Academy of PHYSICAL MEDICINE

Transcript

344R- Men's Health with Gerard Greene

Steven Bruce

Good evening. Welcome to the first of this week's two broadcasts. Thursday lunchtime, we'll be looking at low back pain in adolescents in particular adolescent athletes. But this evening, it's Men's Health, which is under the spotlight. Now, I'm conscious that, you know, this isn't something that we've addressed much in the past, we've had numerous shows looking at aspects of women's health, but I think I can only remember one that looks specifically at men. And it's important in that maybe a lot of specifically male problems. And here I'm thinking of prostate problems, erectile difficulties and so on. They're way outside our remit as physical therapists. But we do need to be brave enough to ask the questions about them, and knowledgeable enough to refer our patients on when necessary. And of course, there are some problems that perhaps we can address. So this evening, we're going to be looking at communication, we're looking at history, taking differentials treatment. And to help me with that, I'm joined by Gerard Greene, a physiotherapist who spent much of his career focusing on male pelvic pain. Gerard Good evening,

Gerard Greene

good evening, and many thanks for the invitation to join you.

Steven Bruce

It's a real pleasure and I'm really looking forward to it. I mean, I'm interested to know you're a physiotherapist and rather like osteo is and chiropractors, male pelvic pain, male men's health so it's not the thing you immediately have associate with physiotherapy. So what's the scope of your practice in that regard?

Gerard Greene

So I spend most of my time split between my physiotherapy clinic in Birmingham and my physiotherapy clinic in central London. And between those two clinics myself and my other colleagues who see male pelvic health, we see probably the main patients we see are those men with male pelvic pain. So that's our their termed kind of male pelvic pain, chronic pelvic pain syndrome. Type three prostatitis somewhat pretended nerve involvement. So probably the big bulk of our work probably 60% or so is male pelvic pain. And within those patients presentation, a lot of that is muscular skeletal. The other thing that that might interest people who are viewing is within that pelvic pain group, we see lots of very fit sporty men, so men who are triathletes, footballers, rugby players cross fissures, people doing lots of training who've got an element of pelvic pain. So they may present with maybe chronic sacroiliac dysfunction, coccyx pain, maybe chronic groyne pain, but then someone picks up that they have got some symptoms, that indicates a pelvic floor component. So they're start to then fit into that kind of male athletic pelvic pain. I'm

Steven Bruce

intrigued by that because as I said, I'm it's not something we would naturally associate necessarily physiotherapy but I mean, our our physiotherapist generally well versed in male pelvic plate pain beyond the musculoskeletal,

Gerard Greene

it's probably safe to say that there aren't a lot of people within physiotherapy who specialise in male pelvic health. I think that the big area within physiotherapy, in terms of pelvic health is female pelvic. So it can be challenging for patients to find someone who specialises in male pelvic health. There are other brilliant people out there who do it. But I think in terms of the profession, you know, if you look at some of the big cities like Birmingham, Manchester, Leeds, Liverpool, Lon, there won't be a won't be too many people who do male pelvic does

Steven Bruce

that imbalance reflect demand, I can understand why perhaps pelvic problems are more apparent in the female population. But does that mean does that mean that there aren't many men who are getting this sort of problem? Or is it just that they're not being addressed properly?

Gerard Greene

I think I think the reason that there are few people who work in that area is historically it was quite, it historically would have been quite difficult for someone like me as a male, to work in pelvic health, because there was a feeling that and this sounds very bizarre to say now, it there was a feeling that you could only work in male pelvic health, if you already had expertise in female pelvic health. So there weren't many courses available to train on. And one of the prerequisites to train on that male pelvic health course, was someone who was already experienced in female internal vaginal assessment. So there was a really a big barrier there for a lot of maybe muscular skeletal physios, or who may be wanting to go into male pelvic health, but they maybe didn't have that expertise and female pelvic health. And so I think one reason there were there wasn't a lot of training

opportunities. That's a little bit better now. But probably we still have a way to go. I think in the in a lot of trend, most physiotherapy training programmes, there is minimal pelvic health, there is minimal female pelvic health and there would be no male pelvic health. So I think clinicians graduate not really knowing that there is probably a role for physiotherapy there. And I think the other probably big issue that maybe physiotherapist fodders is we're not amazing at as a profession of shouting out well, we can help with this condition or, you know, we can help with male pelvic health or male pelvic pain. So I think the awareness within the public of what physiotherapy can do for male pelvic health conditions is on the low side. I was

Steven Bruce

going to ask that actually, I mean, it just occurred to me as you were as you were talking there. How do you make the public aware of what you're how do you market your services as it were?

Gerard Greene

Right. I think To our clinics are probably somewhat unusual in that a high percentage of our patients are referred by other clinics. So we get lots of mail patients referred to us from other physiotherapy clinics. But we also get patients referred was particularly in the clinic in London where there's a high percentage of other claims from we have osteo osteopathic clinics, chiropractors who, who refer patients to us. So those clinicians have picked up. You know, I think Stephens got, you know, he's come to me with, he would one condition, but it looks like he's getting elements of pelvic pain, maybe scroll through pain, testicular rectal pain, so they will then send those patients to us. The other area that we have kind of worked quite hard with is we've done lots of kind of advocacy work for some of the pelvic pain organisations, some of the there are really big patient forums, patient groups around male pelvic health, Padana, neuralgia, chronic pelvic pain. So we've done a little bit of work with those groups in a software to say, well, this is what maybe specialist male pelvic health physiotherapist could do. And then we also have probably a bit like people listening in, you know, we do lots on Instagram, Google, a bit like this, what are the high tech that I'm surrounded here, we've done maybe, so long, short, kind of YouTube clips, podcasts, zoom, just to really promote what we do. So our clinics are really busy, which is good. But for initially, that was quite difficult, because no one really knew what we did. Even a lot of our physio colleagues didn't really know what we did. The public had no really idea that they had a condition that that we could help with. So it's just as much as just taking time. And I think the other thing that links in there is, is men in general, are not fantastic at seeking help. So we, you know, we procrastinate about seeing the GP. And then we also are, you know, particularly if someone's getting maybe ejaculatory pain is a common symptom rectal pain, pain, our pain, urinary frequency. So if men are getting those symptoms, they're generally, you know, they won't discuss that with their friends, whether they're playing squash with them, whether they're in the gym, whether they're playing golf with them, they sometimes don't discuss it with their partner or family. Men, so they're not brilliant at then seeking help.

Steven Bruce

So this is taking me down a thought process of differential diagnosis here, because you've talked about these characters going to a physiotherapist with coxing GOP and secretly itis or groyne strain.

Is it? Is it straightforward diagnosing that there is something beyond those conditions? Or will was it common for people to carry on treating those conditions hoping that the whole thing will clear up?

Gerard Greene

Yeah, so that's a question that people commonly ask. All of the patients who walk through our clinic doors or email for an appointment or ring in those patients have been hit through a lot of intensive medical investigation. So they will have been through Urology. If they've got a rectal pain component, they will have been through colorectal. They will some of them will have been through a spinal specialist and sexual health. So what you tend to see is, all of those patients are coming to the clinic, having been heavily screened. They've been told that you know, the good news is you don't have bladder cancer, you don't have testicular cancer, you don't have a bowel condition. The good news is structurally nothing wrong, no sinister pathology, however, that is good news. But it creates a sense of frustration because this person, you know, they still can't train. They can't get on the bike. It's they can't have sexual activity because it's too painful.

