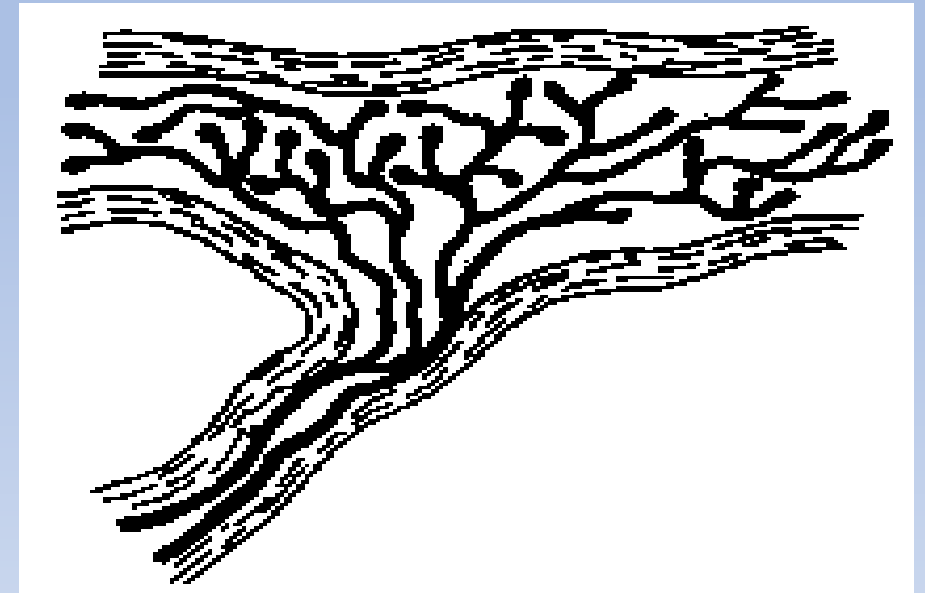
	Location	Stimulation	Results
Golgi	Myotendinous junctions, Peripheral joint ligaments, Joint capsules	Golgi tendon organ (muscular contraction) Golgi receptors (strong stretch)	Tonus decrease



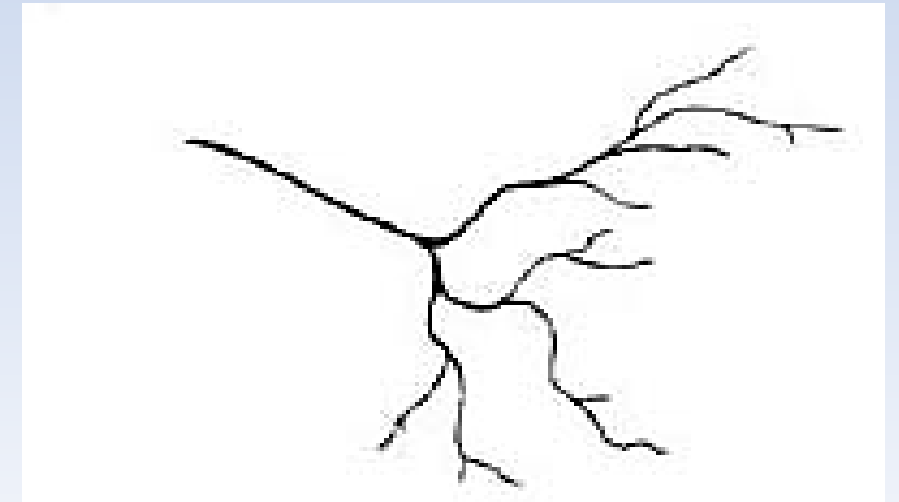
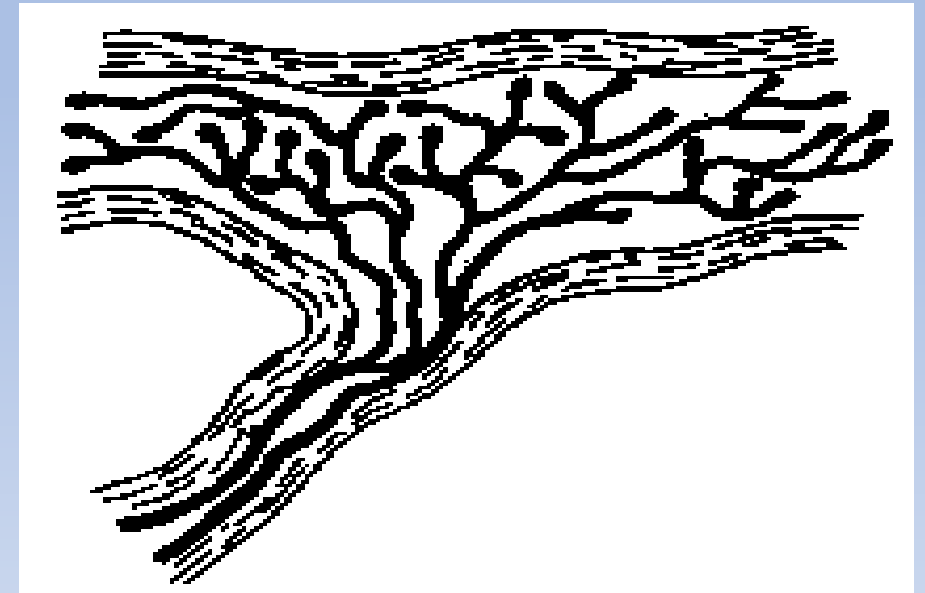
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Interstitial	Highest density in oseotenous junctions, most abundant receptor	Rapid as well as sustained pressure change 70% high, 30% low threshold	Changes in vasodilation



Techniques

- Softening by the mechanoreceptors allows the pelvic girdle joints to be tracked into the neutral biomechanical position.
- Repositioning sacrum and iliae and Symphysis pubis, thus changing the position of the deep anterior/posterior pelvic floor muscles (sacrococcygeus, pubococcygeus, illiococcygeus, ischiococcygeus)

Techniques

- Lengthening of the lumbosacral joint capsules bilaterally allows normalisation of the L-5/S-1 joint position, in turn neutralising piriformis.
- Decompression of the pubic symphysis normalises joint position and function whilst softening the obturator membrane and the origins of the anterior group of lateral hip rotators.
- Normalising and lengthening the superficial lateral slings of the pelvic floor (obturator internus/externus, superior/inferior gemelli).

Treatment

5 Stages to basic bilateral pelvic treatment

ALWAYS START CENTRALLY

The treatment techniques are named after the restrictions

Treatment

- 1) Bilateral sacral torsions – neutralises piriformis muscles
(Reassess ilial positions)
- 2) Bilateral downslips or upslips or combination
- 3) Bilateral anterior ilial rotations
- 4) Bilateral decompression symphysis pubis
- 5) Treat L-4/L-5 iliolumbar ligaments bilaterally

1 to 2 treatment sessions should resolve the vast majority of pelvic symptoms and increase ROM at lumbar spine, pelvis and hip