

Women's health, the Pelvic Floor Paradox and a Naturopathic approach

If you didn't catch this Masterclass at the last Total CAM you missed a treat. **Tracy McLoughlin** interviews **Leon Chaitow, ND, DO**, Honorary Fellow, University of Westminster, on the 'mystery' health symptoms that he noticed were plaguing young, female patients.

CAM: What focused your attention on pelvic health conditions?

Leon Chaitow: Over the past several years I noticed that more and more of my younger female patients were reporting symptoms ranging from variable to acute pelvic pain, to stress incontinence, interstitial (non-bacterial) cystitis, vestibulitis and painful intercourse (dyspareunia).

Because of the multiple potential aetiological features, these kinds of pelvic disorders are relatively poorly understood; many of my patients had seen experts in genitourinary medicine and most had been prescribed toning/ Kegel-type exercises

for presumed laxity in their pelvic floor muscles, plus various forms of medication.

Clearly, these had not worked for the young ladies consulting me, some of whom were in constant pain and others socially incapacitated due to their incontinence – and most of these women were no older than their early 20s.

CAM: What is the pelvic floor paradox?

LC: Structural evaluation often revealed very well-toned musculature. Many of these women had a history involving athletics, gymnastics or dance, and often Pilates toning exercises, but with

insufficient emphasis on flexibility.

Frequently there was extreme shortness of some of the muscles attaching to the pelvis – particularly the adductors, hip flexors and the ('core stability') abdominals. "Core rigidity" was the result, and therefore pelvic floor dysfunction.

CAM: So the problem was not reduced tone, but excessive tone?

LC: Exactly. I attended the World Congress on Low Back and Pelvic Pain in 2004 and a physiotherapist called Diane Lee (1) presented on stress incontinence. She showed ultrasound images of the pelvic

Dietary Strategies

Probiotics: oral or suppositories helpful. (Hoesl C et al 2005

European Urology 47 (2005) & Uehara S et al. 2006 Int. Jnl.Antimicrob. Agents 28S.1)

Low oxalate diet with calcium citrate supplementation helpful: (The Low Oxalate Diet Book. General Clinical Research Center, University of California).

Elimination of dietary irritants: Decreasing dietary acid load; Urinary alkalinization with baking soda or potassium citrate; Steady intake of water; calcium glycerophosphate reduces titratable acids in foods and decreases interstitial cystitis symptoms.

Helpful nutraceuticals: L-arginine, mucopolysacchrides (hyaluronic acid, chondroitin sulfate, and aloe vera), bioflavonoids (quercetin) and Chinese herbs. (Whitmore K 2002 Reviews in Urology S28.)

Foods that irritate IC symptoms within 2-4 hours of ingestion: alcoholic beverages, carbonated drinks, caffeine, spicy foods, tomatoes,

citrus fruits, and vinegar. (Whitmore K 1994 Urol Clin North Am.)

Arylalkylamine-containing foods: tryptophan, tyrosine, tyramine, and phenylalanine have also been implicated including – bananas, beer, cheese, mayonnaise, aspartame, nuts, onions, raisins, sour cream, wine and yogurt. (Gillespie L.1993. Br J Urol. 72.)

Mucopolysaccharides: Potentially benefit interstitial cystitis patients and include hyaluronic acid, chondroitin sulfate and aloe vera. (Morales A et al. 1996 J Urol.156.)

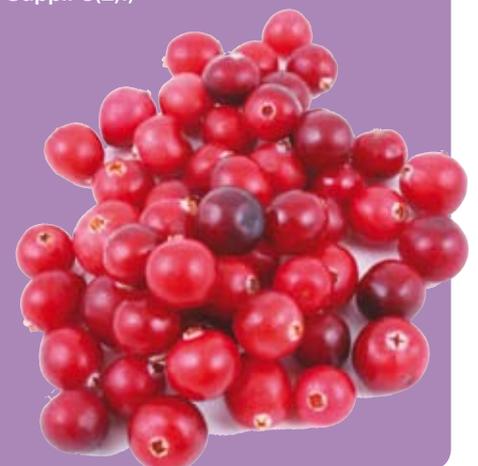
Bioflavonoids: Quercetin, a naturally occurring bioflavonoid that inhibits histamine release, has anti-inflammatory & anti-oxidant properties: found in seeds, citrus, olive oil, tea, red wine or 500mg supplement, twice a day for four weeks. (Katske F 2001 et al. Tech. Urol. 7.)