Steven Bruce

So that patients for their pain quite apart from anything else, don't they and being told that you haven't got cancer is a wonderful piece of news, but it doesn't solve the problem that you've got immediately. So does this mean that those consultants the oncologist and so they are sending people to you thinking okay, we can't find anything. Let's send them to a pelvic painting. Yeah. So

Gerard Greene

the criteria really for pelvic pain is that a pair? issue and we're talking about male pelvic pain here that they're getting pain in that abdominal or pelvic area. And the common areas are the is perineal pain. So that's pain in that kind of soft area underneath between the scrotum and rectum. So they're getting maybe perineal pain, they may be getting some scroll skull, penile pain, they may be getting pain in that pubic pubic lower abdominal area.

Steven Bruce

So they want circumstances all the time or only on sexual activity or

Gerard Greene

so. It's as far as like other patients that people see there tends to be a spectrum, however, it tends to be lots of patients tend to be quite constant, some maybe activity based people don't like sitting, cycling is a big irritant. But in addition to that pain, what what moves them into the pelvic pain kind of diagnosis is that they're also getting a combination of maybe urinary symptoms, and common is frequency urgency, they may be getting some mild bowel symptoms.

Steven Bruce

So that again, frequency and urgency for our

Gerard Greene

common one is incomplete, empty, and so someone feels that you're in a bad mood, but it's just not just not easy to finish that bowel movement, constipation, pain or discomfort and bowel movements, and then some sexual health centres, which tends to be the ejaculatory pain,

Steven Bruce

what's the physiological process behind all that.

Gerard Greene

So what you tend to what you tend to get is, you tend to get a big pelvic floor component. And what what that a lot of men don't really have any insight that there is a pelvic floor in there. I think people generally know a little bit about the female pelvic floor, and this is the public re rather than than a professional setting. So so most men are not aware that there is a pelvic floor in there. And that pelvic floor has a role in bowel function in that a loop of it that that pubic talus wraps in around the rectum to form that external anal sphincter. So if that becomes overactive sensitised, it will create pain there. And it will also affect bowel function. And we know what the front the urethra, that kind of small kind of tube from the bladder passes to the front of the pelvic floor, and the pelvic floor wraps around that urethra forms that outer external urethral sphincter. And certainly in men that doesn't have too much to do, because we've got our prostate sitting above it, we've got some smooth muscle fibres within that prostate. But if that pelvic floor at the front becomes a bit overactive, it can cause too much pressure on that urethra, you start to get some urinary symptoms. And then finally, what I think men definitely aren't aware of is the pelvic floor attaches into the base of that penis. So we've got a big bobble muscle on each side, got an issue or muscle, the balloon issue, Kevin notice, so those muscles attach into the base of the penis, and they work really hard to maintain that direction. to kind of keep that tumescence keep it kind of nice and firm. They anchor it, and they work quite strongly during ejaculation. So if those muscles are overactive, working too much sensitive, that can cause that ejaculatory pain. And I think finally, it's a bit it's a bit like if we have you know, if people who are listening or seeing maybe lots of office workers who maybe get lots of spasm over activity in their upper traps or neck muscles, those muscles will become a little bit you know, starved of blood a little bit hypoxic, acidic cause pain, and they may cause maybe local referred pain. And the same with the pelvic floor, that's a muscular structure. So that can cause either local pain in that perineum, rectum or referred pain.

Steven Bruce

So what is what do you think is causing the over activity in the pelvic floor?

Gerard Greene

So what you tend what you can get is with some of the younger sporty patients, you can get over activity due to maybe a change in exercise so that they're doing more kind of abdominally driven exercises a lot heavier exercises in the cyclist is probably a more of a direct mechanical issue and you get pain to those sit bones. You can get a little bit of irritation of that potential nerve, you can start to get pain that where you start to get then this protective spasm secondary to that in in the peep in the very the typical pelvic pain patient is probably our edge Steven You know, kind of mid 40s, optimistic there, maybe late, late, you know, late 40s, early 50s very flattered to, um, to anatomy as well, to maybe you know, late 50s. So with that it's it's people who are maybe sedentary, sitting, doing sitting, lots of sitting at work sedentary, a bit more stress, anxiety, lots of sympathetically driven nervous system, which causes this secondary pelvic floor over activity. And you also get people maybe who've had maybe some urinary bowel condition, and of course, secondary to that.

Steven Bruce

Okay, can I just get to a specific that's coming through one of our questions, before we go on with some more of this. Charlotte asks, If you have any advice on proctology, a few jacks in a nine year old boy, which he's had since he was two. And I want to first of all, I don't know what that is. So

Gerard Greene

that's really for you getting some rectal pain, and some pelvic pain, I think, I think with children, and it's interesting, someone has asked about this because it can be difficult to find people to treat some of those children with, with a bowel and bladder condition, what you tend to, and that's not my area of expertise. But I'm, as I said, to see, even earlier, I'm fortunate to work with a brilliant lady Lisa, who sees those children, what you look at in those children is bowel pattern. Because what can be driving that condition is a pattern of constipation. A pattern of stool holding, which causes pressure in that rectal area, which also transmits to the bladder causes bladder symptoms. So what you tend to do with that child is look at, they will do a bowel diary, they will probably do a bladder diary, you also look at their toileting position. But that's what that really looks like is you try and get them into little bit more flex position on the loo feet, and students are almost in that kind of pseudo squat position, you get them to do lots of pelvic floor relaxation, which is lots of gentle breath work. And what how my colleague does that in clinic is they stick an ultrasound probe in their lower tummy. So you can see the bladder and with nice, relaxed belly breathing, you can get really nice, they can see that bladder moving up and down. So that so you can get them kind of doing fun things with the ultrasound. And then what you also look at in those children is what their passion of physical activity is. And that can be different. Because if kids have constipation, urinary symptoms, their level of energy can be quite low, which means then their level of muscular tone is quite low, which contributes to it. And then I think what they also do is look at the General Dynamics in house because I've got four children, myself, and though they're all come teenagers now, but you know, my daughter at one point, kind of very mild urinary symptoms, a lot of anxiety on it. And and that kind of generates quite a lot of stress in the house. So they kind of look at that as well.

Steven Bruce

Okay, so getting back to the more general talking about patients coming in to your clinic or any of the other related clinics, is it a standard part of your history taking to ask questions along the lines of the things you've discussed so far? Yeah.

