

Osteopathic Manipulative Medicine Considerations in Pelvic Pain

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Chronic pelvic pain is a common, multifaceted presentation seen daily in primary and specialty care offices. While it is a more common presentation in women (15%-20%), it is also reported in 8% of men.¹ Chronic prostatitis (CP) or chronic pelvic pain syndrome (CPPS) is defined as urologic symptoms and/or pain or discomfort in the pelvic region.² Such syndromes may include epididymal pain syndrome, pelvic floor muscle pain, penile pain syndrome, postvasectomy pain syndrome, and prostate pain syndrome.¹ Presenting complaints of CP/CPPS may include penile, testicular, perineal, and lower abdominal pain; pain during or after ejaculation and/or urination; urinary frequency and urgency; sensation of incomplete emptying; and erectile dysfunction. Currently, there are no uniformly accepted treatment regimens, and the pathophysiologic process is not yet understood.^{2,3}

The pelvic girdle consists of the sacrum and 2 ilia meeting anteriorly at the pubic symphysis. This symphysis is composed of hyaline cartilage lining the iliac surfaces, connected by a midline fibrocartilaginous disk.⁴ This disk is primarily reinforced by the superior pubic ligament from above and the arcuate pubic ligament from below.⁴ Muscular forces from the lower extremity and above from the abdominal muscles affect motion and somatic dysfunction at the pubic symphysis.⁵

The pubic bone serves as an attachment site for the muscles and fascia of the pelvic floor. The superior pubic rami are the site of attachment for the rectus abdominus, pectineus, and obturator internus muscles, as well as the pelvic floor muscle levator ani (pubococcygeus, iliococcygeus, puborectalis).⁴ The levator ani, or pelvic diaphragm, is a muscular sheet that supports pelvic organs and maintains continence; also, it has been shown to function during quiet respiration.⁴ The

inferior pubic rami serve as an attachment point for many of the adductor muscles of the lower extremity.⁴

Somatic dysfunction of the pubic symphysis is related to abnormal tension and dysfunction of the pelvic floor, potentially affecting genitourinary function.⁵ Treatment of the patient's pubic bone may assist with pelvic girdle biomechanics in gait, address pain, and improve symptoms. A pilot study conducted in Germany found improvement in CPPS symptom scores and quality of life with the use of osteopathic manipulative treatment (OMT) vs physiotherapeutic exercises.⁶ Additionally, recommended treatment sequences for pelvic girdle somatic dysfunction begin with treatment of the patient's symphysis pubis.⁵ One OMT technique that may be used in both men and women is muscle energy technique of the symphysis pubis ([video](#)). This technique is sometimes called the "shotgun" technique because of the treatment's ability to address a variety of pubic bone somatic dysfunctions.⁷

Contraindications to this technique may include acute trauma, fracture of the pelvic girdle, and moderate to severe joint instability. Caution must be taken with patients with suspected infectious causes of pelvic pain, severe osteoporosis, or moderate to severe muscle strains.⁸

Osteopathic diagnosis and OMT may be beneficial in the setting of pelvic pain, as they may assist in restoring pelvic floor and pelvis biomechanics, normalizing autonomic tone, alleviating pain generators, and improving circulatory homeostasis.⁵ However, treating the pubic symphysis somatic dysfunction as shown in the video is only 1 aspect of a diagnosis and treatment plan and only 1 pelvic girdle technique an osteopathic physician may use to address the whole patient. (doi:10.7556/jaoa.2019.130)

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