

Barral Institute Case Study

Visceral Manipulation – Coccygeal Pain

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Last treatment session: 17th May 2017

Presenting Symptoms

This 52 year old female who works as a genetics secretary presented with coccyx pain and intermittent numbness in both buttocks. In May 2015 she initially developed lower back spasms and superior buttock pain, this settled and in September 2016 she was left with residual severe coccyx pain. Her symptoms had been gradually worsening; she had tried physiotherapy and regular acupuncture sessions with short term benefit. She had seen a Pain Management Consultant who diagnosed an 'overactive pelvic floor' and suggested a ganglion impar injection. The coccyx pain was constant and 8/10 on a visual analogue scale. She was having great difficulty sitting down, was unable to drive and working at a standing desk. There were some mild bladder/bowel symptoms including occasional lack of awareness of full bladder emptying, post-micturition dribble, mild stress urinary incontinence, mild difficulty in evacuating her bowels and occasional rectal pressure. Her significant past medical history was an L5/S1 fusion (anterior approach) in 1999. Recent lumbar MRI and x rays had been reported as normal.

Evaluation and Treatment

General Listening (GL) in the initial evaluation was posterior, midline and below the diaphragm. Local listening (LL) was to the left pudendal nerve close to the coccyx. Lower Limb neurology was normal although there was some diminished sensation to light touch in the perineum (S5 dermatome). Mobility testing: sacral compression was positive at the lower sacral segment at 5% depth (elastic feel) and was associated with a listening inferior/laterally to the left sacrospinous ligament. Coccyx mobility was assessed and the anterior sacrococcygeal ligament was mildly restricted. Palpation of both sacrospinous and sacrotuberous ligaments revealed some tenderness (L>R).

The left sacrospinous ligament was treated in side lying and a technique to open between the sacrospinous and sacrospinous ligament was used to reduce entrapment on the pudendal nerve. The left pudendal nerve was treated using external techniques in side lying and in supine on the medial aspect of the ischial tuberosity in alcock's canal. During subsequent treatment sessions the left and right pudendal nerves were both treated to improve their longitudinal and transverse mobility and with lower limb movement in order to facilitate the nerves ability to move within its environment. Extended listening was to the lumbosacral dura and treatment also focused on treating localised dural restrictions in the cauda equine in both sitting and standing.

In a following session GL was emotional with the client falling posterior. The emotional GL was posterior, right and above the diaphragm. LL was to the right parietal pleura and

extended listening to the right pleural dome. Mobility testing: restrictions T5/6 costovertebral joint on the right and restrictions of pleural ligaments, specifically right pleurovertebral ligament and right transverse pleural ligament. Treatment focused on the right posterior parietal pleura, pleural dome and the restricted pleural ligaments, treatment was in sitting (direction of tension & breathing). Emotional listening settled and the physical GL was posterior midline and below the diaphragm. LL was to the filum terminale, posterior to the sacrococcygeal joint. Mobility tests: coccyx compression and sacral compression of S5 was positive at 10-15% depth with a short membranous feel to the dura of the sacral canal. Treatment included sacral coccygeal viscoelasticity technique (sacral pumping) to facilitate CSF in the lower aspect of the cauda equina, longitudinal compression/release of the sacral coccygeal joint, treatment of the dural tube in supine and also in sitting focusing on the local area (S5) and also the whole dural tube (sagittal suture to anterior coccyx).

In the 4th session general listening was to the left anterior pelvis, LL was to the pouch of douglas in the inferior aspect of the parietal peritoneum between the posterior/lateral border of the body of uterus and the rectum with extended listening to the anterior parietal peritoneum on the left side of the pelvis. The uterine fundus was pulled inferiorly into left rotation and side flexion. Mobility of the uterus was restricted (in a superior direction and to the right). Inspir and expir of the uterus was restricted to 20-25%, with inspir being more affected. There were restrictions of the anterior peritoneum on the left side of the pelvis on mobility testing of the peritoneum. The uterus and rectum were associated and treated with double induction. The pouch of douglas was associated with the anterior parietal peritoneum in the left side of the pelvis where there were restrictions, direct techniques, 3 plane stacking, pelvic tilting and lower extremity movement were required for release due to chronic scar tissue. The left round ligament, uterosacral ligament and broad ligament were also treated in order to balance uterine position. Motility induction of the uterus facilitating expir was used at the end of treatment with noticeable improvements in motility to 70-75%.

Further GL was to the posterior/inferior spine with LL to the pudendal nerve within alcocks canal on the right side. Right SLR test was mildly positive at end of range. In addition to further treatment of the pudendal nerve superiorly and more inferiorly in alcocks canal bilaterally, the obturator foramen were both assessed and obturator externus, obturator internus and levator ani muscles were released within the foramen to aid the lateral boundaries of the ischiorectal fossae (which contain the pudendal nerves and vessels). The key listening from the obturator foramen was posterior to the rectum, bilateral obturator foramen releases combined with the rectum were used to assist the rectal obturator relationship. Motility balance of the rectum was done at the end of the session, with induction of expir as inspir was more restricted.

Results

Currently there have been five treatment sessions. Following the 4th session there had been a 60-70% improvement in symptoms, the coccyx pain was significantly less although she was still uncomfortable with prolonged sitting. There were still some rectal symptoms of possible incomplete emptying and slight lack of awareness of anal sphincter control; she also felt her pelvic floor activation was inhibited. It was felt that internal vaginal evaluation and treatment may be required at the next session to assess for pelvic organ prolapse,

pelvic floor function and to make further improvements in the patient's symptoms using specific internal techniques (neural, visceral & vascular).