C CAROL BROWN
CHANGING LIVES: ONE HABIT AT A TIME

Aging Gracefully Health Series

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Interview with Pelvic Physiotherapist Lauren Campbell

Pelvic Physiotherapist Lauren Campbell (left), and
Holistic Health, Life and Financial Literacy Coach C. Carol Brown (right)

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Carol – Thank you so much for taking the time to speak with me Dr. Lauren Campbell. Your title is officially…

Lauren – So, I'm actually not a doctor. I'm a pelvic physiotherapist. So, Lauren Campbell Physiotherapist. I have a Master's in Science in physiotherapy and previously to that I attained a Bachelor of Science from Queen's University in Kingston.

Carol – Awesome! So you have a lot of experince. The first thing I'd like to know is what is pelvic physiotherapy?

Lauren - What is pelvic physiotherapy? You and everybody else. It is a great question. Pelvic physiotherapy is basically physiotherapy that addresses problems that people are having with their pelvic floor or their pelvic girdle. So lots of times, I'll see pregnant during their pregnancy who are having problems whether it be pelvic pain related to their pelvis growing and expanding related to pregnancy. Or they may have sort of more classic pelvic floor pain like pain during intercourse and theymay also have really weak muscles and have things like stress urinary incontinence where women are coughing, sneezing or laughing and they are having leakage of urination—loss of control or they may have urge incontinence where all of a sudden they have that urge to go to the washroom and they can't quite make it in time and so they are getting in there, they are hustling and ooh! I'm already peeing! Classic example is you get home from work, busy day, you put the key in the lock and oh my goodness all off a sudden, you start to do the dance. If you hadn't had been stuck on the subway for another five minutes, or stuck in traffic, you wouldn't suddenly be having that urge, five minutes away from home. It is very much, I'm at home, we tend to like to urinate or deficate in our home environment and so it that kind of trigger of I'm here and I really need to go and if the muscles are not working properly then we can have loss of control. People will hold themselves or have little dribbles.

Carol – Okay, so in all that you have just said, you ar focusing in on women. Is this an issue for men as well?

Lauren – It absolutely is! Thank you for pointing that out. I see men and I also see children as well. Men classically they will have both tight and weak pelvic floors as well. So just to kind of break that up, I kind of jumped into that in the last question, but the muscles can be very very low toned, and that is were we will have loss of control or the muscles can be very very tight and women will have painful intercourse and they may have a lot of urgency and frequency with urination. If you think about those muscles being very tight and the bladder is kind of filling, filling, filling, it doesn't get very full but all of a sudden we have this premature urge and we empty. It doesn't take very long again for the bladder to kinda fill, fill, fill, then Ah! I gotta pee, gotta pee, pee, pee! And so we do this all day long, it's only been where we are getting every hour we are having to pee as opposed to Oh! It's been three or four hours! The muscles are really beautifully stretched and accommodate a nice full bladder and now we empty. So

there is the weak pelvic floor and the tight pelvic floor. Everyone in the middle is hunky-dorry and has no problem but those low-tone people who are having problems and those high-tone people who are having problems. So with men, same thing. They can have a low-tone pelvic floor, which often happens after they have had prostate surgery, like a prostethectomy, and the internal sphincter get disrupted when the prostate gets removed so they are entirely reliant on the exxternal sphincter and if those muscles aren't strong they'll be wearing pads and having leakages as well. Not that it is easier for women to deal with but I think women are more accustomed to having to use pads and supplies because of menstrual cycles whereas men have never had to put anything in their underwear before and they are hugely distraught. So it is just a matter of looking at what the muscles require, tailoring a program and then people are good to go.

So the other piece of that, the men are very weak and can e very tight. And when men have tight pelvic floors they will often present with the same idea of the frequency/urgency with urination, so they will be peeing all the time. They might have premature ejaculation, they might have pain with ejaculation, they might have pain after ejaculation, and they may feel like they are sitting on a golf ball. Often the prostate gets blamed and we'll see gentlemen diagnosed with conditions like chronic prostatitis but when you look at the prostate, there is nothing wrong with the prostate. It is a pelvic floor problem. Muscles are very tight, we relax those muscles and look at the other psycho-social drivers that might be involved and treat them sort of holistically and everything settles down and that golf ball sensation disappears.

Carol – So at what point does someone know that they need to come to you as opposed to going to another medical profesional?

