

Pelvic Organ Prolapse

Thorough Evaluation and Myofascial Release

Walt Fritz

Referrals for myofascial release treatment can come from a wide variety of sources for an even wider variety of conditions. When questions come in regarding if I can help with a certain condition, I am optimistic . Therapists may have their comfort level, depending on their training and licensure, which can actually limit the referrals that come their way. Treatment of women's health conditions has always been a strong part of my practice. Even for common conditions, such as lower back pain, women are often faced with a different set of causative factors than men, especially in the United States, where pelvic surgeries are all too common. The role that scar tissue can play with pelvic pain/dysfunction is huge, and we can play a significant role in helping this population.

Pelvic organ prolapse is a common referral to a physical therapist, with pelvic floor musculature strengthening the most common intervention. But there are other views on causative factors, as well as treatment approaches. I recently connected with Sherrie Palm, who heads the Association for Pelvic Organ Prolapse Support, Inc. Sherrie has recognized the role that myofascial release treatment can play in pelvic organ prolapse. While pelvic organ prolapse may seem an obscure disorder, consider the following:

POP SYMPTOMS AND CAUSES

Half of all women over the age of 50 suffer from at least one type of pelvic organ prolapse (there are 5 types), many women in their 30's and 40's have POP as well. Although POP is not extremely common in women in their 20's, it can occur in this age bracket. The 5 types of pelvic organ prolapse are cystocele (bladder), rectocele (large bowel), enterocele (intestines), vaginal vault (vagina caves in on itself after uterus is removed-

hysterectomy), and uterine (uterus). When the PC or pelvic floor muscles weaken or become damaged, one or more of these organ/tissue areas shift in the pelvic cavity beyond their normal positions.

Each of these 5 types of POP has its own symptoms, but in general symptoms can include:

(Use with permission from Sherrie Palm. http://pelvicorganprolapsesupport.org/pop_basics/pop_symptoms_and_causes)

- Pressure, pain, or fullness in vagina, rectum, or both.
- Feeling like your "insides are falling out" or like you are sitting on a ball.
- Urinary incontinence.
- Urine retention (you have to (urinate), you just can't get it to come out).
- Fecal incontinence.
- Constipation.
- Back/abdominal pain.
- Lack of sexual sensation.
- Painful intercourse.
- Can't keep a tampon in.

There are multiple causes of POP; it is likely that most women have more than one cause that fits their health pocket and lifestyle. The most common causes of POP are:

Vaginal childbirth - complications from large birth weight babies, forceps or suction deliveries, multiple childbirths, improperly repaired episiotomies. (It is also possible for women who have never given birth to have POP; there are many non-childbirth related causes.)

Menopause - age related muscle loss due to drop in estrogen level; this impacts strength, elasticity, and

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density of muscle tissue.

Chronic constipation - IBS (irritable bowel syndrome), poor diet, lack of exercise can all cause constipation.

Chronic coughing - smoking, allergies, bronchitis, and emphysema can create chronic coughing.

Heavy lifting - lifting children, repetitive heavy lifting at work, weight trainers.

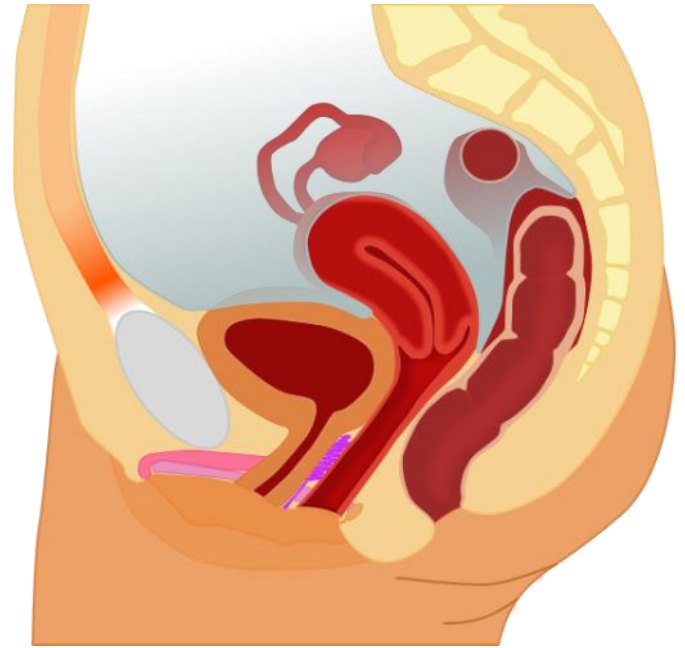
Joggers, marathon runners - constant downward pounding of internal structures

Abdominal surgeries - structural weakness from surgery or myofascial restrictions and scar tissue can lead to POP

Diastasis Rectus Abdominus (DRA) - a separation in the two bellies of the rectus abdominus muscle during pregnancy may predispose women to a weakness in core support which can lead to POP issues.

