Osteopathic Medicine

The Bladder and the Prostate

Luc Peeters & Grégoire Lason
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1. Introduction

The osteopath is often confronted with patients suffering from low back or pelvic pain associated with a somatic dysfunction of the sacrum.

The initial osteopathic findings are then connective tissue swelling at the level of the sacrum, palpation pain at the tip of the coccyx and loss of mobility of the sacrum and the pelvis. There is often a relationship with the visceral pelvis.

The anatomy and the function of the bladder and prostate are discussed from an osteopathic point of view.

Furthermore, it is clearly demonstrated how and when visceral techniques are most appropriately used for these organs.

For the reader who is not familiar with the osteopathic visceral approach please consult chapter 11 at the end of this e-book.
4. Mobility

4.1. The Bladder
The bladder has two fixation points: the pubic symphysis via the pubovesical ligament and the urethra.

The inferior fixation point is stronger in the man due to the prostate enveloping the urethra.

The superior and posterior aspects of the bladder are very mobile so as to allow distension when filling.

The infero-lateral part of the bladder is lightly fixed (in a latero-lateral direction) by the lamina sacro-recto-genito-vesico-pubicalis.

4.2. The Prostate
The prostate is not very mobile due to the fact that it is embedded in the pelvic floor via the levator prostate muscles - part of the levator ani muscle.

The prostate is fixed to the pelvic floor and therefore follows its movement in a cranio-caudal direction.

4.3. Possible Lesions*

4.3.1. Ptosis of the Bladder
A ptosis of the bladder is induced by a ptosis of the uterus.

The posterior and inferior parts of the bladder are most displaced – the strong anterior fixation from the pubovesical ligament holds the anterior surface of the bladder in place.

Bladder ptosis is usually associated with a hypotonic detrusor muscle and results in an incomplete emptying of the bladder during micturition, which increases accumulation of urine residue. This can, in turn, lead to chronic bladder infection.

*PS: a lesion is a functional loss of mobility. The term lesion has another meaning in osteopathy than in classic medicine where it refers to a structural defect in the human structure. Due to the descended position of the bladder in case of ptosis, it is referred to as a loss of mobility under the influence of diaphragmal respiration.

Associated findings:

- Hypotonic detrusor muscle
- Hypotonic pelvic floor.
- Ptosis of the uterus.
• Congestion of the abdominal organs.
• Hormonal dysfunctions leading to general hypotonic pelvic structures.
• Ptosis of the peritoneum.

**Figure 16 - Ptosis of the bladder**

### 4.3.2. Adhesion of the Bladder with the Uterus

Occurs due to adhesion of the peritoneum in the vesico-uterine recess (*Figure 17*).

Often associated with intestinal congestion.

**Figure 17 - Adhesion bladder - uterus**
4.3.3. Adhesion of the Bladder with the Small Intestine
(Figure 18)

Often associated with congestion of the small intestine.

4.3.4. Adhesion Bladder or Prostate with Levator Ani / Internal Obturator Muscle
(Figure 19)

Often associated with:

- Hypertonic internal obturator muscle.
- Hip in external rotation.
- Entrapment of the obturator N/A/V in the obturator canal, which can lead to decreased vascular supply to the acetabulum and caput femoris – a predisposing factor in the development of cox arthrosis.
- Hypertonic bladder.
- Hypertonic prostate (increased sympathetic tone) and levator prostate muscles, painful palpation of the prostate, premature ejaculation, weakness of adductor muscles.
6.2.6. Transverse Mobility Test of Bladder or Test of the Lamina Sacro-Recto-Genito-Vesico-Pubicalis

Two fingers of each (supinated) hand are placed equally left and right of the bladder.

The fingertips are used to push the bladder medially from left and right. The resistance in both directions is compared.

Video 7 - Transverse mobility test of bladder or test of the lamina sacro-recto-genito-vesico-pubicalis

6.2.7. Palpation for Pain in the Direction of the Obturator Membrane (Unilateral)

The knee of the patient is placed relaxed against the hip of the osteopath.

Using the thumb, the osteopath follows the cranial surface of the adductor longus muscle.

In this way a pressure is given in the direction of the obturator membrane. The patient's leg is kept relaxed and placed in external rotation so that the palpation is easier.