Lauren – Great question! At this point, the bulk of our referrals are coming from gynecologists and urologists. I would love to see more people kind of go, "Oh, I'm having bladder leakage" and whether they pick up the phone or jump online and seek out a pelvic phsyio, that would be great. I think patients and people in general are not aware of this and so they are going through the family doctor and often family doctors are not great at screening. They kinda go "bladder problem, sex problem, I better send you to your gynecology or urology". If you equate it to shoulder pain or a low back problem, we wouldn't be running to the orthopaedic surgeon when we have a little bit of shoulder pain. We might go "I've got a tight shoulder here, maybe I should seek out a physiotherapist or go see a chiropractor". We kind of think more mechanical type problems when we have other typical shoulder, elbow, knee, joint pain. We think it is probably a physio thing and I can probably do some exercises and improve that but when it is problem down there, we get into catastrophic thinking and then end up in the office of the specialist. The specialist rules out cancer and anything more serious and the streamlines them to physio but at the same time they have waited often six month to a year for that specialist appointment and taken up a ton of the specialist's time only to be told "it's a muscle problem". So It would be nice if we

were recognized as a more frontline provider and people sort of knew more about it but I think one of the biggest barriers is the number of theraists trained and working in this space.

Carol – And that was going to be my next question. So this is a new thing for me. I'd never heard of this until our common patient told me about it. So, I'm interested t know, how many of you are there?

Lauren – We are growing in numbers. I initially did my training in New York back in 2010 and there were two therapists in Ontario doing it at that point and I kinda been in touch with them for a long time and reached to to one of them and said, Im moving to New York and I think this is kind of a cool area and can you tell me more about it. My husband and I were going to live in New York at the time and she said do you all your training there and call me when you are ready to come back and so that it exactly what we did. But, I did all training at the Herman Wallace Pelvic Institute because there was really no teaching company in Canada that offered any post graduate training. We moved back in 2012 and by then there was a teaching company established by Nellie Figani and Carolyn Vandyken, two of my mentors, and then it sort of grew from there. In the last six years, here we are 2018, we've grown exponentially. I believe there is now close to 400 therapists in Ontario that have rostered. If you think about it there are over 7000 physiotherapists in Ontario and 400 of them have rostered. That doesn't mean that they are all actively practicing or some of them have an orthopaedic practice and then have taken a few courses on the side and then now it is like they have the training and the skills to maybe get into it but everyone is a little bit apprehensive I find to kind of take the plunge and dive right into it. So that is one of the reasons why we opened this clinic is to try and give some more brand around pelvic physiotherapy calling it Advanced Pelvic Physiotheraphy Centre so tht people recognize oh, it's pelvic physiotherapy, I wonder what that is? And as opposed to where I used to work we were tucked away in a general physio practice and not that we didn't get lots of referrals but that was one of the reasons we wanted to have this place so we have a multi-disciplinary pelvic wellness centre where we could collaborate amongst professionals including sex therapy, naturopathic medicine, massage therapy and physio and all work together for the benefit of our patients.

Carol – That sounds really awesome! Patients are going to be blessed when they get here and they see all the miracles that you guys can work. I'm really excited about this and I know that the folks that are going to be reading this transcript will be equally excited to know that there is help for those that have some of the issues—the bladder leakage, the urgency, and painful intercourse—beause that is a huge problem for a lot of women that just goes unaddressed through their entire life.

Lauren – Totally! So we'll see women come to the clinic who have never been able to have good intercourse, from their very first sexual experience and then we'll see women who come more peri-menopause or menopausal period where sex has been great for their whole sex life and then all of a

sudden estrogen declines, vaginal tissues thin and they start to experience pain at that point. So, someone who has never really had a problem is suddenly experiencing discomfort into their late 40s and 50s. And so again, as soon as we experience pain, those muscles can then kind of tighten up and try to protect in anticipation of what's to come and there is an anology in that at much as we are fully engaged and ready "okay, here I am ready set", but I'm not really because I'm already kind of bracing so that it is like hitting a brick wall. So we need to kind of unlearn that behaviour help the muscles be soft and flexible and malleable again and patients do great.

Carol – Can you give me, without getting too graphic, how exactly you manipulate the pelvis?