Gerard Greene

The most important part of this patient assessment, is that really detailed, subjective or questioning, and that's why we don't rush these patients, we try and see these patients for a minimum of 90 minutes the first time. And because some of these patients might be travelling, you know, fair distances, maybe two, three hours, we will then see those patients for two hours. Now. What what what I like to do with oil longer if they've travelled further, it's just it's a bit like me getting here. It's in case anything happens on the way take your allocated that time just to take the whole stress out of that appointment. And also, it may be that they are not because they are travelling further do not it's going to be a bit more difficult for them to come back for lots of appointments. Yeah. So getting back to the question. I think some key things that I want to know is well, you know, what does this person do? And how is their condition affect them? So it may be that, you know, two years ago, they were training, go into the gym, hillwalking, having fun with their kids, their partner or go on a nice holidays. And that's all stopped. You want To know that that kind of change in activity, and then we want to know, you know, is, is Does this patient have pelvic pain? So, you know, the people listening will be really used to doing your body charter patients in terms of back and neck pain patients. So what we want to know is, well, you know, are you getting, you know, where are you getting that pain? And then we will go into a bit more data? Well, you know, are you getting any in that kind of perineum? Are you getting any at the front? So, you kind of start with the not too much the safer is with the areas of people are easier to find easier to talk about? And we might say, well, you know, are you getting any kind of tailbone or back pain or in Iran, those sit bones? And then we will say, Well, you know, what we find is common with this as people might get scrotal pain? Are you getting that? Are you getting any pain that feels like it's inside the back passage, your rectum. And we know with patients that pain at the tip of the penis is common, is that something you're experiencing? So some patients will be will forward that information freely. Whereas some patients, maybe first appointment, they're a bit anxious, high levels of stress. So we're a bit we kind of, you know, warm, warm things up with them. But what we also really want to know is, are they getting your enri bawal sexual health related symptoms? And I think it will be interesting to see what the people listening feel is, if you say to most men, are you getting urinary symptoms? That probably means them well? Am I having maybe Am I having to get up at night? Well, I'm not having to get up at night. Am I leaking? I'm not leaking. So a lot of those men will say, well, actually, I might. I'm merely here for the pain. So so some patients, they're not getting very obvious, you're in response, we will say to them, okay, well, has there been a change? You know, are you having to urinate maybe every hour? Are you having a sudden urgency to urinate? Does it take a bit longer to initiate? Which is hesitancy? Are you getting any mild kind of droplets after which is post void? So sometimes the patient initially might say, Well, I'm not getting urinary stuff is fine. It's the PNM however. But then when you dig a bit deeper, do a bit more detective work, you find actually, they're starting to fit into that box of urinary symptoms, and bowel even more. So you say to people who haven't any bowel Sims, and they can sometimes process that well. Am I leaking or not leaking? But what we're interested in is, well, are they getting? Are they having to strain? Is it uncomfortable? Is it Do they feel like they can completely do a bowel movement. And then the big one we ask patients about is flare of post sexual activity. And how we so a lot of my dear is talking about what happens after ejaculation and I think we all know what happens after ejaculation. It's a great thing. But so I will say to person, you know,

well, we know that probably about 60 70% of men with pelvic pain, get a flare up post ejaculation, you know, is that something you're experienced? And they'll go actually, yes, you know, it's it's much worse for a day or two or, you know, that perineal Rector penance flared up. So, we and then we also ask, well, you know, is there a change in erectile function. However, the kind of good news is, most men with pelvic pain have good erectile function, except it causes lots of pain,

Steven Bruce

right? But pain, not necessarily in the penis itself. It could

Gerard Greene

be the European Court. So it could be that it could be that it could be a groyne pain, it could be a coccyx, it could be rectal, it's really the European. So you get so we, we hear lots about fear avoidance with back pain. So I've got back pain, I'm not going to bend down and pick that box off the ground because my back might explode. So you get fear avoidance, whereas these men get fear avoidance over kind of masturbation, sexual activity with someone else. Right. Okay, because it's really, because it's really, so this isn't kind of, or I'm getting mild discomfort, because I've had sex or I've masturbated. That's gone in five minutes. This is this is a buildup of significant pain that lasts maybe several hours a day or to to the point where paper thinking I'm not doing that again for a while because that's bloody painful.

Steven Bruce

I don't want to belabour the communication aspect of this but I just wonder whether you find when you're Training practitioners in this area? Do they themselves have problems asking these questions of patients? Because I certainly just after my qualification or during my training as an osteopath, you know, you'd ask the standard questions, as you said, are your bowel and bladder? Okay, yes, okay, fine. Move on, or your new hospice is no more specific than that? Is it? Is there a sort of a skill to asking those questions sensitively of a patient?

Gerard Greene

It initially, it is something that people find difficult. And what I think helps people initially is, there is an NI hitch questionnaire. So that's the national institute of health questionnaire. So, sometimes we say to people, well, as you're getting used to us to asking these questions, if if you feel you know, you've got someone with you, or you, you've had a patient who's thinking like, that sounds like that pelvic pain thing that I read about. But I'm not, I can't really, I'm not sure if I can ask about pain on masturbation. So what you could do is, you know, download the NIH male pelvic pain questionnaire from Google, and say to them, you know, I'm just just based on some of the symptoms you getting that we that you've, you know, do you want to just fill in this questionnaire, it just asks you a little bit about urinary symptoms, but symptoms with sexual activity, but your pain? Do you get them to fill that in? And that's something that that asks about, are you getting pain in those pelvic areas? Are you getting urinary symptoms, bowel or sexual? So that's a nice, soft way to introduce it. It's a bit like anything. Once you start to ask those questions, you relax into it. And then the patient gets

comfortable. However, the the patients I see, there have this kind of huge sense of relief, that someone is finally spending time asking about the different components of their condition, and starting to link it all together. So they're starting to link the pain to the urinary symptoms to the, maybe the bowel ejaculatory, particularly some of the patients that all of you will see, particularly those sporty men, you know, the sporty guys, you know that you know, that currently, I've got a 1500 metre runner, an elite runner, now he's getting in terms of pelvic pain, he's getting mild symptoms, he's, you know, he's still training at a high level 1500 metre running. But the symptoms are significant enough, that he's missed a lot of competition. So for him, they're very significant symptoms. He's getting really deep pelvic obturator area pain, which is really limited his training. So with him, asking those questions are still relevant. And, you know, some of the footballers, some of the weight lifting guys, they get the they get the symptoms, they get them much milder. But sometimes that NIH questionnaire is is a is a nice entrance to task and ease question. Simon

Steven Bruce

sent in a question asking your opinion on the link between diabetes and penile pain. In his opinion, he says it's largely ignored. Yeah.

Gerard Greene

So I think what the patients with diabetes are at risk or have a high risk of erectile dysfunction. So that's one of the big risk factors for erectile dysfunction. They also have a high risk of neuropathy. So what those patients can get is they can get a combination of erectile dysfunction, and lack of penile sensitivity. And they can also get penile pain. But I think because some of those patients have lots of comorbidities. I would agree with Simon that the penile sensation, penile pain, erectile dysfunction is kind of lost.

Steven Bruce

Is there any hope for those patients if they've got an underlying comorbidity like diabetes? Is it something that can be done for him to help?

Gerard Greene

Yeah, so that's starting to get into the into that kind of area for erectile dysfunction. So I think probably the most important thing we need to we need to be aware of what erectile dysfunction is that it can And a bit bit like Simon as always, it can be indicative of something else going on. So if someone presents with onset of erectile dysfunction that can indicate heart cardiovascular disease, because those those penile arteries are kind of small circum ferns, they tend to be some of the first arteries that are affected by heart disease. And my my good friend, Dr. Joel milliers, who's a, an amazing Men's Health physio in Perth in Australia, she's got a great face that heart health equals heart health. So it's, it's picking up while this patient is reporting erectile dysfunction, you know, have they been screened for cardiovascular disease, diabetes? Then, to answer your question, what those men you look at those men in terms of lifestyle, and that's the difficult one, so it is relatively straightforward to prescribe those men for their GP, low dose daily Cialis or to Dad filled, so that's

one of the erection modifying drugs, the so that so those men should be on low dose Cialis or to data fill spot five milligrammes per day, some of them will benefit from using a vacuum pump. So the vacuum pump is, is a is a kind of a device that, that creates the hubs, it helps create erections, you try and use it maybe four or five times a week, and it almost replaces those housekeeping nocturnal erections, morning erections.

Steven Bruce

I'm glad you didn't bring one in to demonstrate.

Gerard Greene

So as Jack, who's sitting to the left, who was who was almost heading out the door, in terms of in terms of erectile dysfunction, the medication is relatively easy to take vacuum pumps, some of the older men get on better with them, right? The difficult thing is looking at lifestyle, smoking, alcohol, BMI, visceral fat, abdominal fat, exercise, levels of stress. And those are the things that people sometimes find it difficult to engage with.