When one researches pelvic organ prolapse on the major Internet medical sites, muscular weakness is an oft repeated cause for many prolapse issues. Weakness of the musculature or overstretching of lower pelvis soft tissue can certainly be at the root of prolapse and should not be discounted. Weakness is said to result from childbirth, including cesarean section, as well as a myriad of other pelvic surgeries. What is missing from these explanations is the profound tightness that can develop secondary to surgeries and childbirth, especially scar tissue tightness. It can be this tightness that FORCES an organ to move from its original position. While traditional strengthening, including various types of electrical stimulation, can improve certain issues, often the treatment is incomplete. Unless the tightness is addressed, an increase in tightness may be the result.

Myofascial release is an accepted therapeutic modality practiced by physical therapist, occupational therapists, and massage therapists. Having a bit of an education regarding the most effective types of myofascial release is in order, as there are many variations. Both direct and indirect myofascial release have been used for decades, first by osteopaths and eventually therapists. Direct myofascial release involves a deeper, more forceful type of pressure that is typically short in duration. Indirect myofascial release is gentler and is typically sustained for a longer time period. While I was trained in both methods, I find that the indirect approach is both better tolerated and also provides more lasting results. A trained myofascial release therapist will be proficient in evaluating and treating a wide variety of pelvic pain and dysfunction syndromes. A GoogleScholar.com



Female reproductive organ anatomy. From: http://commons.wikimedia.org/wiki/File:Female_anatomy.svg

search will give you a large number of examples of myofascial release being used effectively in the treatment of pelvic organ prolapse.

Particular attention should be paid to any and all scar tissue in the lower abdominal and pelvic regions. Scar tissue evaluation should be a regular part of all therapeutic treatments. Assessing the tissue quality of superficial to deep soft tissue of the lower abdomen/pelvis, as well as the lumbosacral regions, and connecting that tightness to their pain or dysfunction, closes the loop. This loop is an important part of our role. If, during evaluation, we can reproduce their pain/dysfunction, whether local or distant to the pain, this creates a positive feedback loop between what we feel may be at fault, connects it to their pain, and feeds back the information to the therapist. The therapist now has a firm place to begin treatment and the client has trust that the therapist understands and acknowledges their pain/dysfunction. As I travel, teaching my Foundations in Myofascial Release Seminars, I find that many therapists feel that evaluation time is time wasted from the session. They relate an assumption from their clients that they expect the full amount of hands-on time. Here is where education, of both the therapist-in-training as well as their clients, is crucial. Without a thorough evaluation, one is really treating blindly.

As a physical therapist, clients are often confused when they walk into my office for the first time. They expect to see the typical array of exercise machines, modalities machines, etc. But what they find is a simple treatment

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table. I explain to them that the weakness model of pain or dysfunction has its place, but I find that not everyone responds to the traditional sort of intervention. We then proceed with the evaluation where, hopefully, I am able to connect their symptoms with my findings.

Clients may wonder what myofascial release treatment is like? While all therapists evaluate and treat in different ways, there should be some commonality. After a thorough history taking, your therapist may perform a head to toe evaluation, in standing, sitting face up and face down. This is an important aspect of myofascial release, as tightness, injury, or surgery in other areas of the body can influence the pelvis. They will then narrow the scope of their evaluation to the area of dysfunction. Gentle pressure into the lower abdomen will often reveal a great deal of information to both the therapist as well as to you. You may be surprised as to how easily your therapist can reproduce familiar sensations of tightness, pain, or pelvic organ dysfunction with just a small amount of pressure placed into very specific area.

(It is important to note that in certain circumstances it may be necessary for your therapist to perform evaluation and/or treatment vaginally or rectally. Individual regional licensure laws vary. Physical therapists are often permitted to perform internal examination and treatment. It is important to note that internal treatment is NOT always needed to successfully resolve pelvic organ prolapse issues. Your therapist should exhaust external treatment before proceeding further and only with your consent. In my experience it is only occasionally necessary to treat internally. If you feel pressured by your therapist in any way, find another therapist.)

