Do You Really Need That Hysterectomy? What No One's Telling You About Pelvic Health Transcript

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Introduction to the Vagina Coach

Hello ladies. Welcome back to mess during the Menopause Transition Summit 4.0. I am still your host doctor Sharon Stills, and I am really excited to be here with you today.

I, I always tell you, I'm going to get the best of the best and Kim Varney, our guest today, is known as the vagina coach. And I'm, like anyone who calls himself the vagina coach, has to be on my summit and has to be me and of mine.

Because, you know, we need we don't talk about coaching for our vagina. And a lot of times we don't talk about our vaginas. And it's something obviously that's really important, especially as we're going through our hormonal journey.

And so Kim is a certified personal trainer, menopause support practitioner, published author, CEO of Global Pelvic Health company that is helping women ditch the incontinence pads, lift without fear, and stop planning their life around the bathroom.

I bet that sounds good to a lot of you. And she's the author of three books Your Pelvic Floor Prepared to Push, and Pregnancy Fitness. She shares information and education through her various social media platforms and her podcast, Between Two Lips.

Oh my God, I love that. And she also certifies other fitness and movement professionals in her buff muff method. So like she's got the names down, you say great names, I need you to help me with some name stuff.

We're going to learn a lot of really important information today, ladies. So grab your tea, grab your pen, get comfy, turn off distractions, and let's welcome Kim to the summit.

Thank you so much for the lovely introduction. It's excited. I'm excited to be here. I we were saying offline I've I've been following your work for many, many years and and love all the summits that you put together.

So I'm really honored to be a part of it. Thank you, thank you, thank you. So I guess my first question is just like, how did you become the vagina coach?

Yeah, that was the first question I got to start there. Yeah, yeah. It I it really started with a fear of childbirth. To be honest, I, I saw a childbirth video in grade school.

I remember asking my mom, like, I kind of had this fear fascination about childbirth. And I remember looking at the women in my life and my mom obviously being one who I was with a lot and was also, as we grew up witnessing her not running anymore.

And she had surgery for incontinence. She had chronic back pain. And so I had this picture painted, that childbirth really kind of did a number on your body.

And I grew up saying I was not going to have children. And then fast forward, I met my husband, decided I did want to start a family, and my midwives had recommended a biofeedback device to me called the App, you know, which is from Germany and EPI no stands for no economy.

How Kim Varney Became the Vagina Coach

Palliative means where they cut into the tissues within the pelvic floor with the intention of creating space. Thankfully, this is not a routine practice anymore.

It was when my mom was giving birth. And so I use this product and I had a great experience and I thought, well, I think everybody should know about this.

And so I contacted the company and said, could I be a distributor here in Canada? And I didn't necessarily intended to be a business. I thought, I'll just sell it on the side and carry on.

And so anyway, long story short, it it turned into that was 21 years ago, it turned into a business. And, and was kind of the catalyst that started this, you know, learning of pelvic floor and all these different phases of life where I was recognizing, why aren't we talking about this?

Where are we telling people earlier? So initially, I started with pregnant women and new moms, and that was the population. I was really I created that the Prepare to Push program.

I wrote that book. I wanted people to have this information before they gave birth because we know that pregnancy and childbirth are major contributors to pelvic ascension.

Then I was looking at postpartum recoveries as being something that's very overlooked, and I formed a second business with two other women, and we wanted to take inspiration from other cultures around the world that really honor the postpartum recovery phase and, and bring that to North America.

So we created a company called Bellies, Inc., and we we manufactured our own postpartum wrap and coupled it with restorative exercise. So juggled those two businesses for a while.

Then started to go through my own perimenopause menopause transition. And then I was like, okay, now here's a whole other chapter we need to talk about.

And so the Vagina coach piece came originally I was known as the Fitness Doula because I was working primarily with prenatal postpartum women, and then the majority of people who started to come work with me, as you know, just kind of they were following my life journey as well.

We're in that perimenopause phase. And doula didn't resonate so much. So about eight years or so ago, I was speaking to a group of women entrepreneurs at a at a was a called the mom Preneur conference, and all of the speakers were some sort of a business coach.