Lauren – Yeah, it is all done through internal palpation. Either one finger or two fingers get inserted either vaginally and/or rectally. Obviously with a male pateint we don't have the option to work vaginally so we are working rectally. And women know we often work both vaginally and rectally only because vaginally we can access more of the anterior part of the pelvic floor, rectally it is going be more of a posterior. So dependng on where if they have got—we didn't talk at all about bowel disfunction. I see a lot of patients who have irritable bowel syndrome and endometriosis so depending on where their pain lies dictates where we are going to access the pelvic floor muscles. If I'm going rectally, I would never use two fingers, only a single digit. Basically the pelvic floor is like a bowl and so one finger at a time, you palpate around, you get a sense of where the muscles are tight or irritated or painful and them we do some soft tissue techniques not unlike if you were working on someone's upper neck and you feel the muscles are a little bit tight and it it like "oh, there is a tender point" you hold that and the muscle softens and relaxes and then we move along to the next point.

Carol – That is awesome!

Lauren – Yeah!

Carol – How did you get into this? Where did you hear about this? What made you interested in doing this?

Lauren – I fell into it by accident to be honest. I had graduated from The University of Toronto (UofT) and like most physiotherapists wanted to go into sports medicine and orthopedics—the bread and butter of most physio practices—and work with athletes. I was a competitive swimmer myself and so had seem physio on and off for rotator cuff injuries to my shoulder and liked my physio when I was in highschool and though I would have a job just like her was how I got into physio. And then my husband and I moved to New York and I had been working at a sports medicine clinic at the time here in Toronto for a couple of years and I thought I would find another sports medicine clinic in New York you know there are tons of athletes in New York it will be great. We really moved for his career. I'm so glad we had that opportunity because that was when I met my previous employer Evelyn H. she was running a clinic

on the upper east side Manhattan and had a posting. So after I did all of my board exams for the US to get my licencing and credentials I started looking for positions and so she had a posting for orthopedic/sports med/pelvic. At the time I was thinking "pelvic" like broken trokinteric bronsitis or hip arthritis and gluteal stuff and thinking more generally hips and not the internal pelvic floor stuff. I met her and we got along great and she was prepared to hire me but then she said "so Lauren you haven't told me anything aobut your pelvic floor dysfunction experience?" And I thought, "you mean like kegel exercises?" I was so green at that point. In our undergraduate training, well really it is a post graduate degree, Masters in Physiotheraphy, we had a one hour lecture on pelvic floor and it was really more in association with core strengthing and talking about building the abdominal wall and using your pelvic floor at the same time. There is so much more to it than that but it was glossed over and I think the physio school just wanted to draw a dotted line between the pubic one and the tail bone and the two sit bones and said "we are not going there…everyone is keeping their pants on!" and that was that. I thought I really don't have any experience. She said, if you are willing to learn you have to accrue a number of mentorship hours and take all the continuing ed courses. If I was willing to take that on she would hire me and I would start doing sports med and orthopedics, like I had been used to and accustomed to treating and then I would build a pelvic floor caseload as I had the training to do so. I became a fly on the wall for a lot of her appointments. She had been doing this for 25 years. It was an invaluable learning opportunity to sit and listen and hear people coming in and talking about their painful sex and the different problems they had been experiencing such as "I don't go to social engagements anymore because I have to take a pair of extra pants and that's embarassing if I have to change my pants, so I just won't go. Social isolation that comes for older patients because it doesn't get better with age so if you are already having a problem post partem in our 30s and 40s and then menopause hits and we get older this area just needs attention like every other part of our body if it is going to age well. So, I had huge appreciation for her and the work that she was doing and I thought this was really interesting and I started working with my own patients and was getting some really great results as so the story goes. Then we moved back here and I've never looked back since.

Carol – We are glad to have you. Is there anything that patients need to be concerned about in coming to you for therapy? Are there any worries that you are hearing patients expressing?

Lauren – when people are pregnant they will ask questions about is it safe for the baby? It is absolutely 100% safe for baby and for mom during pregnancy. Unless the woman has been told to abstain from sex because she is having placenta previa or some sort of other medical complication associated with the pregnancy and has been told to avoid sex, that is a red flag for me and I would not work internally, we might do some external things, if she was experiencing a lot of pubic or pelvic girdle pain but I would not do any internal work with that patient. But no, really there is minimal risk in terms of doing this type of work. The other question people ask is about insurance. I'm seeing less of this now but a few years ago it was more comment people requiring a physician referral to get their extended

health benefits to cover the physiotherapy. They would only cover physiotherapy if it had of been physician prescribed. So as much as people don't need a physician referral to come and see me, they can just book an appointment, I'm a direct access provider, so there is nothing to stop you from saying "I have a pelvic floor problem. I'm gonna book an apointment and go from there" you don't need to be referred through a doctor but in some occasions people's extended health insurance requires it.