Steven Bruce

I imagine it is because I suppose everybody's, everybody's now well versed in the fact that smoking is bad for your health, generally, unless people are smoking. So if you're a smoker, you're obviously not going to change your way I would have thought because you, it's hardly possible to create more information about the perils of smoking, drinking, maybe more difficult to overcome, because it's a social thing. But you can probably address that there have been people who are clearly drinking too much. Exercise I always think is a difficult one, because we always say exercise is good for people. But it's not as though it happens straight away is it and that means you've got to go do something and patients don't like in many cases having to do something they'd rather it was done to them or for them.

Gerard Greene

And I think what exercise and I suppose I can speak from experience here, because I'll put my hand up here. Up until the start of December. I did. I had two years of doing nothing. I played golf, but you know, not a huge amount of golf played maybe 18 holes once a week bit more in the summer. But for two years, I did nothing. And I kind of knew I knew I should be exercising. And I was telling my patients the benefit of exercise. But then I noticed that, you know, I was putting on weight I was putting on that kind of middle aged Tommy probably wasn't eating well. So then eventually I procrastinated and then started in December. And I know do maybe three four sessions a week, but it's probably taken two months to start see the difference. So it's it's it's difficult to do it because it's it's the benefits tend to be down the line and we're protected with erectile dysfunction. The benefits are way down the line.

Steven Bruce

Yeah, we could probably spend a long session just talking about strategies to get patients that comply with that sort of thing. Simon has got another question. He wants to know the link between ejaculation and piriformis spasm says he's asking you on behalf of a friend as you said patient sorry. took him a long time to actually disclose this. So I know I'm not surprised that that's especially if you come to a physical therapist. It's not the sort of question you're expecting to be asked for information you want to devote it. Why are we going to shy about revealing problem why are we men I think he means here so shy about revealing problems with a pelvic area.

Gerard Greene

I think A brilliant question. I think the the link between ejaculation and piriformis is a very muscular one. So when you look at that pelvic floor, so that pelvic floor is kind of one kind of big, muscular sling internally, that's got different components. One big anterior component is that Balbo spongiosa muscle that attaches into the base of the penis, it's a big fleshy muscle, you've got the issue coming in. So that front part of the pelvic floor is intricately involved, it's really active during erectile function, as is the rest of the pelvic floor, which, which then brings in that obturator internus. So when we palpate internally, don't go when we palpate, internally, that lateral wall of the pelvic floor internally kind of medial to that that obturator foramen, is made up by the the kind of muscle belly if obturator internus, which is one of those lateral rotators of the hip, as is the piriformis muscles, so they kind of work together. So if someone has either maybe pelvic floor over activity or spasm, some pelvic floor discomfort, what it erectile function works those muscles very intensively, ejaculation pushes them to works the fast twitch fibres more, so that it's just that it's almost that it's flaring those muscles up. And that's why people commonly post ejaculation we'll get some of that either perineal pain or posterior hip pain, or kind of that sit bone pain. So the link between ejaculation and piriformis pain is a very mechanical one. And I think when it's explained to the patient, they see it, that it's that it's muscular related. And the way I like to explain to the to the patients is that, you know, if someone has a calf muscle problem, you know, if you get if they're kind of jogging or walking, that's the slow twitch fibres, so the slow twitch fibres in the product or working hard during sexual activity. And then if someone breaks into a sprint, that's the fast twitch so the ejaculation is the kind of Sprint bit, or if they're trying to control ejaculation, if they're, if they feel that I'm close to ejaculating, but I want to, I want to delay that they'll work those fast twitch hard. What you also then what you also try and find out is you kind of delve a bit more deeply and well, what are they actually doing in terms of sexual activity? So it's a bit like if someone comes in with calf pain and running, we would probably ask them well, what are you doing? You know, are you running? Three times a week? Are you running once a week? Are you running? Are you doing hills? You doing flat here and sprinting? So the same again, we just we lock on it as another activity? So we find out while you know, Is it painful when they're masturbating?

Steven Bruce

Have you ever had any kickback from patients being asked questions like this? And we think what the hell you asking me questions? No,

Gerard Greene

because I think I think what I think what we all have, what we all as clinicians have is probably good intuition. And we can build rapport. So you know, if I've got a patient, if Stephen is the patient, and Steven looks really on edge, so Stephen is not making eye contact, he's fidgeting a bit. He looks he is displaying a lot of stress and anxiety. And if I'm asking him about the pain, and he's been a little bit reluctant to answer those questions, and he's looking down and he's not making eye contact, I will kind of pick up he's not going to be happy talking to me about sexual function. So I would probably then leave that to the next appointment. So it's definitely and that's as long as that's clinical intuition. That's, that's, that's deciding Well, what's that patient going to be comfortable with me discussing? And that's a bit like we get we see lots of couples. So that may be a male patient with their female partner, their wife, it may be a male patient with their male partner. And similarly, you you develop intuition as to what these people are happy to discuss with. So you get some couples who are happy to discuss everything So you can see that you pick up that if I ask Stephen, about sexual activity, ejaculatory pain, that he's him and his partner are going to be happy about that. Whereas if you pick up that there's, you know, there's a bit of a divide here a bit of stress. Things aren't maybe brilliant here. You know, sometimes you see that with patients, They bicker in front of you over simple things, then you're thinking, well, I'll ask those questions when I've got the patient in the room.

Steven Bruce

Okay. We're gonna do some practical in a second. But before we do that, Joe has asked whether you've got any advice about a patient who has constant severe UTIs and I'm assuming he means a man.

Gerard Greene

Right? So without making an assumption, but I will usually, those men may have been screened for UTI so sometimes they can get symptoms of a UTI. But their urine test is negative. So they have symptoms of urethral discomfort bladder pain, pain on urination urine so they're getting symptoms of a UTI. Yeah. But they're their clinical tests are negative.

Steven Bruce

So juris patient could have been screened ones knows what the symptoms are, and is now inferring that this is a UTI. So

Gerard Greene

really hot day what what that patient needs they do need, they do need to go back to the GP, they definitely need to go back to GP and get, you know, they need to get urine testing bloods done to make sure that there isn't either a urine, bladder, prostate infection there. Yeah, so we will, we'll assume that the patient probably had that dogs usually patients with those symptoms, they'll go to their GP, they don't tend to come and see someone like me or or an another osteopath or, or physiotherapist. If they've, if they have an infection that needs to be treated, but someone's with recurrent infections, they need to find a urologist with the expertise in that recurrent UTI, rather

than maybe just being purely GP managed. If their tests are negative, which is probably the more of the patients I see. So they're starting to manifest symptoms of maybe bladder pain syndrome. So they are getting a type of pelvic pain but it's more urine refocused. So they may be getting urethral pain, they may be getting bladder area pain, they may be getting frequency urgency, they may be up at night. So that tends to come in to you do a bladder diary with them, you work out what their input is, what their what their drinking volumes, how many times avoiding, they may need some bladder retraining. And then they may need some pelvic pain type work, which is some of the pelvic floor type treatment. Okay.

Steven Bruce

Right. Now that we've had all this discussion about prostate issues and internal examinations, we've got a very nervous model on our treatment, we should go over and put his mind at rest perfect. After you

This is Jack Jack is one of our regular models here. And I'll leave you to talk about how you would go about assessing him. Right.