And I joked when I came on stage that, you know, now you have a vagina coach for your business. And anyway, that's where that came from. And it stuck.

And that's who I've been for the last eight plus years. I love that, I love that, and I always admire women, men too, but who like, have an issue, figure out how to solve it and then share it and turn it into their passion in their career to help other.

I think that's the so admirable and so cool. So all right, so let's talk about our pelvic floor. Our vagina is the majority of women watching. And you know for the our perimenopausal menopausal postmenopausal they're having incontinence.

They're having vaginal dryness. They're having pain. And so what is it that's happening. And what can they do to prevent it. Or what can they share for like whether they have daughters or nieces or younger people.

So kind of like a whole overview. Yeah. The pelvic floor is a group of muscles that I've got my pelvis model here show. So here's our pelvis. And here from an external anatomy perspective we can see the labia our urethra, our vagina, our anus and all.

What's in red here is all the group of muscles that we call the pelvic floor. So it is three different layers of muscles. It's highly vascular. There's lots of nerves.

And we have lots of estrogen receptors. And just like any other muscle in the body that is facing age related muscle loss, just like the bone loss that we face, we have a bony pelvis as well.

The estrogen loss, the hyaluronic acid loss, the collagen loss as we are aging is all contributing to either symptoms showing up for the first time or potentially even an exacerbation of symptoms.

If somebody has been dealing with them for a while and the majority of people that I see have been struggling for years, and it's when they reach the menopause transition where all of a sudden the symptoms are now just getting so much worse.

It's interfering with the quality of their life and now they start taking action. So it is my hope that at some point in my life we see this taught much earlier in life, see this taught in schools when we're teaching kids about the menstrual cycle, about sexual health, about their bodies planting the seed, about pelvic health, what the pelvic floor is.

Both men and women have a pelvic floor. Females, obviously, the people who are giving birth, who have a menstrual cycle, who do reach menopause, are all under influences that will increase the risks of pelvic floor dysfunction compared to those with male anatomy.

Prostate issues are usually when things show up for for men, but it's it's usually the loss of estrogen associated with the menopause transition that really kind of ramps things up and really, again, makes things show up for the first time or, exacerbates existing symptoms.

Understanding Pelvic Floor Dysfunction

So especially people who've given birth, a lot of people will say, you know, I've had these problems ever since I had my babies. Could you I mean, I know I said a few symptoms, but could you, like, list off?

So for women listening because I'm sharing this, like, these are things. If this is going on for you, then you should be looking into pelvic floor. Yeah, yeah.

So urinary incontinence is a big one. And we see ads that tell us that late bladder leakage is just part of being a woman. And we are often we giggle about, oh, yeah, I can't jump on a trampoline anymore.

And we've maybe heard from our mothers that that's just what happens after you have babies ready. We haven't been told that by our care providers. So urinary incontinence is where.

Well, stress urinary incontinence is where a little bit of urine leak out with laughs cough, sneeze, jump lifting weights, pushing a heavy door up, standing up from a chair.

So we leak a little bit of urine. And that is very treatable with pelvic floor muscle training. Then we have urge incontinence, which is where some people may have some leaking as well.

But they notice that, you know, if I hear water running, if I put my key in the door when I get home, if I once I get to my exercise class, like there will be some sort of trigger that the bladder has become trained to recognize as we have to avoid and we have to avoid right now.

And it's this very urgent, overwhelming need to go to the bathroom. Some people leak a little, some people will have a complete release of the bladder, and that would be called urgency or urge incontinence.

And people can have the two together, which would be mixed urinary incontinence. You can also have anal incontinence where gas or stool leak out, much less common but much more life altering.

You can have, a lot of people will sort of self-diagnosed themselves as having overactive bladder. And there is a medical condition, OAB, overactive bladder, that you would need to go through some extensive testing to determine if that's actually what you have.

But most people, when they have been suffering for it's usually on average six and a half to seven years, they finally go to their doctor to get some help.