Carol – So it is not covered by OHIP?

Lauren – No, it is not covered by OHIP. Physiotherapy has been delisted now for quite a while. It is not covered under OHIP so peopl ehave extended health insurance through work they are covered for physiotherapy or they are covered 80 per cent for physio or they have a dollar value. We don't do direct billing. People pay and then they have their receipt with my billing number on it and they submit for their extended health coverage and we go from there.

Carol – Do you want to talk about cost?

Lauren – Our initial assessment if $140. The assessment is an hour and then each subsequent treatment session is $95 and those are typically 30 minute sessions. How many sessions you are going to need depends on what brought you here in the first place. I'll see someone who has stress urinary incontinence—the coughing, sneezing, laughing, jumping, running for the bus—loss of control. Often as few as three or four sessions and that can be spread out over a number of months if finances are an issue. Some of the more complex pelvic pain cases can included a slew of things. They may have bladder pain syndrome, they may have endrometriosis and irritiable bowel syndrome and painful intercourse and the list goes on, there could be lots of psycho-social issues at play. We take a very bio psycho-social approach so we are not just looking at the mechanical piece, which we haven't talked about yet. I might see those patients once a week for a number of months. I wouldn't put a hard fast timeframe around it. Often I meet a person and we have one session then I have a better idea of whether this is going to be a handful of sessions or many many months but I would say I work with patients anywhere from a handful of sessions to six months at a time.

Carol – Let's talk about the bio since you brought it up.

Lauren – What the bio-psycho-social framework means is the bio piece is what we have about extensively in looking at the nitty-gritty –the muscles are tight, the muscles are weak. What we also need to appreciate is the psycho-social piece and how our thoughts, our attitudes, our beliefs, affect our pain experience. A classic analogy that I give patients all the time is think about if you stub your toe and it is the weekend and you are heading up to a cottage and it is a beautiful sunny day and nothing but fun times are ahead. You stub your toe on the bed and it barely hurts. You forget about it because you've got to hurry up and get in the car and get going to the fun times ahead. Versus, it's Monday morning,

you are late for work, the kids are fighting, the coffee spills, and now you stub your toe. Very same physical experience yet the pain is very different. So why is that? And that I find fascinating. Why is it that someone can be in a relationship and have pleasurable enjoyable intercourse for a number of years and all of a sudden the partner cheats something happens and now sex is hurting. It is a very different experience. There might be a mechanical piece—those muscles have tightening in protection—we can do great physio work and help relax those muscles and those muscles feel perfect and healthy but the person continues to experience pain. And so that's where we need to look and dive a bit deeper into what else is driving this problem. Is there stress? Is there anxiety? Is there depression? Is there catastrophization? Is there fear avoidance? Are there other pieces at play that are perpetuating a person's experience? Pain is an experience and I like to think we do a thorough job of capturing all of that and addressing beyond just the pure biomechanical issues which is a more classic kind of physiotherapy approach but pain science is very fascinating. Most of our pain cases are not coming in with a "this has been a problem for two weeks". By the time they get here it is, "I've been struggling with painful sex for the last four years" or "I've had IBS, I've had endometriosis, I've had pelvic pain and painful periods since I was 13 years old. Now I'm 30 and the pain has gotten debilitating. Now I take a week off of work every month. So it is about dealing with the more complex things. It is a lot more than just looking at the tissues.

Carol – So this pelvic physiotherapy could have significant impact on your overall health?

Lauren – Very much so. I'm not going to hold myself out as a psychologist, and this why we have a lot of disciplines here like sex therapy and a naturopathic doctor to address a lot of the nutritional pieces and inflammatory things and sensitivity in the nervous system. As long as we have experienced persistent pain for a long time the sensitivity of our nervous system is going skyhigh such that you might have light touch but it isn't feeling like light touch it is feeling like sharp stabbing burning and that experience is 100 per cent real but it is disproportionate to what is mechanically driving that. We need to help that patient understand that yes this is pain but that there is disconnect. So helping people to understand that is huge and once they have the education, that's really what therapeutic neuroscience education is, as soon as people have that, their ability to bring down their pain response is better than things like Advil. We are doing a better job with education than we are in terms of popping pills. We look at the randomized control trials that dive into this area.