Decreasing fluid?: Decreasing fluid intake improves symptoms of urgency, frequency and incontinence, however can cause constipation.

(Swithinbank L et al 2005 Jnl of Urology 174.)

Chinese herbs: For interstitial cystitis, Cornus, gardenia, curculigo, rhubarb, Psoralea and Rehmannia, in a tea, 2 x day for 6 days a week, for 3 months, then 1 x daily. (Interstitial Cystitis Association. ICA Update 1997.)

Cranberry juice: Can significantly improve overall quality of life in these patients. (Nabi G et al 2006 Eur Urol Suppl. 5(2).)





Leon Chaitow speaking at TotalCAM Show Brighton 2007

floor and bladder in which, when asked to “retract” or “draw the pelvic floor upward,” the opposite happened and the pelvic floor, along with the bladder, dropped toward the floor – with incontinence consequences. Such women would try to prevent from wetting themselves by the natural response of tightening and drawing up and in, but what if these muscles were already as tight as they could be? I speculated at that time that perhaps the better response would have been to learn to relax these clenched muscles and to be able to influence the pelvic floor via a relearned awareness of muscle control. To me, the “wow factor” that day was the recognition that these women were almost certainly also going to demonstrate paradoxical diaphragm behaviour and unbalanced breathing (and most do), which is one of my main areas of interest.

CAM: So your area of interest ‘moved south’ as it were?

LC: To incorporate that other diaphragm, the pelvic floor. My belief is that if normal diaphragm/breathing function can be restored and the pelvic floor muscles relaxed, re-education can take place efficiently and relatively easily.

CAM: And what is the connection with breathing patterns?

LC: There is a clear connection between respiratory function, pelvic floor function, and sacroiliac joint stability, particularly in women. If pelvic floor muscles are dysfunctional, spinal support can be compromised, increasing obliquus externus activity, which alters pelvic floor muscle activity, potentially leading to urinary incontinence.

A motor control deficit, operating in incontinent individuals, affects levator ani and pubo-coccygeus muscles, and therefore lumbopelvic stability. Also, work I reported on in 2004 and 2007 (2) showed motor control to be disturbed by the effects of breathing pattern disorders such as hyperventilation. After about 60 seconds of over-breathing, the postural (tonic) and phasic functions of both the diaphragm and transversus abdominis are reduced or absent, with major implications for spinal stability.

Another point here is that studies have pointed out the connection between low back pain and pelvic symptoms, including one that evaluated 38,000 women and found disorders of continence and respiration were strongly related to frequent

back pain (3). Pelvic problems involving low back pain may be due to failed load transfer through the musculoskeletal components or the organs of the pelvic girdle.

CAM: So for excessive tone patients, how is pelvic relaxation and re-education best brought about?

LC: The wonderful work of some American-based practitioners rediscovered the evidence that trigger points can cause all of these symptoms, and that the trigger points and the symptoms frequently can be removed manually. Weiss’s 2001 study (4), which was a landmark, and the other quality studies that followed it, all confirmed the validity of the link between major, often debilitating, pelvic symptoms, and the presence of high-tone pelvic floor musculature containing active trigger points.

Manually deactivating trigger points in the lower abdomen, inner thigh and sometimes internally, will help restore the muscles to their normal length and tone, ►

► and in many cases has been shown to improve or eliminate functional symptoms, as well as associated pain.

CAM: Is there evidence to support trigger point treatment?

LC: Sometime before World War II, a physician named Thiele developed a technique in which coccygeal prostate problems were treated by means of massage of specific muscles, mainly levator ani.⁽⁵⁾ This approach is still being used in the US to treat prostate pain and pelvic floor problems. Other studies have shown a whole variety of chronic symptoms involving the bladder, urethra, prostate and the lower bowel, can be caused, aggravated or maintained by the presence of active myofascial trigger points in the muscles of the region.

Transvaginal Thiele massage has been shown to help normalise high-tone pelvic floor musculature in 90% of patients with interstitial cystitis (6), as well as a myofascial release technique whereby a trigger point is identified, pressure held for 8 to 12 seconds and then released. The proximity of the bladder to its muscular support means internal vaginal massage can lead to improvement in interstitial cystitis.

