Pelvic Floor-Analysis & Rehabilitation

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- We are going to learn a lot together and it will be based on common sense function
- **The traditional strategy of pelvic floor dysfunction**
  - Thorough history, especially medications
  - EMG assessment and/or manual assessment of the pelvic floor
  - Adductors versus obturators
  - Theraband for the obturators
  - Ball between legs for the adductors
  - Standing plie' for the adductors
- Home exercise program
  - Relaxed awareness of the pelvic floor
  - Conscious concentric contraction of the pelvic floor (Kegal exercises)
  - Theraband obturators and/or ball between the legs adductors
- Looking at the **individualization** of the program
- Discussion of the bladder diary
- Other questions that we may need to ask
- The traditional program just doesn't "feel right"
- In the good old days our patella femoral dysfunction programs didn't "feel right"
  - VMO controlling the patella femoral joint
  - Biofeedback of the VMO with knee extension
- It just didn't make sense, especially when we understand the true function of the patella femoral joint and the VMO itself.
- The VMO decelerates eccentrically knee flexion, abduction and internal rotation
- To treat the knee effectively we need to know the entire Chain Reaction . . . we need to know who turned the VMO off in order to get it to contribute to overall knee success
- We need to put our ear next to the butt
- Just telling the VMO to contract, just telling the transverse abdominous to contract, just telling the pelvic floor to contract . . . doesn't effectively treat the dysfunction, it definitely does not treat the cause, and doesn't answer the question: "Who turned it off?"

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- As kids we did three dimensional plies without realizing it
- Diaphramatical breathing
  - With inhale my belly should lengthen
  - With inhale air goes into the lungs and the diaphragm compresses the abdominal contents and the bladder to load the pelvic floor eccentrically (the dual hammock effect)
  - When the abdomen concentrically contracts the pelvic floor needs to concentrically contract as well reflexively
- Description of external rotation of hips caused by the ability to first of all internally rotate the hips
- How many ways can I turn on the abdominal muscles with various body drivers
- **"I wonder if we should use a functional strategy to treat pelvic floor dysfunction?"**
- On one hand it will be easier . . . on the other hand it will be much more complex based on our need to individualize each treatment program based on the assessment of causes of the compensations that lead to the pelvic floor dysfunction
- There is a need to do a comprehensive biomechanical and functional assessment on each patient
- Is there really a need to do biofeedback?
- Mobilization of the hips in all three planes to turn on the pelvic floor
- There is a direct fascial and neurological link between the pelvic floor and the feet
- S2, S3, S4 innervate the pelvic floor as well as the feet
- The Chain Reaction . . . sacral tuberous ligament - hamstrings - posterior tib and peroneals - intrinsic muscles of the feet
- Tri-plane loading and unloading of the feet that turns on proprioceptively and stimulates the pelvic floor . . . it is gravity, ground reaction force, momentum, other muscles forces, and body drivers that facilitate this
- Is it a possibility that someone with pelvic floor dysfunction may in fact need the driver of foot orthosis? . . . it is dependent upon our comprehensive evaluation
- **Everything goes through the pelvic floor**
- Based on what is wrong, what is causing the pelvic floor to become dysfunctional, we develop a specific and properly tweaked individualized strategy for each patient for their comprehensive rehabilitation

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- All the “what we might need to dos”
- Neurological, skeletal, myofascial Chain Reaction from the head to the toes
- Right stride stance - discussion of the function of the adductors in the transverse and sagittal planes
- Tweak in the frontal plane with the wider base
- Tweak in the transverse plane by toeing out bilaterally
- Shoulder to overhead 3D Lifting Matrix with light weight dumbbells
- Posterior reach tweak with the 3D Lifting Matrix shoulder to overhead to facilitate more abdominal loading
- Toe in transverse plane tweak
- Vertical displacement to facilitate gravitational effects to get the “bulbulous” effect
- Making diaphragmatic breathing more functional
- Taking a preventative approach with pregnancy
- The timing of the exercise program, relative to a full versus empty bladder, and relative to how much fluid is in the bladder
- The tweak of the position of sitting with the use of inflatable ball
- The “bulbulous” effect of the bounce of the ball
- The 3D Lunge Matrix loading and exploding the pelvic floor
- The 3D Lunge Matrix with various reaches to facilitate a bottom up and top down load to the entire chain and crossing through the pelvic floor
- Exercising in functional concert with an emphasis on what is individually needed

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- We need to look at our patients more functionally and to treat them more functionally and then follow up with functional documentation to determine the efficacy of our rehabilitation

- Our program follows function:
  - Its subconscious versus conscious
  - Its eccentric before concentric
  - Its three dimensional, from the top down and from the ground up
  - Its integrated isolation
  - Its isolated integration
  - Its functional and its fun

- **Who turned the lights off?**