Gerard Greene

So I think a really important point to make is when you assess a pelvic pain patient, and let's maybe focus on that, that younger, active or that kind of athletic pelvic pain patient that the patients that you that you will see. So that assessment probably is composed of two main aspects. A lot of it is muscular skeletal. A lot of so a lot of that is is kind of things that you would be doing anyways. And so that's the muscular skeletal component that we'll talk through. And then what you add on to that is the pelvic health component. I always say to people, and the person who trained me was an amazing woman, Dr. Ruth Jones and Southampton and Rhodes background was muscular skeletal physiotherapy, muscular skeletal sports, and then she went into pelvic health. And she always said, it is much easier to train the muscular skeletal clinicians and bring them into pelvic health because they've got the skills. They can do the spinal assessment. They already know how to do the hip assessment. They can do the SI joint assessment They've got good hands. So

Steven Bruce

generally they've got longer with their patients than your average GP has as well. Exactly, exactly.

Gerard Greene

And they're used to doing that, you know, those of you listening, who see patients, maybe with chronic low back pain, chronic hip pain, chronic, you're used to taking quite a detailed history, and you're used to managing complexity. So, big thanks to Jack for coming along. So what we would do with Jack initially, so you know, we'd initially do some spinal assessment. But I think because he's coming to me as a pelvic pain patient, the spinal assessment that I would do, will be quite a small component compared to what you would do in a low back pain patient. And one of the reasons for

that as we want to really, in our assessment, focus on a bit more time in some of the pelvic health. So just to tell you what we would do in terms of spinal assessment, I would have a good luck at Jack's kind of lumbar spine movement. So doing these kind of your flexion extension, so flexion, I would want to have a look at his thoracic spine. And the main reason why I look at his thoracic spine is in a minute, we're going to see what his breath pattern is like. And obviously, for that good belly breathing, abdominal breathing, you need kind of good thoracic expansion. And also, what I want to do is have a general look at his hip movement. So that's just doing his, you know, hip flexion rotation. What you find with some of these pelvic pain patients is, is there can particularly the patients who've had lots of pain for a lot of time, is there can get deconditioning. So if JAXA pelvic pain for two years, and he's not doing, he's had to give overalls training, and he's not playing football, he's not going to the gym, it is likely he may have developed maybe some secondary lumbar spine, hip stiffness, thoracic stiffness. So that's, that's what some of the muscular skeletal assessment looks like, looking at lumbar spine, thoracic range of movement, hip range of movement, when we get into when we start to get into a bit more of the the pelvic health aspects, what you find with pelvic pain patients is that they can have a lot of abdominal muscular referred pain. So patients with back pain, if I palpate. With a patient, I'd have this lifted up and we can leave it down because we're on the camera. So if I were to palpate in two, that kind of rectus abdominus, that right and left rectus abdominus. So if I pop it in here with with Jack's, we could find maybe that linear midline, find that left direct. So if I were to palpate into that muscle belly, that should feel, you know, relatively soft, comfortable. And it might feel like a bit of light local pressure. And what I'm really doing is just going into that rectus right and left, what you find with some of the pelvic pain patients is there get some of that abdominal referred pain. So particularly if it's, let's say Jack symptoms are very left sided to the side that I'm on. And Jack's getting maybe left sided perineal pain, so in that soft area underneath, he's getting left sided scrotal pain, and he's getting maybe left groyne pain, so he's very much left unilateral pelvic pain. So when I palpate into that left rectus, what I may feel is real areas of resistance. And as I press in, what's common is the so I'm feeling resistance, I'm feeling that there's a little bit of local kind of spasm contraction there. And sometimes what the patient reports is when you palpate they're getting either increased symptoms or reproduction of those symptoms. So I could press in here, and this might give Jack some left sided scrotal pain, or maybe left sided perineal pain, but if I do the right side, I'm not going to move to Jack's right side or the people who will wrestle me to the ground. Whereas if I do the right side, it feels very soft, asymptomatic. And why does that happen? We're proud of it. And the reason that it's thought that there's a bit of maybe visceral referral mechanism. There are also some degree of central sensitization so you're getting a little bit of validation, you're hyperalgesia so

Steven Bruce

when you're you're palpating. Are you feeling a sort of a general resistance there or is it more of a trigger point type?

Gerard Greene

Probably more that kind of localised trigger point resistance. Okay, but what you what you are looking for is, is this either increasing those pelvic symptoms? Or is it producing them?

Steven Bruce

So I may be getting ahead of myself here because you may be covering this. But we've done as we you and I discussed before we went on and we've done a number of trigger point related dry needling courses here. If we were to needle that trigger point, are we likely to address that with it? Yeah,

Gerard Greene

and death. And this is, this is where you know, all the muscular skeletal people listening and the people who've got either good hands, they can do good soft tissue work and start to treat them, or the people who've got dry needling skills. So that's where you can start to target some of this pelvic pain without having to go into that perineum without having to go internally. What we also look at it in in a bit of detail is palpating, that pubic symphysis. So the pubic symphysis is is important to us, because posterior to it, you get attachment of that pelvic floor. So what you tend to find is a lots of men, lots of patients will get pubic discomfort, or pain, but it will maybe then relay it down and underneath. Lots of those men won't be able to wear a belt, they won't be able to wear like a suit trousers. So they are the men where they're happy working at home, because they can wear loose shorts to trousers. Whereas the day they've got to go into the office, it's quite uncomfortable, because because if they don't like that pressure around the waist, so they're getting that real kind of Allah Denecke response. And what you find there is when you move down, so I'm just in the midline here. And then as I move down, onto that pubic symphysis, I'm applying just very gentle pressure. And that should feel just like pressure. So what I say to patients is I tend to palpate, maybe tibial tuberosity. Okay, this is what it should feel like, light, pressure. And then I'll go in on that. pubic symphysis and what you find with some of these patients is that when you press in, that it's exquisitely painful. And what it may also do is affect the pain in that, whether it's perineum, whether it's that that bladder area, whether it's that rectal area, or let's say with Jack, we've decided he's got a unilateral presentation on the left. So if I go to that, right, pubic tubercle, nothing really left quite painful for quite a difference. And the way I kind of explained to these patients is that, you know, if someone has a calf problem, they can get lots of tenderness along their heel calcaneus because of the attachment, or some of those very sporty teenagers, they've got like, an Osgood. Schlatters they've got lots of problems with that quads muscle, they get lots of issues. Not ischial tuberosity maybe a tuba so I'm glad we're not doing the knee. The tibial tuberosity so it's a bit like it's it's tenderness, sensitivity secondary to that attachment. A bit like there can get symmetry with the coccyx. And what we what we would do palpation wise is we would palpate that circle and also that coccyx posterior only if we had jaggedness front. But I think where the coccyx fits into this, the coccyx, if they're getting coccyx pain, or a coccyx tenderness on palpation sometimes that can be secondary to what's attaching to it internally. Because it's not that they're presenting with just coccyx pain. You know, they're presenting me with coccyx pain scrotal penile pain, urinary frequency bowel. So it's kind of part of the picture. Now, what patients really like is we can initially examine that pelvic floor externally. And how we do that is we use ultrasound imaging. So with ultrasound imaging, if you so it's a bit like the imaging that's used during pregnancy, so you pop that ultrasound probe, lower abdomen kind of just just above the pubic symphysis. So if I had that, which I should have brought, you have to admonish me for not bringing it but maybe the next time I'll bring it. So if you put an ultrasound probe on here, that gives you on the screen big picture of the bladder and We can, when you do a pelvic floor contraction, the base of that bladder will elevate. So on the screen you can see the bladder. If jackers do big pelvic floor contraction, heat, the base of the bladder would lift up. So that confirms to me, he's getting a contraction, it should relax, contract, relax. If it's overactive, you get less movement in it. So you get less movement, or no movement. So that's a way

that that I or one of my colleagues can initially assess Jack's pelvic floor externally. So I think one thing that's helped bring people from the muscular skeletal world into pelvic health is initially they can use that ultrasound imaging to assess that pelvic floor externally, and patients like that, I think that we that they can see what's happening internally by just doing that trans abdominal scanning. So