The doctor in that, you know, 7 to 10 minute visit that we have doesn't have time to go through all of that testing with you, and they usually will give people an overactive bladder medication that might help a little, but generally will stop working because it's not truly the root cause.

Or people are put down the path of, well, we've got this surgery for you. And and I don't want to take away from the fact that drugs and surgery can absolutely be the best option for some people, but the root cause investigation and the all the other interventions that we can, like the noninvasive stuff we can do is never offered, unfortunately.

And then we have so we have the incontinence piece. We have the anal incontinence piece. We have pelvic organ prolapse. And that's where the bladder, the uterus and or the rectum start to shift out of their proper anatomical position and they can bulge into or descend into the vagina.

And this is graded usually on a stage or grade of 1 to 4, for being where there's a visible bulge outside the opening of the vagina. And early stage prolapse can often be asymptomatic, and when we catch it early, we have an opportunity to intervene and prevent things from getting worse or sometimes even reversing early stage prolapse.

But again, nobody necessarily knows the screening and the people to see to be able to catch these things early. So they're often really sidelined by this diagnosis of pelvic organ prolapse.

And 50% of women who've given birth have some degree of prolapse. Super, super common. Incontinence wise, it's about 30 to 40%, urinary incontinence. And anal is usually somewhere for 4 or 5, 8% somewhere in there.

Then we have pelvic pain. So pelvic pain would be painful sex. It could be pubic joint pain, tailbone pain. Pain in and around the vulva. Pain in around the vestibule which is the opening of the vagina.

And that painful sex could be pain from tight muscles, or it could be pain from dry, irritated tissues. Again, from that loss of estrogen and hyaluronic acid and collagen.

So those are kind of the three main categories of symptoms associated with pelvic floor dysfunction that people might be struggling with. So for the catching the early of the prolapse, what do you recommend women do to know if that is an issue for them?

I recommend all women see a pelvic floor physical therapist, even if they have no symptoms with their pelvic floor, and then especially if they do. And I always equate this to the dentist.

Most of us are. We go see the dentist once or twice a year for a checkup, and we go, even if we don't have a toothache and we brush and we floss in between.

And then when we go to see our dentist, if they say, yeah, you're great, you have no cavities and everything's fine, they've done their checkup. We don't then stop taking care of our teeth.

We have this ongoing routine. We take care of our teeth. And I think if we had that same PR for the pelvic floor, where we were taught pelvic floor muscle training, we were taught about posture.

We were taught about all the contributing factors like constipation and proper and proper lifting strategies, chronic coughing. If we were taught all this stuff early and we knew that pelvic floor physical therapists are there to help us, I really feel like it would change the landscape for women's health.

And so at what age is this something when you're going through perimenopause or even before getting a I recommend once you become sexually active so very young.

There's also a lot of young people who struggle with pelvic floor dysfunction. They deal with pain, painful periods, endometriosis. All of those can also influence the pelvic floor.

So working with a practitioner early on to ensure that this person is set up for pleasurable sex and that if they have any other issues along the way, that we can intervene early again to mitigate these from becoming chronic, lifelong things that they're suffering with.

Gotcha. Okay. So now I got to ask a question that I hear all the time, and I want to know, like, is this can can you help? Is it a pelvic floor issue?

I wake up all the time to pee, right? I, I even I start my water at 6 p.m., I go to bed at nine and I'm still waking up to pee. So it can be very much, pelvic floor issue.

It could also be, behavior, like a trained behavior. So we want to understand why are we waking up? And it could be a blood sugar issue.

Symptoms and Early Screening for Prolapse

It could be sleep apnea related. It could be a snoring partner. It could be a temperature change. It could be an uncomfortable bed. Like there's so many reasons why we might wake up, and a lot of people will wake up and be frustrated by that.

We get this little bit of a sympathetic nervous response, especially if it's blood sugar related. We will there be some sort of it, dysfunctional cortisol response.

So we get this sympathetic response. The bladder gets excited, you might feel the symptoms of needing to go, but that wasn't what woke you up. And so a lot of people are waking up and then thinking it was their bladder that will come up, and then they go, and then they go back to bed.

