Barral Institute Case Report

Neural Manipulation - Pudendal Neuralgia

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**Abstract**

Falls on the buttock account for significant longstanding injuries of the nervous system. In this case, a fall on the buttock resulted in a pudendal neuralgia and inability to perform daily activities. Manual therapy of the nervous system, including the pudendal nerve can have a great effect on this troubling condition.

**Key Words**

Pudendal neuralgia, neural manipulation, pelvic pain

**Introduction**

55 year old female presents with primary complaint of coccyx and pelvic floor region pain and an inability to sit on hard surfaces or for longer than about 15 minutes on cushions. She reports painful intercourse lasting for a few days after. She also has difficulty jogging. Symptoms began after a fall on her buttocks 8 months prior.

**Method**

Treatment One: General Listening posterior, inferior and slightly right. Local listening at sacrum was inferior then right and a buzzy line – to the right pudendal nerve. Mobility test in sitting confirmed tightness of the right sacrospinus and sacrotuberous ligament and ROM of lumbar spine and bilateral hips were limited in a capsular pattern. Treatment first on the sacrospinus and sacrotuberus ligaments to open the pathway for the proximal pudendal nerve. Neural manipulation on the pudendal nerve was then performed at that point which immediately improved ROM of her hips/pelvis by about 20%. Then the pudendal nerve was manipulated by induction elongation through the Alcocks Canal. Branches were treated at the perineum and the perineum was balanced at the central tendon.

Treatment Two: General Listening, posterior inferior right, slightly down the leg. Local listening to the ischial tuberosity, hamstring attachment on the lateral side to the sciatic nerve. Local listening of the sciatic nerve went to it’s piriformis perforation. A release of the fascial ring at the piriformis was first done, followed by neural manipulation by induction elongation of the sciatic nerve with leg movement for increased induction (long lever). This was then done bilaterally to balance the sciatic nerves. This immediately improved her lumbar ROM and pelvic tilt ROM. Home exercises were given to re-educate this movement.

Treatment Three: GL: cranial. LL: R tent. LL at rectus capitus posterior minor: R superior. Treatment of the tentorium cerebelli with relaxation of the tentorium with R side bend, then engage with expansion phase of CSR with R LE with sacral plexus bias. LL at rectus capitus posterior minor: R inferior to sacral plex. Treatment of sacral plexus R then L for balance.

**Results**

After three treatments the patients pain decreased by 80% and sitting tolerance increased over 100%.

**Discussion**

Pudendal neuralgia can be a source of great pain and anguish. Traditional treatments include nerve blocks which can have some debilitating side effects and doesn’t address the issue of a pudendal nerve entrapment. The Pudendal nerve passes two points of compressive vulnerabilities, the “button hole” of the sacrospinus and sacrotuberous ligaments and also Alcocks canal. Pelvic asymmetries are common and can contribute to tension in the sacrospinus and sacrotuberous ligaments.

It is difficult to balance forces in the pelvis from a mechanical standpoint but also from a neurovascular perspective as well. With so many forces in play, differing in sitting and standing, diagnosis can be a challenge. In this case, the osteopathic tool of “listening” proved very helpful in determining the drivers of the dysfunction for maximum efficiency of treatment.

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