Carol - Is there anything else that you want folks to know about you and what you do? I am going to spread the word. I'm going to tell folks how fabulous you are and I'm going to tell them what you are doing here and they are going to ask me questions and I want to be able to answer all their questions. So is there anything else that you can think of that I need to know in order to tell others?

Lauren – Good question. I feel that we've gone through quite a bit. I have great job satisfaction because this is effective. If we look at the literature surrounding treating incontinence, 80 per cent of stress urinary incontinence is fixed with pelvic floor physiotherapy alone. This is first line. In Britian, for example, they will not do any surgery in the pelvic floor until they have "failed" physio. So their surgical numbers are way lower and their surgical outcomes are better because they are doing surgery in cases where it is absolutely warranted. I think here in North America we tend go "I have a prolapse", we haven't talked aobut prolapse at all, we'll have to come back to that, but people are having leakage, have to go to the doctor, have to have surgery to fix that. And if you think about surgery in this area, we are upright human beings, so if we try to lift things up or kink the urethra in hopes of stopping the leakage, the surgical longevity of that is not very good because unless we are going to lie flat on our backs for the rest of our days, we are going to continue to go and get on the floor and play with our grandkids and run all over the place and do active things because we all like to lead active lives. I see a lot of people who have had surgery and then the surgey fails or the surgery hasn't lasted and they say, "I wish I had of know about this before surgery. And they ask "why was this never offered to me before?" or they tell me "my family doctor streamlined me to urogynecologist and then booked for surgery but no one ever mentioned physio." I would love for people to know this is an option and that there are more conservative measures that can be taken before we consider the most maximally invasive surgical intervention in the hopes of fixing that. But, surgeons like to do surgery. We all have our biases I suppose.

Carol – Let's talk about prolapse since you brought it up.

Lauren – Thank you for the reminder. Prolapse is also associated with a weak pelvic floor. Rememer we were talking about the two ends of the spectrum—the low tone and the high tone—the low tone pelvic floor. Prolapse can happen with women have undergone childbirth and had to strain and push, people who have chronic constipation—heavy dry spool is like mini childbirth—and so you can imagine someone who has had a lifetime history of chronic constipation of pushing. With all that intra-abdominal pressure that you are creating with the straining, you are essentially pushing those organs down and that is essentially what prolapse is. The organ should we sitting nice and high up on either side of the vagina basically with the bladder up here and the uterus here and then the rectum on the backside but what ends up happening is those organs sit lower into the vagina and we'll starytto see some tissue, part of the anterior wall and the posterior vagina wall comes down because the bladder is pushing on that anterior wall. It isn't that the bladder is coming out but we are seeing what should be inside the vagina coming down. There is something there. There is too much viseral mobility in those structures. We want to strengthen those muscles so they physically get bigger, much a like a bicep does when you exercise it, and keeps things sitting higher up in the vagina. Often people won't notice those symptoms—the heaviness, the bothersomeness—associated with their prolapse.

So prolapse is another thing that people will often be told “you have to have surgery” and again, we are just suturing things higher up in the vagina and if we haven’t address the constipation, through education such as toileting positions, the squatty potty, which is a great invention to getting your knees higher than our hips and what I would consider basic things but things that people don’t know. It like, “I’m not supposed to sit up straight and defficate on my toilet like that?” And how much water are we supposed to have? Health Canada would like us all to have eight glasses which is probably a bit excessive unless it is July and you are outside and you are sweating all day long. We should have half a fluid ounce per pound of body weight and that encompasses all of the fluid that we are getting in the day. How much fiber should we have? How much exercise do we need? There are all kinds of techniques and massage which will help improve intestinal motility and help get bowels moving better. There is a lot we can do but people think, “I’ve always had constipation, you can’t fix that” but there is lot that we can do to improve that so that you are not having those heavy hard bowel movements daily and creating mini childbirth on your pelvic floor. Over time, it will catch up with you, I promise!