Steven Bruce

sorry to interrupt you there. But are you saying that for your work, ultrasound scanning is an essential tool? Or can it be done without because I my own experience is that it's a great tool, they're within the budget of many clinics now, but you've still got a lot of work and be able to interpret what you're seeing on your screen? Yeah,

Gerard Greene

I don't think it's essential. But it's really useful. Trans abdominal scanning, is relatively straightforward to do. Because all we are doing it all we're doing it is as part really of biofeedback. So we are not, we're not looking at is there a bladder pathology, we're not looking at the bladder neck, we are looking at, can this patient easily contract and relax that pelvic floor. So the the, the level of skill for trans abdominal scanning is relatively low, because it and it's definitely not diagnostic scanning, okay. What we would get jack to do with the ultrasound is, so if you just bend the knees up, so and you can do this at home, you can do this at home, or wherever you're watching. So the pelvic floor has got fast fibres, so fast twitch fibres, and slow twitch fibres. So with a patient who's got pelvic pain or athletic pelvic pain, we want to see, can they contract both types of fibres? So what we want and we want to really work out, you know, can they do that posterior really. So that's around the back passenger rectum, and can they do it front. So in males that's around that kind of urethral sphincter that bulbar muscle. So you're at home, what you're going to do, first of all, is some fast twitch, rectal contraction. So this is where you're going to squeeze around the back passage, really strong and quick. Let go. So you're going to do 10 Of these, you're going to squeeze, let go, squeeze, let go, you're gonna do 10 of those. So we'd get jack to do 10 of those. And, and I would look and see what's happening on the screen. But I also want to know what what's happening with with Jack. Now most of you at home, when you do that contraction, it shouldn't be painful. With the pelvic pain patients it is it can be painful, or they can say well, actually, that's given me that feeling of scrotal discomfort, that's giving me that feeling of the golf ball in the rectum. So we're seeing really, when they do that fast twitch rectal contraction, Is it painful. And it shouldn't be when you're doing it at home, you should probably be able to do a contraction and let go. And then contract and let go. What you find with the pelvic pain patients is after they've done a couple, it's much harder to relax the muscle. So what they tend to describe as well, I'm not I'm not really sure what I'm doing now I'm trying to relax, but I kind of feel I can't. So they're kind of stuck in a bit of no man's land. And what you tend to see in screens, you get this lack of movement. We also want to see what's happening when they do that that endurance activity. So what I'm going to get you to do this time is use let's still squeeze around the black passage, but you're going to do a lighter contraction. When you're going to hold for maybe 10 seconds, so lighter Squeeze and hold for 1010 seconds. and let go. And then just squeeze again. And let go. Now similarly, with Jack, those of you at home, that shouldn't be painful, some of you might find it easy to do, some of you might find it difficult. But it shouldn't be painful for these patients, it can be painful, it can cause discomfort, or it can give them a feeling of going into spasm, or a lack of endurance where they can't maintain that

contraction. So that indicates that there is some degree of dysfunction there. What we also want to know though, is well what's happening with those anterior muscles, those anterior pelvic floor muscles. So those are that they're part of the pelvic floor. That's, that's more involved in urinary symptoms. And that's more involved in those ejaculatory type symptoms that Simon mentioned with his patient. So the same again, what we want the patient what we want the patient to do, and you can, you can kind of do this at home as what you're going to visualise is that you are trying to that you're mid flow so that you're urinating, and that you're going to squeeze at the front to stop mid flow. So you're going to squeeze at the front and let go. So that's kind of activating that urethral sphincter, so you're urinating, you're going to squeeze at the front. Let go. Once you feel you've got that, what you're then going to do is squeeze at the front again, and this time for the male people listening, you're gonna imagine that you're lifting the scrotum up. So that brings in that Balbo issue muscle. So the phrase we use with the men that they seem to really get is is not to Gods, that's kind of my friend Joel Miller says razor nuts to God. So they're doing this lifted front. Let go, we want to see what what happens when they do this fast twitch contraction. So we get them to nice strong from contraction, let go front contraction, and there should be a clearer contracting, relaxation. And the same again, when you're doing it at home. It should that shouldn't be painful, so that you know for the male people doing or even the famous so that shouldn't give you scroll. So Falvo pain shouldn't give you pain in the perineum, it shouldn't be like the whole thing is going to go into spasm. And there should be a clear difference between when you feel it's contracted and relaxed. And then we would do the same with that small slow twitch, we will get them to do just a lighter contraction, little bit lighter. nuts to Gods hold for 10 Nine, eight, don't zero,

Steven Bruce

I hope you're doing all this clever, we got a modelling to demonstrate money well

Gerard Greene

spent. So what So we're looking at so when I'm doing this, I'm going to talk Jack through it. So I want to know what he's feeling experiencing. And then I'm lucky in on what's happening on the ultrasound. But if you're doing it, you you, you know you you can just get feedback from the model. And the big thing is shouldn't be painful. The key things you want from the patient, is it comfortable or not? Can they feel the difference between contracted and relaxed? That's the second it's the first thing you want to know. Is it comfortable or not? IE is a painful. Second thing. Can they feel the difference between contracted and relaxed? And then the third thing is can they feel the difference between contracting it at the back and front? So if you're asking them to contract you're on the front can they actually feel it at the front?

Steven Bruce

When you're assessing the front? Are we still getting the same response on your screen

Gerard Greene

here with a little bit less smaller muscle a bit less but you still get the lift? Okay. Where are you can take this further with the with the with the ultrasound as you can then do what we do with some patients is trans perineal ultrasound. So that's still Steen externally, but you put the probe you cover it, you have gloves on you rest the probe and the perineum and that allows you to visualise in much more detail What's happening at that anterior front and posterior pelvic floor? Now, people probably won't probably want to know, well, you know, when do you decide to do some internal examination? So don't worry. Yeah, we're not doing it tonight. So that decision to really based on how the patient presents, so if someone comes in with full blown pelvic pain, and they know they have pelvic pain, you know, they've they've been researched it, they've contacted clinic, they've said, you know, I think I've got pelvic pain. You see them, they know a lot about it, they've got like pain, bowel, urinary, they've got everything they can sit. So with that patient, at some point, they would benefit from having that internal assessment. But those those generally the patients who come into clinic, knowing that they're going to have that and wanting to have that, because they want that detailed assessment of that pelvic floor,

Steven Bruce

sort of curiosity, what in your profession, what is the consenting procedure for that in hours, we have to give them 24 hours as a sort of a cooling off period from knowing that we want to do an internal investigation treatment.

Gerard Greene

So within physiotherapy, it it it depends probably within the NHS, there's trusted trust variations, some have written content, but most its verbal consent. And within private practice, and physical, it's generally verbal consent. However, the consenting process takes place at different stages. So it's a bit like, if when, when Stephen and I were sitting down, let's say I was asking him all the questions. So I'm Stephen is very clear, pelvic pain pattern, he's been in touch with us with the clinic pre. And I might say to him, okay, it will save and what we're going to do is we're going to do some assessment, we will do some of the ultrasound assessment. And, you know, I think we will, it will probably be a good thing to examine you internally. That's really to confirm what's happening with those internal structures. But we can talk about that as we do the assessment. Is that something you're happy with? And Steve, Michael? Yeah, that's what I, that's what I kind of assumed we would be doing. So we've started to broach it there, then I get them on the plant. And I say, Okay, I'm going to do the ultrasound. This is what I've, this is what I found, I think what it would be good to do is to do that internal rectal examination. The reason I'm doing that is to really assess that internally, that external internal sphincter, that deeper pelvic floor, that obturator internus, some of those, those superior muscles, are you happy for me to do that? That's consenting again, then I would. And when we do the internal assessment, we do it in supine in this position. So the patient is very much part of that internal assessment. So if I was doing an Jack, he, he would have his knees bent up towel over him, he would scoop up in the scrotum. So I would see the perineum in lope. Name, and, but Jack can see me, I will explain to him this is what I'm going to do now. Are you happy for me to do that? So you've probably consented them about three times.