And then the same thing happens again and they go again. And so the bladder becomes conditioned to signal at 130 or 2, 30 or 30 or wherever it is, so you can intervene when you wake up.

First of all, do some investigation. Why am I waking up? And what can I do to stop that from happening? But if you do wake up and you feel like you, you need to go.

You tell yourself bladder, you're you don't need to go. We can make it through the whole night. I know that I've contributed to you signaling more often and inappropriately.

I'm taking back control and then you're going. So you're doing your self-talk. And then you also can do things like scrunching your toes, pointing and flexing your feet, doing some pelvic floor muscle contract and relax some breathwork just to calm the, the nervous system, get into more of a parasympathetic state with some breathwork and, and then wait for that signal to subside and go back to sleep.

So don't get out of bed and and respond. You're going to fight back and you're going to take back control because it's not normal. The other thing that could be contributing is tight muscles or constipation.

Low estrogen, dehydration through the day. Those can all be contributing factors as well. Interesting. That's I've never heard that take before. So that's really cool.

I love that taking control and very, very cool. So I have this on my mind because a patient was just asking me about it. But can you talk about like, hysterectomy and, are they ever a good idea?

What is the detrimental like post effects that you see? What can be done about it. Yeah. Hysterectomy are one of the most common surgeries performed. There's over 600,000 of them done in the US alone each year.

And we know that the majority of them are done for benign conditions, with the top three being heavy bleeding, fibroids and prolapse. And there I there will be times where it is the right solution.

And of course, for somebody dealing with something like cancer, it's going to be it's going to be required. But for people who have heavy bleeding and fibroids and prolapse, let's see what we can do without just jumping to removing the uterus, because we know that hysterectomy is increase the risk of incontinence and pelvic organ prolapse.

And so it's not just the uterus that can prolapse the bladder can the rectum can the intestines can descend into the space where, where the uterus used to be the top of the vagina can start to collapse, called a vaginal vault prolapse.

So we we again need information ahead of time to help us make an informed choice. If we aren't dealing with at, say, a cancer diagnosis. So, so we want to, make that informed choice.

And then if we still are needing or choosing surgery again, there's no shame in wanting or needing one. Let's prepare. Let's train your body for surgery.

So do your pelvic floor muscle training ahead of time. Also, be lifting weights, eating your protein, reducing inflammation, optimizing your sleep, knowing that you are going to have a period of time where you will be not doing much because you need to recover.

So get your body in the best state possible before your surgery. Then you want to pre-book an appointment with your pelvic floor physical therapist at around 6 or 8 weeks post-op.

You will be doing some recovery exercises in that that initial eight weeks, you're not doing nothing, but you're you're going to be avoiding things like heavy lifting.

But you can do some gentle pelvic floor activation to get some blood flow circulation going. And then everything that you've done to prepare everything that you've done to train is what you continue to do afterwards.

Nighttime Urination and Bladder Retraining

A lot of people have this misconception that, oh, once I have surgery, my problem is fixed and I'm good at. I argue we need it even more after we've had a surgery to because we've now had we've had a change to the landscape, especially if the hysterectomy is involved.

And this goes for any type of pelvic surgery. We've had a change to the landscape. We've now have scar tissue that can interfere with muscle function.

So we really need to make sure that we stay on top of keeping the tissues healthy, keeping the blood flow circulation. People can be prone to to tension in the pelvic floor muscles after a surgery.

Given the there's a like a trauma response. And also it's disrupting the core function and other things are going to come in and try to save the day when, when a piece of the core, so to speak, is not working as optimally as it should.

So there's a place for hysterectomy. But anybody who has a benign condition, I would make sure you see a pelvic floor physical therapist are using vaginal estrogen.

If you're around the start of your menopause, are you have you avoided like are you making sure you're not constipated? And, have you released tension in the pelvic floor?

Have you tried? There's a practice called hypo presses, which is very effective for early stage prolapse. Maybe you you have your hormones optimized looking at progesterone for heavy bleeding, fibroids, you know, all that.