This is an intimate personal area so no one is saying, “hey! I have painful sex.” We think that we are the only person in the world who has this problem. Which is also why we have this clinic because everyone who is walking through the door here is having pelvic floor problems. You are not alone and this is a busy practice. One in three women have incontinence. One in three is high and an even sadder statistic, one in two people will end their life in diapers. It is the number one reason we put people in nursing homes. We will care for mom and dad as they age…we will get them supper and these kinds of things but no one wants to change mom or dad’s diaper. I think this is so sad because these are just muscles that need attention. It is like people who have had heart surgery or blood pressure and are in cardiac rehab. We get them moving, we get them active, and they do fine. It is the same thing. It is a matter of getting this area active. No one knows how to do a Kegel. The number of people that I say, do for me what you think is a Kegel? I’m blown away with how much breath holding I see. How much glut squeezing I see. How much inner thigh activity. It is amazing how many people—and really, how should we know? The term Kegel comes from Dr. Arnold Kegel who back in the 1930s taught women through internal palpation how to resqueeze their pelvic floor following childbirth. Over the years we digressed and we maybe gave people a piece of paper that showed people how to squeeze those muscles down there. No one wants to go there because it is a personal area but we have really digressed. And it may show up in pregnancy books and pregnancy apps but really, who the heck knows what they are doing? Should I hold for 5 seconds? 2 seconds? Should I do them fast? Slow? What’s my endurance? There are so many factors it would be like saying do shoulder exercises but not being clear about what that looks like. I think we need to break it down and demystify for people and help them understand that these are the muscles that I want you to use—and internal palpation is really the gold standard. It I can feel those muscles and palpate what they are doing, we don’t know, are they tight? Are they weak? Where are they on the spectrum. Sometimes they are tight and weak and that can also be a stress incontinence

case. Sometimes a patient appears weak beause they can't access the strength they have. So if we don't assess what is going on we can't say for certain. Sometimes we are a little bit leary of the internal exam and we say, "just teach me how to do the Kegel exercise and I'll be okay", but I never teach Kegel exercises without first assessing those muscles because I tell what you are doing. You might be saying "I'm doing it" but I don't know. Are you squeezing your bum? Are you squeezing your urethra? Those muscles are more complicated than that.

Carol – I want to spend the last few minutes talking about men. Talking about your male patients. Because women are the majority of the population we seem to be a little bit more in touch with our bodies. But I do want to focus on men because I know there will be some male readers. What per cent of men come to see you versus women?

Lauren – I would say it varies at any point in time but probably the caseload is between 20 and 30 per cent.

Carol – Well that's not terrible.

Lauren – It's not terrible. This morning alone I've seen seven patients already and two of them were men. It is definitely a lower amount but that is not to say that I never see men. I see men on a very regular basis.

Carol - What are the most common, say 1,2 3, issues that men will bring to you?

Lauren – Frequency, urgency with urination. They are peeing all the time. It is a stress phenomena. What else makes these muscles tight? Stress. The classic analogy I give patients all the time too is think of when you get nervous, you probably don't get nervous public speaking because you do this all the time, but if you think about someone who is socially anxious in a situation—gonna meet a whole bunch of people, gonna give a speech—right before it is time to get up infront of the podium, "I've gotta pee, I've gotta pee, I've gotta pee". You do your 15-20 minute pitch, you sit down, ah, it went well, urgency is gone. Those muscles tightened up in response to being nervous. Those muscles are the first to fire. Here we are right downtown Toronto so maybe my patieint population is a little bit skewed but I see tons of men in investment banking and lawyers—people who I would say are high strung—brilliant careers, brilliant minds—and this is how their tension manifests. People grind their teeth, clench. So we clench here too. We hold, hold, hold. So it is a matter of learning to let go and do reverse Kegels and pelvic floor drops which I do with women as well.

So I would say frequency, urgency and pain with ejaculation in a young male population like I am thinking 25 to 50 and then in a 60 plus the bulk of those men I'm seeing are post prostetectomy and the are dealing with leakage. Again, opposite ends of the spectrum. The high tone—labelled as prostetitis—the prostate is completely fine but the urologist labelled it as that because they don't know what else to

call it. It is a catchall condition when we are not sure what else to call it. We should call it the hypertonic pelvic floor. Relax the pelvic floor, all those symptoms—the urgency, the frequency, ejaculation problems, the bowel problems—disappear.

Carol – What about erectile dysfunction (ED)?

