Pelvic Pain and Dysfunction Due to Pelvic Girdle Dysfunction

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Whenever an architect spots a fissure on a gable, we do not expect him to wait for the wall to collapse before he repairs the trouble. In the same order of ideas, when a door is built it would not be very wise to erect solid stone jambs and top them with a worm-eaten wood lintel; you could not expect the door to open for very long! Yet, it seems to be frequently illustrated when we come to the analysis of some serious pelvic disturbance.

It might even be considered that we may favor their occurrence in quite a number of patients.

Most physical education programs in schools foster the acquisition of technical moves which are very specific to one sport or the other, e.g., tennis, football, baseball, etc. Usually, most kids manage to master those specific technical moves quite easily, but in doing so, they also specifically develop the articular and muscular chains which are involved in the particular requested movements. These movements, for efficiency’s sake, are repeated over and over. Hence, youngsters develop strong specific leg, buttock, and abdominal muscles involved in such moves, but only those. The pelvic floor muscles and their efficiency are among the factors which are completely overlooked. It creates a situation very similar to the badly built door.

To illustrate the proposed approach, we propose to consider three clinical cases analyzed from one of our practices.

Case history #1:

White, 48-year-old, female patient, mother of five children (all delivered without any trouble). She fell from a loft at age 18 while pregnant with her first child. No fracture resulted from the fall. Frequent LBP, on and off, which radiates bilaterally at times to both sacroiliac and groins: no pain if she remains sitting, only when she gets up. She feels she cannot move freely. Other traumas: car accident 10 years ago after falling asleep while driving (whiplash); right ankle fracture after a fall on stairs three years ago.

For the last five years, she’s suffered what she describes as "low abdominal inflammation," which was treated by homeopathy. She remembers suffering this condition ever since her grandchild knocked his head severely against her pubic symphysis. She has sensations of deep pain but none felt during sexual
intercourse. No pelvic floor muscles nor adductor muscles involvement in this case; no coccygeal pain; no urinary trouble. She also feels quite depressed and "worn out." X-ray findings consistent with her several traumas, but the most striking feature illustrated bilateral, localized osteocondensation areas, not strictly mirroring each other at the same level, but slightly out of symmetry.

Treatment consisted of the usual specific vertebral adjustments, full spine required in her case, plus Nimmo technique on a very sore and tight right groin, plus a specific pubic correction as currently practiced by the authors. Exercise regimen called for a full right knee to sternum press, repeated three times and performed in the evening while lying in bed. The aim is not to correct the pubic dysjunction, but to restore pain free function despite the observed pubic arch rupture.

Note: No joint instability and no pelvic floor involvement in this case. Only a pubic bilateral and localized osteocondensation is observed on x-rays.

Case history #2:

Female patient, 23-year-olds, single, physical education teacher, experiencing severe deep groin pain when engaging in physical activity. She clearly remembers first experiencing the pain at age 18 while training for the long jump. Since that first occurrence, she has felt the same pain time and time again. It also completely prevents any sexual intercourse due to unbearable pain. Pelvic and spinal chiropractic examination negative, as well as x-ray findings. A one-fingered exploratory introitus reproduces the exact pattern of pain, only much more acute.

Diagnosis is established as iliac, sacrospinalis, ligamentous strain. The protocol called for treating the pelvic floor fascia, sacrospinalis ligament, and piriformis muscle in a three-step procedure which cleared the problem in two visits.

Note: Only the young age of this patient, as well as the quality of her muscular tone, explains that no other dysfunction was found in her case.

Case history #3:

Male, 22-year-old, student; participates in bicycle racing at national level. Three severe falls in last two years before consultation. The most serious fall came while sprinting in a tight group of bikers and falling on right hip with no time to clear his shoe free from the pedal. No apparent pelvic pain at the time of
consulting but a mid-thoracic pain increased by training, as well as a sciatic type of pain in the right posterior thigh when cycling more than a few minutes. The injury has prevented any further training.