So doing again that root cause investigation first before just jumping down the surgical path is really important. Yeah. It's always so sad when I see patients who it's like, oh you would have come.

But you know hindsight's always 2020 and you need to be where you are and you can't beat yourself up. So yeah, I saw you're blocking it now, but you have your keep calm and keep go on so it archegos enough.

Like what's the deal with Kegels. Is there something better to do? I think so key goes I want to honor Doctor Kegel. Who was he? He was witnessing women after childbirth, experiencing challenges with pelvic floor dysfunction.

He used a biofeedback device called a perineal ometer that helped women see when they were contracting and relaxing. That ended up that's where the Kegel came from, was a voluntary activation lift and let go of the pelvic floor.

What has happened over time is there's been a misinterpretation of what a Kegel is, and people think of it as just a squeeze. They're often squeezing their inner thighs or squeezing their glutes.

They're sometimes bearing down. So we have evidence to show that kegels work when they're done correctly and consistently. But we also have evidence to show that the majority of people do them incorrectly because they've never been taught they might have been given a brochure, or they might have just been told, go to your Kegels.

But nobody's ever evaluated their pelvic floor to see. Is that appropriate for you at this stage? So somebody who has excess tension in the pelvic floor, which a lot of people do, because if they're afraid of leaking, if they're feeling vulnerable, like something's going to fall out, if they've had, painful sex or some sort of pain episode, there's this unconscious guarding that happens, creating tension, restricting blood flow and circulation.

And then we now have this stuck tension in the pelvic floor that can be a contributor to incontinence and pelvic organ prolapse and pelvic pain. So if that person was to then go and do Kegels, especially if they think of it as just a squeeze, they could potentially exacerbate things where I kind of, you know, carry on from where Doctor Kegel started was the Kegels again? Yes.

Evidence shows that they work when they're done correctly. And gold standard says three sets of ten, ten second holds done three times a day.

Hysterectomy, Recovery, and Prevention

I don't know how many people are going to really commit to a three times a day type routine, but also it doesn't train the pelvic floor dynamically. Kegels are usually seated or, you know, people say do them at every red light or lie down. Right.

And and there's a, first of all, you're not in optimal posture at a red light in a car. And also you probably have time to do maybe, I don't know, 810 the stimulus is not enough to really trigger much of a response.

You need to as you do with any other muscle. You need to impart a load where it fatigues the muscle and it gets to the point where it it needs to. Then now go and repair itself and build itself back up. So I expand on Kegels to train to bring pelvic floor muscle activation relaxation into whole body movement so that we are training functionally and training it dynamically.

And some people will be told don't do Kegels if they have a tight pelvic floor. And while I agree initially work on relaxation, work on calming the nervous system, figuring out why you have that tension.

I still think we benefit from taking the muscle through its range of motion period ically. Sometimes even with a max contraction. There was one piece of research looking at people who had provoked vestibular denia, which is a pain

condition.

When they were asked to do a max voluntary contraction, it elicited a greater relaxation response. So I think we can we have to nuance things. As with anything, it's not a blanket statement.

Do your Kegels or don't do Kegels. We have to. Again, if we're working with a pelvic PT, have an understanding of what's the status of our pelvic floor and what would I benefit from and where do I start, and how do I nuance things for myself?

Gotcha. So I want to I want to leave the women with like a good roadmap. So like you've mentioned, pelvic floor therapist, but I know you have a lot of programs.

So do you need your program and a pelvic floor therapist? Does your program take the place? Is there anything you should be looking for in your pelvic floor therapist or all pelvic floor therapist created equal?

If you can kind of speak to all that. Yeah I so yes my program is it's a do it yourself. Well do it kind of under my guidance so to speak. But it's a, it's a home based. You can do it wherever you want.

It's an app or online program that you log into. And it teaches you about your pelvic floor, about the different symptoms, posture, breath, constipation, like looking at all the different contributing factors.