The palpation tests for pain. Care must be taken not to irritate other structures in the region.

Video 8 - Palpation for pain in the direction of the obturator membrane (unilateral)
6.2.8. Palpation for Pain in the Direction of the Obturator Membrane (Bilateral)

Both thumbs are placed caudal to both adductor longus muscles facing in a cranial direction. A pressure to cranial is given so that the thumbs deviate lightly medially – in the direction of the obturator membrane.

The test evaluates pain and elasticity.

Bilateral comparison is readily achieved.

Video 9 - Palpation for pain in the direction of the obturator membrane (bilateral)

Video 10 - Palpation for pain in the direction of the obturator membrane (bilateral)
6.2.9. Lift of the Bladder: Sitting Position
Using the fingers of both hands, the bladder is palpated and 'hooked onto'. From this grip it is possible to lift the bladder. This is very difficult and in cases of ptosis, impossible.

![Image of Lift of the Bladder: Sitting Position](image1.jpg)

*Video 11 - Lift of the bladder: sitting position*

6.2.10. Test for Adhesion with the Uterus
The fingers take up as much skin slack as possible and are placed on the anterior surface of the uterus, just above the pubic symphysis.

A pressure to posterior/caudal upon the uterus is used to test the mobility to posterior. If the bladder is adhered to the uterus an abnormal resistance is felt and most likely a light stretching pain.

![Image of Test for Adhesion with the Uterus](image2.jpg)

*Video 12 - Test for adhesion with the uterus*
7. Osteopathic Techniques

7.1. General Techniques

7.1.1. Visceral Drainage of the lesser Pelvis

The patient flexes both hips.

The osteopath cups both hands as deep as possible, caudal and posterior, in the lesser pelvis. The visceral mass is lifted during an exhalation.

This cranial traction is held until the patient feels the traction as a stretch. The patient is then instructed to inhale again (the lift is held).

During the following exhalation the hands are placed deeper into the lesser pelvis.

This technique is repeated until the patient feels no more traction.

During the last phase the osteopath holds the visceral mass cranial and instructs the patient to slowly straighten both legs along the table. The drainage occurs mostly due to the stretch of the underlying fascia – where many of the blood vessels are embedded.

*Video 19 - Visceral drainage of the lesser pelvis*
7.1.2. Muscular Drainage of the lesser Pelvis

The patient lifts the pelvis during a deep abdominal inhalation. The pelvis is held in this position.

During full exhalation the patient is instructed to open the knees (hip abduction) against the resistance from the osteopath.

During the following abdominal inhalation the patient continues to push the knees apart against resistance from the osteopath.

During the last exhalation the patient slowly lowers the pelvis back to the table.

This procedure is repeated up to 10 times.

Video 20 - Muscular drainage of the lesser pelvis
7.2. The Bladder

7.2.1. Direct Stretch of the Urachus
The urachus is palpated and stretched by spreading the fingers apart.
This technique can also be done using both hands.

Video 21 - Direct stretch of the urachus

7.2.2. Stretch of the Median Umbilical Ligaments
The osteopath places the fingers on the topographical line between the umbilicus and pubic tubercle.
A light pressure to posterior is given to palpate the ligament.
The stretch is in a cranio-caudal direction.

Video 22 - Stretch of the median umbilical ligaments
9. About the Authors

Both authors are holders of university degrees, namely the Master of Science in Osteopathy (MSc.Ost. – University of Applied Sciences), and are very active with the promotion and academic structuring of osteopathy in Europe. In 1987 they began The International Academy of Osteopathy (IAO) and are, to this day, the joint-principals of this academy. The IAO is since several years the largest teaching institute for osteopathy in Europe. Both osteopaths are members of diverse professional organisations, including the American Academy of Osteopathy (AAO), the International Osteopathic Alliance (IOA) and the World Osteopathic Health Organisation (WOHO), as part of their mission to improve osteopathic development.

This osteopathic encyclopaedia aims to demonstrate the concept that a proper osteopathic examination and treatment is based upon the integration of three systems: the musculoskeletal, visceral and craniosacral systems.
This e-book is a product of Osteo 2000 bvba.

If you are interested in publishing an e-book or if you have questions or suggestions, please contact us:

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