Medically treated for a sciatica by various types of shots, pills, and physiotherapy programs to no avail. Negative x-ray findings. Examination revealed a very sore coccygeal area; pain increased by pressure on the left side. Even a soft Logan maneuver further increased the irritation and pain. Introitus to treat the left iliococcygeal ligament. The case was cleared in three visits, after which rest from biking for three weeks.

Note: The curious feature in this case, beside the fact that coccygodynia was not diagnosed before, is the right location of sciatalgic symptoms when, in fact, the left coccygeal ligaments were involved.

The clinical oddities which have been described in the notes are best explained when correlated to an analysis along the lines defined below.

Discussion:

Originally, it is considered that any subluxation complex also implies increased neural axial tension. The latter has to be compensated so as to prevent further lesion misadaptations. It is the way these lesions and tensions are interpreted by the practitioner which validates the varied procedures purported to correct the observed trouble. As a point in this argument, it has been shown by Claude Illi, among others, that abdominal muscular hypertonicity, far from decreasing segmentary vertebral dysfunctions, in fact does increase their frequency and pathogenicity. To remove any spinal alarm signal, i.e., pain at one level, one frequently must displace and diffuse the involved dysfunction and strain lower down, i.e., pelvic floor, legs or feet.

It has often been observed that stability of the entire pelvic girdle principally lies with the symphysis pubis, especially with Trendelenburg testing, but apparently proper therapeutical conclusions have not always followed suit.

A most important factor in this analysis lies with the fact that walking is to be considered as inducing a sinusoidal movement from the foot upwards, which involves the body as a whole. This sinusoidal movements mediated through and by reference to the body center of gravity -- about S2. This happens through specific torque and rotation control assumed by the various pelvic floor muscles and ligaments.
Another point to be considered: The pubic symphysis is the last joint in the body to present its definitive adult characteristics, at about 27 years of age. It is also the only symphysis in the body which does not fuse completely; on the contrary, it exhibits a very eclectic ligamentous apparatus. If we further consider that the last suture of the skull base to ossify is the sphenobasilar, at about 20 years of age, while it is only after 25 years of age that first and second sacral vertebrae usually coalesce permanently, we are led to consider that all this timing is not an accidental phenomenon. Nor is it accidental that these structures should coalesce just in the vicinity of the skull and of the body’s respective centers of gravity; that all these events should chronologically occur in phase one with the other, only stresses the important role of the pelvic floor as a true diaphragm with a very complex function. Fundamentally, should this complex role fail to be performed properly, its function can only be assumed, but partly, by other muscle groups, i.e., abdominal, thigh or buttock muscles, but certainly never with the exquisite precision which an efficient pelvic floor diaphragm allows.

A complete functional analysis, i.e., biomechanical, neurological, and clinical would request another level of analysis than that empirically derived from clinical observation alone. One such study is in preparation and is to be published when completed. Yet, it is obvious that any form of Trendelenburg gait results in permanent abnormal shearing stresses and repeated sways. It would be more accurate to describe the observed phenomena in terms of angular displacements, but the approximation is correct. In Fred W. Illi’s phrase, the whole body is forced to function as if it were "in a twisted press.”

Hence, the example quoted in the introduction of a strong door with a poor lintel is relevant. It is particularly relevant when considering it applies to growing kids, often involved in competitive sporting activities; to young mothers, endeavoring to recover from the toils of childbirth; also to disabled drivers, after one of their knees knocked against their car dashboard; all in all, quite a number of patients and a good proportion of our daily professional load.

Any pattern interference in normal movement implies a compensation which brings into play specific structures. That pelvic floor muscles and ligaments, as well as symphysis pubis and coccygeal dysfunctions, should be more involved than usually thought, is an observation that is frequently made by the authors. With the obvious conclusion that any correction is only maintained through additional strain and further neuroarticular fatigue, when such a dysfunction is overlooked.
Comments from the field are requested to further the completion of the main study. Also, an increased awareness of the problem may benefit many a patient in our office.

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