Treatment with indirect myofascial release involves the therapist placing mild to moderate pressure into an area of tightness and maintaining that pressure for time frames up to or exceeding five minutes per technique. Typical sessions last an hour. Frequency of treatment can vary, but your therapist may wish to see you more often for the first few sessions. Trying to predict the necessary length of treatment is difficult, but when working with a well-trained and experienced myofascial release therapist, one can expect to notice lasting, positive changes in as little as three sessions. While it may take longer than three sessions to find full relief, you should be able to determine in a short length of time whether myofascial release is working for you. Your therapist will also recommend home stretching to allow you to continue to progress.

To find a qualified myofascial release therapist near you, please refer to the Myofascial Release Therapist page on this website:

http://pelvicorganprolapsesupport.org/health_care_connections/myofascial_release_therapists

You may also email me at walt@myofascialpainrelief.com or check the therapist listings at [www.FOUNDATIONSINMFR.com](http://wwwFOUNDATIONSINMFR.com).

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Walt Fritz, PT has been a physical therapist since 1985 and has been teaching Myofascial Release to physical therapists, massage therapists, and occupational therapists since 1995. His Foundations in Myofascial Release Seminars were developed in 2006 and have been taught across the United States. Working from the strengths of his predecessors, Walt emphasizes the straightforward effectiveness of Myofascial Release without the hype. In his Foundations in Myofascial Release Seminars, Walt brings an approachable, easy to understand style of teaching, one that can easily be assimilated into your treatment regime. Evaluation is a strong component of his teaching style, in order to create a logical progression from evaluation to treatment. Read 6 questions to Walt on page 44.

Look for his videos on the WaltFritzPT YouTube Channel. Walt also owns the Pain Relief Center, a physical therapy private practice in Rochester, NY, with a specialty in treating pain conditions.

6 Questions to Walt Fritz



1. When and how did you decide to become a bodyworker?

After failing miserably as an engineering major in college, I shifted my sights toward physical therapy. While in theory, physical therapy is bodywork; there was often little resemblance to what I do now. After moving through a variety of job situations for 10 years, I began my first few continuing education seminars in MFR and CST and I was hooked. I was so impressed at the changes that I could make in my clients, even after only one weekend seminar. I took all of the classes I could and spent the next ten years instructing at myofascial release seminars for another teacher. After a parting of ways, I began my own line of myofascial release seminars (Foundations in Myofascial Release Seminars) in 2006.

2. What do you find most exciting about bodywork therapy?

Simply put, it is being able to help those who others were not able to help. I love being able to positively influence the lives of others, whether it is my clients or the therapists that I teach.

3. What is your most favourite bodywork book?

Netter's Atlas of Human Anatomy. The artistry is magnificent and every time I pick it up I am amazed just how well we function. It is also my favorite teaching tool for clients.

4. What is the most challenging part of your work?

Two things come to mind. One is trying to ignore the garbage that continues to exist in the therapy community when it comes to myofascial release. The science is quickly emerging and evolving, thanks in no small part to the Fascia Research Congress. There is no need to continue pursuing alternative explanations that bring no credence to our field. However, there is money to be made in continuing to push this agenda onto unsuspecting therapists.

Second, as a physical therapist I have many obstacles to overcome in dealing with stereotypes of just what physical therapy is. In many ways, massage therapists have it easier. A bodywork-centered approach is what new clients expect, even though the modality may vary. Mention physical therapy to the average person and their vision of that is very different than the way I practice. It is a pleasant surprise to most new clients, as they are not used to being touched and given so much one-on-one treatment by their physical therapist.

5. What advise you can give to fresh massage therapists who wish to make a career out of it?

Find your passion. I discovered mine 20 years ago and continue to love what I do to this day. How many people can say this? Whether it is my choice, myofascial release, or any of the other excellent modalities available, find a teacher who matches your style and pursue the work. Fill your toolbox with skills that will allow you to meet the needs of your dream client. I believe specialization is key to success in our professions. Be very good at something and word will spread.

6. How do you see the future of bodywork and massage therapy?

I believe that the science-based approach to bodywork will continue to spread, replacing unfounded modalities and approaches. Therapists will need to keep up with the changes or get left behind. Massage schools will need to better address this science and continuing education will need to keep pace as well. "Because it works" will no longer be good enough.