

Hip and Groin Pain in Cyclist resolved after *pelvic floor fascial mobilization* treatment – a Case Report

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Background: Treatment of dysfunctions in pelvic and hip areas almost never evaluates involvement of pelvic floor muscles. In addition, currently, physical therapy for pelvic floor dysfunctions uses mostly different types of exercises. Existing manual approaches focus on myofascial trigger points and currently there is no systematic approach or treatment for pelvic floor dysfunction originating from fascial restrictions.

We developed a method of *pelvic floor fascial mobilization (PFFM)* that evaluates and treats restrictions in fascial movement both internally (per vaginal and per anal) and externally, in pelvic floor area.

Currently we completed a dozens of successful treatments of groin/hip/pelvic/pelvic-floor pain and dysfunction that were treated with *PFFM* approach.

Aim: to present a case of successful treatment by *PFFM* of a chronic pain in hip and groin area that was not resolved by other physical therapy methods.

Case Report

32 y/o male professional cyclist, with complains on Rt. hip and groin pain during cycling and prolonged sitting, which commenced after a Rt. Hip severe contusion with tear of Tensor Fascia Lata muscle and Gluteous Medius muscle (2013), with no complains of pelvic floor dysfunctions. **Medical history:** multiple injuries to the lower limbs d/t cycling crashes involving both knees and hips, including: Lt. hip contusion (2012), Rt. anterior cruciate ligament reconstruction (2003), Lt. meniscal tear and repair (1997). The patient received several rounds of conventional physical therapy, including myofascial release, dry needling, mobilizations of the hip joint, stretching and therapeutic exercises, with partial pain relief and slight improvement of hip range of motion.

Initial evaluation: significant limitation of Rt. Hip internal rotation (30°), impaired contraction of pelvic floor muscles during both active contraction and anticipative reaction to increasing in intra-abdominal pressure during cough. High resting tone and painful palpation of Rt. Obturator internus and Rt. Iliococcygeous, and mild elevated resting tone (with no pain) of Lt. Obturator internus.

Intervention: *PFFM floor* include manual friction over the densified fascial points in combination with active motion of the hip joint. 2 treatment sessions (25 min. each) that included internal pelvic floor fascial mobilization over 2 fascial restricted points and 4 "external" fascial restricted points.

Follow-up examinations: after the first session immediate significant difference was noticed in hip joint range of motion (60°) and the pelvic floor muscle function in both, active recruitment and anticipated contraction. Pain was decreased by 80%.

After 2 sessions, treatment was finished completely because patient was pain free and returned to usual sport and work activity.

Conclusions: Results of this case report as well as of many other successful treatments gives us a reason to claim that *PFFM* can be used as effective tool for treatment for musculoskeletal pain and dysfunction in pelvic, hip or lower limb area. Additional studies are needed to evaluate the effectiveness of this method in different conditions.