The Uterus and the Ovaries

Grégoire Lason & Luc Peeters
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1. Introduction

The osteopath is often confronted with patients suffering from low back or pelvic pain associated with somatic dysfunction of the sacrum. The initial osteopathic findings are then connective tissue swelling at the level of the sacrum, palpation pain at the level of the coccyx tip and loss of mobility of the sacrum and the pelvis.

There is often a relationship with the visceral pelvis and the back pain is often associated with the menstrual cycle.

In this e-book the anatomy and the function of the uterus and the ovaries 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. Both the external tests / techniques and the internal vaginal tests and techniques are described.

For the osteopath it is not only important to understand normal anatomy and physiology of these organs but it is also essential to know the anatomical, physiological, neurological, haematological and biomechanical characteristics of a condition, syndrome or disease. Only then is the osteopath able to appropriately assess and influence the regional mechanical, vascular, neurological and hormonal factors. But most importantly this allows formulation of a correct differential diagnosis which provides indication or otherwise for osteopathic treatment. Pure functional complaints can be effectively treated with osteopathy, however, even in cases of structural disease osteopathy can play a valuable complementary role as part of the multidisciplinary approach.

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

2.1. Position

2.1.1. The Uterus

2.1.1.1. Normal Position
The uterus (Figure 1) is posterior to the bladder and anterior to the rectum, central in the pelvis.

The superior side of the uterus reaches to 2 cm above the pubic symphysis in a supine woman (Figure 2).

The corpus of the uterus and the cervix form an angle of 125°.

In a newborn girl the uterus extends out of the lesser pelvis and descends gradually over the years (until puberty) to the adult position.

*Figure 1 - Normal position of the uterus in the sagittal plane*
5.1.4. Congenital Anomalies
Congenital anomalies of the uterus are rare. They occur due to lack of fusion of the canals of Müller during the foetal period. The consequence is that the uterus is of two compartments: a duplex or bipartite uterus. Usually there is no problem with fertility but during pregnancy itself complications can occur.

5.1.5. Endometrial Polyp
An endometrial polyp (Figure 33) is a polyp, which grows within the endometrium. This condition is benign but can lead to bleeding.

The condition cannot be palpated. The polyp can be identified with ultrasound or hysteroscope (intra-uterine observation). Surgical removal is the treatment of choice.
6.1.2. General Tests of the visceral Pelvis
(Video 2)

6.1.2.1. Test 1
• Pelvis central/ventral.
  • Pubovesical ligaments/bladder/uterus.

6.1.2.2. Test 2
• Pelvis central/dorsal.
  • Uterus/Douglas pouch/rectum.

6.1.2.3. Test 3
• Pelvis lateral right.
  • Bladder - internal obturator muscle/rectum - piriformis muscle/congestion broad ligament right.

6.1.2.4. Test 4
• Pelvis lateral left.
  • Bladder - internal obturator muscle/rectum - piriformis muscle/congestion broad ligament left.

Video 2 - General tests of the visceral pelvis

6.1.2.5. Test Criteria
These tests are for pain and resistance.

6.1.2.6. Possible Findings
* If all tests are positive for resistance, with mild pain: a general pelvic congestion is present (Hobbs 1990).

The treatment consists of decongestion of all pelvic structures.
7. Osteopathic Techniques

7.1. General Techniques

7.1.1. Visceral Decongestion 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 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 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 20 - Visceral decongestion of the lesser pelvis
9. About the Authors

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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.

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