Steven Bruce

Be interesting in our profession for we have to get written consent for intimate examination or treatment. Profession. Yeah, everything else oral consent is, is acceptable. We're gonna run out of time shortly. I've had a question. And then if

Gerard Greene

you want one last thing, sorry, you got you. I'll check the question first.

Steven Bruce

Well, one of our viewers, no news, MP to me says I have a patient patient with a prostate cancer who's going for radical prostatectomy later this month. Do you see patients after surgery? And I know you do. Yeah. Do you have more to do with Jack as

Gerard Greene

I've gone? So that's an area I'm really passionate about the prostate cancer. So we'll take that question. We also want to look at with Jack is to see, can he do this abdominal breathing. So if we bend the knees up, so all I'm gonna get jack to do is just to an out I would dam up but all I'm going to get you to do is take a nice breath into the tummy so nice. Right then and out. So you're going to just breathe into here. So here we have a good example of someone who struggles to do that. And this is quite can be reflective of the patient. So what we want is a nice belly breath, abdominal breaths. We want a nice breath. Abdomen moving out. Tommy relaxed abdominals, relaxed, pelvic floor descending, was what you see what some of these patients is when they do that breath In the coal contract, they do a sternal breath, abdominals contract, pelvic floor contract. So this is the pattern we sometimes see with these patients. So what we want to get them to do is move to that more, we would get them doing a lot of exercise in various positions with the legs up on maybe stool of bed on kind of Child's Pose, prayer position down in a supported squat, doing lots of that abdominal Belly breathe, and the reason we get them doing that is to get movement through that pelvic floor. So if you do that abdominal breath, you get nice downward excursion the diaphragm movement into that pelvic floor. So this is where we really start to get into that realm of getting these guys doing a lot of pelvic floor relaxation, rather than what they may assume they should be doing, which is the pelvic floor strengthening. And the other thing we get them to do as an exercise, or one of the key things is a gentle pelvic floor lengthening or reverse kegel. So a kegel is word we contract, the reverse kegel is what we're going to do is gentle downward pressures through direct honest, gently pushing something out. Or we're going to do that downward movement, when we do a nice breath into gonna go, breath in gentle pressure down, hold the pressure down for about 10 seconds, let go. And then with lots of these men, we do lots of abdominal work. We do some very, I think the internal work we do is very, very, very gentle, gentle, sensitive mobility rather than very aggressive pain work. And then we also for some of the men, if they need the internal work, we use this internal device and III said magic can Google it. And we would treat them with that. And we would show them how to use that at home. But it's all very gentle.

Steven Bruce

Very good plinth ornament for the show. And we're not going to do any more with you, we're gonna get back over there and talk about a few of these things, including prostate cancers, and so on. But thank you Jacqueline's been very patient, thank you.

There's a lot more to this than we can demonstrate in the short time we've got here isn't there, which is something we'll talk about in a minute. But I, I've got a load of stuff here. You were complimented on your palpation of the pubic symphysis, by the way, because the way you were doing it with the heel of the hand fingers pointing upwards, was felt by Sam to be much more sensitive to the patient then done fingers down and so on. J says No way, would I even consider doing an internal assessment on a man with pelvic pain, I was trained to do an internal coccyx adjustment, but don't think I'd be within boundaries of my training. And I'd like to know when and with what positive assessment that would justify me referring back into the medical system. I guess, I don't know about standard physiotherapy training. But certainly we were all taught to do internal Coxy GL adjustments during my training. The training was about that long in the course. And I felt coming out of it that we probably needed to do a lot more before we should be confident in that and practising on real patients is probably not a good idea. And in terms of what you were doing there, how long would you spend teaching people to do that? That examination? I think

Gerard Greene

I think you can teach people to do it. So we, we I'm a clinician, but we also train people to do men's health. And on the courses, we train them how to do the internal, however, to do it in clinical practice, you need someone to mentor you. So it's a bit like I used to drive down from Birmingham to Southampton every Thursday, and I worked with this amazing woman, Ruth. So roots are lots of men in her clinic. She saw some of the men, I assessed her men internally with her beside me. Then the next day, I'd see them on my own. And then I assess some patients internally and she was with me. So I think there's a really brilliant guy who works with me in London Constantine. So Constantine is did the same with me. He worked with me in Birmingham. He said he observed me treating patients assessing patients. He then assessed some of them internally. He then assessed some of his own patients and I watched him. So I think, for people to get competent at it and confident you in theory, you can teach people how to do it, but to do it in the real world of patience, especially these are complex patients with a lot of stress and anxiety and concerns. I think you ideally need to have someone to mentor you in the eye Do

Steven Bruce

you train people on models or on each other? No

Gerard Greene

physios are unusual in that we are any any physiotherapy and I think the Osteopath to have common of course is fine this, but different in that so we will practice on people on the course. That's where we do our training. And I think that's a good thing because you use you you get to feel what it's like to be lying in that plinth, what a towel over you drawing up in your scrotum seen someone about to assess you internally, and you also pick up on, you know, if that person looks really stressed the

person who's doing it and they're starting to sweat, you're kind of thinking, if I was a patient, I would, this would not reassure me. Yeah.

Steven Bruce

And I've had a patient is telling me about their experiences, in particular with GPS doing certain examinations where they just didn't feel comfortable with the whole process and felt like it felt almost like abuse rather than examination. I

Gerard Greene

think it is much pressure having this done in supine, because you can see the patient, you can talk to them. You can tell them I'm going to do this. No, I want you to squeeze I want you to relax. How does this feel? Are you okay? So the patient is part of the assessment rather than having the assessment done to them. Yeah. Okay.

Steven Bruce

Can we just go back to MPs question? Oh,

Gerard Greene

yeah, definitely something I'm passionate about. Okay,

Steven Bruce

I've got a few minutes. So you've only got a few minutes. And so

Gerard Greene

men post prostate post prostatectomy get to massive complications that they know very little about. They get urinary incontinence. So they have to wear pants. So what those men should be doing on removal of that catheter at about day seven to 10. In the ideal world before the surgery is they should be doing anterior or front focused, pelvic floor contractions. So they should be doing fast contractions. That's the nuts to go to the Shibuya and fast knots to Gods slow knots to Gods. But they've got to do those in standing. Because they're not they're not leaking in lying. They're not leaking and sitting there leaking when they move when they go from step to stand. So you get them doing them in standing front. contractions, fast contractions, slow contractions, 10 ovitch, you build that up to twice, three times a day. And then once they can do those, you then get them to do them with squatting, lunging bit of resistance bit like we would do another exercise we would make more difficult. The second thing they should be doing is there will be certain activities they do where they will leak and it tends to be in the first few weeks. sit to stand more bending down to do shoes, you get them to do a thing called the neck, the neck is where they do a strong front contraction, strong front contraction, get up, keep contracted, let it go. Or it may be that they're leaking on sitting so

you get them strong from contraction. Done. Now they're not going to do that every time time this sits down what you get them to do it a lot of the time because then what happens is that sphincter take that external sphincter works a bit more automatic,

Steven Bruce

how long before they get to see some results from this generally,

Gerard Greene

generally, even within even within two to four weeks of doing this start to notice that they're leaking less, they're getting drier, okay. The second thing that they are not prepared for is complete. Erectile dysfunction. Most you care surgery is nerve sparing. So those cavernosa nerves are spared. However, they still undergo massive trauma. So they'll still get complete erectile dysfunction, but the recovery, their potential for recovery is better. So those men once their continence is improved. That's generally eight to 12 weeks post surgery should be using a medical grade vacuum pump. And that vacuum pump is a Soma, erect pump from I Medicare and they get that on prescription from the NHS. Those men will know nothing about a vacuum pump and how you get them to use and as you say, you know, if you want to get this erectile function back, you need to use the vacuum pump because it replaces the nocturnal erection and all the other actions. And then the other thing that was men need to be doing post surgery as soon as possible is they have to be on low dose daily Cialis or to data from five milligrammes. So Three things they need

Steven Bruce

indefinitely or for.