I would add that manual Intervention seems to be the most effective for those whose main complaints are urinary frequency, suprapubic pain and dyspareunia.

CAM: Is trigger point deactivation always appropriate?

LC: Not if the myofascial trigger points are serving functional roles such as the stabilisation of hypermobile joints, or enhancing pelvic floor stability in stretched or lax tissues. In which case their deactivation may ease pain, but at the cost of stability, so it would be better to correct the underlying cause of instability first.

Also, for many practitioners the Thiele form of massage may be in conflict with their licences. In which case a referral to an appropriately licensed and trained practitioner is one option. Even then, a focus on normalizing the associated pelvic muscles and breathing function offers a positive option as well.

Another option was offered to me by an ex-dancer therapist who had experienced numerous pelvic symptoms and been instructed in Kegel exercises for her incontinence. She told me these exercises had aggravated rather than helped her, but a yoga therapist had then advised her to get a tennis ball and sit on it (on a non slip surface) with the ball strategically placed

under the perineum, between the anus and the vagina. To then allow the pressure onto the ball to deeply relax the pelvic floor muscles, for five to 10 minutes daily. She told me this was somewhat uncomfortable at first, but that the effects were dramatic in terms of her symptoms. I have since recommended this to several patients and they have all reported benefits.

It is important to acknowledge that in many instances the cause of symptoms may relate to low-tone pelvic floor conditions and to prolapse. It's likely too, that in some instances some of the pelvic floor/lower abdominal/inner thigh muscles (some housing active trigger points) might be hypertonic, while others are hypotonic. In examples where tone is inadequate, or where tissues have been over-stretched, it is not unreasonable to hypothesise that trigger point evolution might be seen as a physiological response that is attempting to restore tone in damaged, dysfunctional or denervated tissues.

CAM: So treatment strategies should reflect assessment findings?

LC: Yes. There may be joint or bladder neck hypo or hypermobility, high or low muscle tone, or combinations of these features. Pelvic-floor muscle training (PFMT) may be useful in rehabilitation of control of bladder function, particularly where evidence exists of hypermobility of the bladder neck. PFMT has been shown to increase the resting tone of the pelvic floor, improve bladder elevation during voluntary pelvic-floor contraction, and reduce bladder displacement during straining (7).

Normalising joint and soft tissue imbalances, together with concomitant postural and breathing pattern retraining, have all been shown to be capable of modifying, modulating or eliminating symptoms, including chronic pelvic pain.

I would say several areas of evaluation would benefit from research, particularly in relation to identification in a clinical setting of methods for establishing whether symptoms relate to high or low tone conditions, as well as whether or not trigger point deactivation is an appropriate treatment strategy.

CAM: What about the psychological aspect in all this?

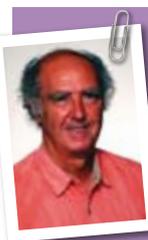
LC: I don't want to leave you with the impression it can all be solved by a tennis ball ! (Although this might offer symptomatic relief for many.) It's essential to be aware that in many such cases of clenched pelvic floor muscles there is a background of assault or abuse, although a

great many seem to be caused by nothing more than mechanically produced, excessive tone with a background of dance, athletics and bad Pilates. Where there is a psychosocial or psychosexual element to the condition, appropriate professional support usually is needed along with bodywork.

Anxiety and other emotions have been shown to recruit motor units into almost constant or repeated activity when influenced psychogenically. This can cause overload and a metabolic crisis. An ischemic environment is a natural breeding ground for trigger points. Working on relaxation of the region (adductors, etc., as a first focus), possibly deactivating trigger points if appropriate, along with breathing rehabilitation, offer practical ways forward. **CAM**

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About Leon Chaitow

Dr Chaitow was born in South Africa and then moved to London, where he trained in osteopathy

and naturopathy. He has authored over 60 books, and is active teaching in America, Australia and Europe. Currently, he is involved in a major project developing a new textbook, *Naturopathic Physical Medicine*, collaborating with 15 leading naturopathic, chiropractic and osteopathic experts from around the world. For more information see his website at www.leonchaitow.com