Lauren – So when we think about in a younger male population versus an older male population, erectile dysfunction can happen with prostate surgery. There is some literature that will suggest that pelvic floor strengthening really does improve that but I never promise any man that he is going to regain his pre prostate level of able to have an erection because often we can improve that but studies will show that we often see an improvement in 50 per cent of men. I would say that it varies and tend to depend a lot on the surgical technique done and whether there was nerve sparing or not and I find that is really more the predictor as opposed to how strong their pelvic floor is. I see lots of men who have really strong pelvic floors and still will have the ED. In the younger male population we are talking about tightness in the pelvic floor and the ED that is surrounding that often when we relax those muscles we get better blood flow into the area and the ED disappears like that.

Carol – Wow!

Lauren – So I would have more confidence in treating the ED in younger men as opposed to the post prostate post surgery male. Not to say we can't improve those too but not with maybe the same degree of success. What else can I tell you about men? And kids! We see kids too. Most common kids referral will be for bedwetting, the medical term is call onuresis. Not is not just bedwetting. We look at the history. The child is also usually heavily constipated because they don't drink enough water and so we have an overflow problem. Their little pelvises are only so small. You get massive bowel obstruction, they have these really distended bowels because they hold and hold, and hold because who wants to interrupt play. And of course there is not much space so bladder gets a little bit full and then bowel pressure and they leak at night. I meet tons of parents who are so frustrated, "oh I think they are doing it on purpose, you know they are eight years old , and he's still". And the laundry every night of changing the sheets and it is a matter of addressing the constipation and getting them to toilet at the right interval, making sure they are fluid loading at the right period of the day and we fix the bedwetting. Parents, families are over the top when we fix that. That is probably the smallest percentage. I would like to see more kids because what happens is these kids so unmanaged or mismanaged and struggle with constipation there whole pediatric life and they end up being the adult patients down the road. So I think if we did a better job of identifying this in kids, we might save ourselves a lifetime of pelvic floor dysfuntion and having to visit here when you are an adult.

Pelvic Physiotherapist Lauren Campbell holds a model of the pelvis.

Lauren - You can see how this is a very highly interactive area. We are talking about where there are three different layers of muscle. Layer one we access externally. I check all these different muscle groups and then we would do an internal evaluation with either one or two fingers vaginally. Then one finger rectally and then we check all the deep muscles inside which really make like a bowl.

So, one at a time I would go around and check all these other muscles to determine where there is any areas of pain or tenderness or tightness and maybe there is no areas of tenderness or tightness and then we'll go right into a strength evaluation. People will contract their muscles and we grade the strength on a zero to five scale to determine how strong they are and what they are doing when I say do for me what you think is a Kegel and that is how I get everyone to start.

Sometimes they are doing it mostly right, most often they are doing it mostly wrong or we are not getting in the right areas and so then it is really my job to help get them to do what they are supposed to do and I do that through gentle palpations—squeeze here—no not there—squeeze here—do you feel me here? Try and tighten those muscles rectally, tighten those muscles here and we start that way.

There are three systems—the bladder, the uterus and the rectal bowel--that's why we really treat all three systems and we take that holistic approach to kind of look is there bladder problems? Is there sexual dysfunction? Is there IBS? Is there something else because you can see how one is going to affect the other.

There is also something called crosstalk. If we see over activity between brain and bladder, brain and bladder, brain and bladder, well it goes brain, spinal cord, bladder and so bladder, spinal cord, brain, so you can see where at the level of the spinal cord where the bladder enters, the uterus also enters there too and the vagina. We'll see kind of that blending and so often we'll see overlap of co-morbidities, so they also have endometriosis and they'll have bladder pain syndrome. We'll often see multiple thing happening at the same time. It is rare that someone comes in with just one of those complex pelvic pain conditions.

That's the model and how that works. I think people often like to see the visual because they go "where is my pelvic floor? I've never known where my pelvic floor is." It is like a whole hammock or undercarriage that has a supportive role, it has a sphincteric role. Think about a female pelvic floor, for intercourse, we have to be able to relax those muscles for penetration to happen but for orgasm, we also have to have a certain degree of tone. It is kind of a fascinating balance that has to happen. Our bodies are really pretty awesome.

Carol – Awesome yes! They really are!

Lauren – Lots of things can go awry and lots of these things can be easily improved with a little bit of attention in the right area. We bark at the right tree and we see the results we need.

Carol – Awesome!! I don't know what else to ask you? We've covered a lot and I appreciate everything you've said and if I have any other questions I'll definitely reach out and you can fill in the gaps. Thank you this was awesome!