

Migratory Fascia Syndrome

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BACKGROUND

The aetiology of most lower back and pelvic pain has remained obscure. Particularly in cases of pelvic obliquity, the description of ridges in the gluteal area as muscle tension seemed at odds with known origins and insertions. The author thought that this may be a fascial aberration due to torsional trauma, and carried out a field study of activities where this torsion is likely to occur. METHODS - Stage one - 88 assessments of pelvic obliquity were conducted at basketball, netball and ballet venues, and a control group drawn at random from a public thoroughfare.. Reported knee, back and shoulder pain were also noted. RESULTS - Pelvic obliquity in all activities except one was more prevalent than in controls. Netballers playing on a hard court reported significantly more knee pain than any other group. Pelvic integrity and fascial control in key areas became the focus of the second phase of investigation. METHODS - Stage two - A follow-up study of run-of-appointment subjects used a protocol that included re-orientation of iliolumbar fascia to secure the repositioned pelvis. MRI images of one typical subject in this study were taken immediately before and after fascial repositioning, a treatment performed on the MRI machine table. RESULTS - In a high proportion of cases a marked reduction of pain was reported, with an increase in ease of movement. The MRI image showed enthesitis in the fascial lesion area [1]. CONCLUSION - Athletic activity on hard surfaces can generate intolerable transpelvic forces, causing inguinal fascia damage and pelvic obliquity. The author's investigation, from a myofascial perspective, suggests that a commonly identified strain pattern in pelvic misalignments had been subject to misinterpretation as gluteal muscle tension. The correct interpretation is that of buckled fascia, most commonly found between the right PSIS and ASIS. Although not showing on MRI, a hitherto undescribed fibrous element of Scarpa's fascia palpated on the iliac crest area has been identified as a fascia-securing element. This element normally lies immediately superoanteriorly to the iliac crest, but can move as described to a position up to 2 cm postero-inferiorly to the crest. Proper sequential activation is therefore compromised, leading to splinting and compensatory strains. Results suggest that migrated fascia may be a pervasive disruptor of recruitment during load transfer, as in some athletic activities. [2].

This paper is presented with the intent of assisting further research in this area. References -[1] Lacroix VJ, Kinnear DG, Mulder DS, Brown RA. Department of Family Medicine, McGill University, Montreal, Quebec, Canada.

Clin J Sport Med. 1998 Jan;8(1):5-9.

[2] Schamberger, Wolf

The Malalignment Syndrome - Churchill Livingstone 2002 pp 262-263

Key Words *Migratory Fascia Syndrome* - a novel interpretation of fascial behaviour in

cases of iliolumbar and pelvic pain with unclear etiology. *Pelvic integrity* -the proper homeostatic position and synergistic relationship of all the pelvic structural elements at correct tension levels.