Gerard Greene

Probably Probably they

could be on it for 1218 months. Okay? So those men, it's front focused pelvic floor contractions in standing, people will tell them to contract the the back passage, it's a waste of time. It's different muscles. The NAC is good. And then low dose Cialis. Then as you're getting drier, eight to 12 weeks, prescription vacuum pump. And the other thing I get all those men to do, find their local prostate cancer support group and go to it. Because those men focuses on the surgery, post surgery, they're really lost because they don't really understand why they're wet wearing pads. No erectile

Steven Bruce

function for anybody. It's an embarrassing thing to admit to any massively massively.

Gerard Greene

Men aren't used to wearing pants, not pads, men are used to wearing men aren't used to wearing a pad to bed.

Steven Bruce

And it is a major blow to one's self esteem not to be able to get an erection, but you still don't want to talk about it.

Gerard Greene

If you're leaking, you're not going to go out to dinner. You're not going to go to the pub, you can't train. So socially, you and you can talk to anyone about it. Unless you have a friend who's had prostate cancer and has had a prospect.

Steven Bruce

This is out of sequence here. Kim says how do you differentiate so a spasm from pelvic trigger point pain.

Gerard Greene

Okay, so I think what you're looking for this comes back to the the key part of this assessment is those detailed questions. For someone to have pelvic pain with a pelvic floor component, really, you're looking at that pattern of pain in that scrotum, penis, rectum, perineum, urinary symptoms. Bowel ejaculator, if they're getting that range of symptoms, it's less likely that the primary cause is a is a psoas kind of local myofascial point. It may be it may be part of it, but it probably is leading you more into that pelvic floor pretending or of territory. Okay.

Steven Bruce

This touches on what I mentioned earlier on about the difficulty of the communication here. But Jen says, To be honest, I can't imagine ever getting into a discussion with a patient about sexual activity. Not really sure how appropriate this discussion is. If it comes out that a male patient mentions in passing, they're experiencing pelvic pain, is there anything that we can do we muscular pain that might be causing this? Can we do some tests and try to give some treatment which might be able to help without getting to sexual activity? Well, we haven't got time at all to get into what you're going to do to treat them beyond what you've mentioned. While we were looking at Jack. The point for me here is that actually, what you've told us is that we've got to get over ourselves because this could be an important part of a case history, sexual activity. And one of the questions we don't have time to go into this either. But, of course, an important question regarding cord recliner syndrome is sexual dysfunction is a vital question we have to be able to ask those I

Gerard Greene

used before I did before I solely did Men's Health, I used to see lots of very straightforward female pelvic health, I didn't do anything internal. The complex, the complex female patients were seen by my colleagues. A really good phrase I find useful with the female patients that people find useful with the male patients is intimacy. Do you get pain and intimacy? So you don't need to say, so I could say to you, Steve, you know, are you getting any symptoms around intimacy, pain, discomfort, rather than me saying to you, and I might think I'm not sure about this is you know, do you get any pain, post masturbation, poor sexual activity, but I am confident that once you ask, once you start asking the questions, it's really to those back pain, coccyx, sacroiliac joint patients, that hip groyne you get more ease with and you find language that you're happy with.

Steven Bruce

I've got a couple here, which I might have time to read them both. I'm not sure. Kim says one question which is important, especially in elderly men is what colour is your P? She says she had a patient excuse me who said everything was fine until she asked that question and the answer these P was black, red flag he said the doctor said it would change colour because of his medication. She sent him back to his GPU, although he didn't want to go and he was immediately sent to hospital for a week or more. Again, question that you would have asked.

Gerard Greene

Yeah, but I think I think I'm maybe in In the

good position of the majority of the patients we see, they have been heavily screened in advance, but by the time they get to us, but yeah, it's an important one to ask.

Steven Bruce

Someone called Jay is commented on the fact that most of us don't have ultrasound imaging, and wanted more advice on how to assess without intrusive questioning, but through muscular skeletal assessment, do you think it's possible to have one without the other? Surely some of those questions, as we just talked about are quite important. I

Gerard Greene

think the questions are important. I think it may be that you ask some of them with a view to picking up well, there is something else here. So I'm going to recommend that someone else sees them. And I think people are usually confident, comfortable asking about the pain. You know, are you getting, coccyx pubic pain? Are you getting pain on your knee? Are you getting any genital pain? People are usually comfortable about the urination and bowel, I think, to maybe start there. Yeah, use the NIH questionnaire, because then you don't have to ask the questions you can get them, you can get them to read.

Steven Bruce

And we'll send a link to that in the email that we will send tomorrow. I understand people will possibly have liked more on a pill on physical examination, treatment and so on. But I just think there's too much to cover in the ultrasound the next time. Yeah. Next time we have. But what I think you know, what you have is take us into an area which many of us will not really have delved into before. And we perhaps could have talked about courses that you run and things like that. But if you've got some information I can share, I can put that out to people. It sounds to me as though there is certainly some space in the market for people who who are experts in your area of these

Gerard Greene

men are hugely appreciative of the help you will give them that maybe help you give them in terms of treatment assessment, it may be the help you give them in signposting to someone else it is very difficult for these men to find people. Ask yourself this where you live, whether you're in Dublin, Edinburgh, Manchester liberal, wherever you are, how easy is it for someone? How easy would it be for you to find maybe a clinician who could help maybe your father, uncle partner who's maybe having prostate cancer? Or if you had some if you had a relative, whether it's a son, brother or a partner with pelvic pain, and they said to you, can you find me someone who can treat this? How easy is it? And I can guarantee you, it won't be straightforward.

Steven Bruce

I'm going to read this one final comment from Kaz. I've only ever treated one male patient in pelvic health patient I've seen for many years maintaining disc injury and various other MSK issues presented with numbness in the tip of the penis and tingling in the in the balls. Thankfully, he'd already been to urology, and they've been scanned, etc. And nothing to report. So Ken says I was like, Okay, I'll assess him from an MSK point of view. I did some research and thought pudendal nerve entrapment and found a very tight pelvic floor on the right, pressed in there externally and with consent, did three sessions and he's never had the issue again, which I mean, that's a brilliant, that's a great story, isn't it? discuss possible causes, it was found that during COVID, he was doing much more sitting and on a harder chair. And this was the causative factor. He was very proud of himself. He was amazed and so happy because we will get into his penis again, was I'm sorry, I have to giggle reading that out. Because

Gerard Greene

yes, and he'll be really appreciate because otherwise, he won't be sitting works affected. He won't be going on holidays driving, cycling. And,

Steven Bruce

Gerald, we're out of time. But thank you, thank you so much for coming down here. You've already agreed to another show. But we will look forward to that. And we'll send out and thank you everyone for for giving up your time. And we'll send out links to all the things that you mentioned in the show today.