The Osteopathic Medicine Treatment for Women with Chronic Pelvic Pain – CPP

Chronic pelvic pain is a common gynecologic complaint, affecting about 35% of women. The differential diagnosis is large, including many medical diseases, surgical indications, musculoskeletal problems, and somatic dysfunction. Women are more affected than men by pelvic pain because their bodies are subject to more changes. These changes include a cyclic hormonal system, major alterations in biomechanics during pregnancy, psychosocial stress, and other modifications during child-bearing, and more adjustments during menopause. Both medical and surgical approaches to management exist, but integrative modes of therapy address the body-mind-spirit continuum. Osteopathic manipulative treatment is a valuable option for many affected women from childbirth to menopause.

Osteopathic Medicine philosophy embraces an approach to wellness through knowledge of interrelationships of structure and function, and a search for the causes of patients' problems. When applied to addressing pain in female patients, it offers a global approach to complex psychophysical and social factors influencing development of chronic pain. Throughout her reproductive life, a woman may perceive pain due to emotional factors and also a combination of peripheral pain signals integrated with the central nervous system and based on mood, circumstances, culture, and personal experiences.

The female body has been uniquely designed for potential roles of child-bearing and caretaker, which make it subject to a variety of gynecologic and structural stresses. During pregnancy, a woman's physique changes to accommodate her growing fetus. After delivery, her body continues to adapt to her role of caretaker—lifting children, groceries, disabled or elderly adult family members. A variety of opportunities challenge her strength and the stability of her musculoskeletal system to influence pain and dysfunction of her pelvis.

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Causes of Chronic Pelvic Pain:

1.Anatomy and Structural Changes:

• During sporting activities, young women sustain knee and ankle injuries that can be attributed to ligamentous laxity, resulting from hormonal influences of the menstrual cycle. Some of these injuries can affect gait and contribute to structural pelvic pain

• Females typically have looser ligaments than males. Women therefore need to develop muscle strength to keep their joints stable. Stronger muscles stabilize joints, reducing injuries and increasing ease of motion. Although pelvic ligamentous laxity is desirable in pregnancy (to facilitate normal vaginal delivery), continuous laxity may contribute to organ loosing and venous congestion in the nonpregnant woman. The sacrum (bone above the coccyx) is suspended between the ilias bones by ligaments. Falling on the buttocks or pelvis may restrict sacral motion and lead to pelvic pain, through ligamentous tension on the uterus or the perineal floor. If untreated, dyspaneuria (pain during sexual intercourse) may result.

• Injury such as laparoscopic gynecologic surgery, cesarian section, pelvic infection, or motor vehicular trauma, may eventually result in CPP.

• After menopause, with reduced estrogen production, weakness of the pelvic floor predisposes to urinary incontinence. Incontinence may coexist with dyspareunia (pain during sexual intercourse) during the postmenopausal years. Abnormal changes in spinal curvature—loss of lumbar lordosis or pronounced thoracic kyphosis—may be a significant risk factor in the development of pelvic pain.

2. Psychosocial Issues:

Women with CPP frequently present with psychological alterations and a life history that includes either one of the following alone or in combination: sexual abuse, family problems, divorce, or a history of violence. Although the chronicity of pelvic pain becomes the focus of a gynecologic visit, some women manifest other physical signs of stress. Muscle weakness, spasm, and pain from disruption of muscle contraction and relaxation become complaints of fatigue, back pain, face pain, bruxism, headache, or fibromyalgia, or a combination of these complaints.

Management:

Management of CPP in female patients may involve a multidisciplinary approach. Stabilization of anterior and lateral pelvic curves through exercise or OMT (Osteopathic Manipulative Techniques) that utilizes techniques of muscle energy, balanced ligamentous tension, Myofascial release, and CounterStrain to assist muscles to keep the spine upright and sufficiently flexible to support good posture.

Osteopathic physicians, by virtue of their training and philosophy, are well prepared to participate in the management of CPP in women by addressing the emotional, psychological, and structural aspects of this complex phenomenon. Through their understanding of female anatomy and physiology, they can identify the biomechanical factors and somatic dysfunction contributing to chronic pelvic pain. They can administer OMT (Osteopathic Manipulative Techniques), which attempts to normalize structure and function, to correct and eliminate CPP.

It is important that patients should be aware that almost all osteopaths in Lebanon are not medical doctors, they have anarchic training and poor medical backgrounds, they are not recognized by social health insurance, nor the health ministry and nor the Lebanese Order of Physicians; so patients, for their wellbeing, should call and verify at the LOP (Lebanese Order of Physicians) if the therapist is a certified and registered medical doctor to ensure a good medical treatment as well as a good follow-up…

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