And then you have exercises. I teach you how to do exercises that incorporate the pelvic floor into it. For relaxation and also activation. The reason why I would say yes to both is a pelvic floor physical therapist is they are helping with the internal evaluation and treatment, and they are amazing.

And I again recommend every single person see one at least once a year for a checkup. You it's costly. It's not something that we should be relying on that person to do the work for us.

We have to have the accountability of keeping up with it's like we go to the dentist, they do the checkup, but we have to do the brushing and the flossing.

So pelvic floor muscle training or my bathroom method is basically you're brushing and flossing for your pelvic floor. Your pelvic floor is like your dentist.

So now that being said, there are some people who don't have access to a pelvic PT. They may not live in an area where there is one. They may it may be cost prohibitive.

They may have trauma in their background where an internal evaluation is just not accessible for them. So coming into a program like mine where they get some information and it puts the power in their hands to know that they can can do something.

We're given so many messages that, well, you need surgery and and yeah, that's just that's just the way it is. It's part of being a woman is part of getting older.

That's what happens after you have babies. There's so much we can do when we have the right information and we have the right tools. So that's kind of where my program would come in with regards to pelvic PT is all being created equal.

I mean there is training that they will go through. So their training is equal. But I would say not everybody is equal. Just like there there's good and not so great practitioners of all kinds.

And also you can have the best pelvic floor PT around. And if you don't jive with them for whatever reason, that's not the person for you. It's a very intimate therapy.

So you really want to make sure you feel comfortable and confident and have, have trust with this person.

Kegels, Pelvic PT, and Vaginal Estrogen

And that might take a couple of times, seeing people and just making sure you've got the right fit. You can look for, you know, you can use Google pelvic floor physical therapy and your city or your town if you lived in Canada or in parts of Europe or Australia, New Zealand, they will say physiotherapy as opposed to physical therapy.

So that's just different nomenclature but the same profession. And then I like to find somebody who has some sort of movement background. So maybe somebody who was in orthopedics before they went to pelvic floor PT somebody who's not relying just on modalities like ultrasound or biofeedback machines, people who do hands on hands in manual therapy, is really beneficial and helpful as well.

So that's my bias. That's my preference. And but really it comes down to who you feel safe and comfortable with. That's, I guess I gotta make an a point I've never seen.

I don't have any pelvic floor issues, so I've never even thought to go see. But now I'm like, I'm all about don't wait. Yeah, yeah, exactly. Yeah, yeah.

We don't. And so many people are waiting until they have a problem, which it's never too late. I have women, I've got a, my oldest is 93, which I just think is amazing that she's not giving up.

Right. But I have loads of people in their 70s, in their 80s who have been suffering for years, who come in and they make change. And I think like if we had this information ahead of time, I just think it could really change people's quality of life.

So for the better, the vaginal estrogen piece in there for this particular population is really important to talk about as well, because that is something that I, it's like I consider it kind of like an essential nutrient.

And once you're reaching your menopause, I think don't wait until you have the symptoms of genital urinary syndrome of menopause. Go and ask your doctor for vaginal estrogen and start using it and use it until you die.

Genital urinary syndrome and menopause GSM is like a subcategory of menopause that is very pelvic floor related. It's urinary symptoms, sexual symptoms, genital symptoms.

We have changes to the external genitalia. We often experience things like itching and burning and dry tissues, sometimes bleeding, discomfort with sex, urgency, frequency, waking multiple times a night to pee, and UTIs.

UTIs is a big one, and UTIs, especially people who've been dealing with chronic UTIs even before they've reached menopause. This is a big problem, and people are put on multiple rounds of antibiotic after an antibiotic.

And I'm speaking to the choir here about how damaging that is. And they're not offered vaginal estrogen, which is the gold standard for the, prevention of UTIs.

And it just yesterday, I think it was just yesterday, there were new guidelines put out about the management of genital urinary syndrome of menopause with vaginal estrogen and some of the statistics.

And there were incredible. It was it was 11 million women with recurrent UTIs. And of the women in there using vaginal estrogen, there was a decreased risk of mortality by 73%, decreased risk of sepsis by 55%.

There was another stat in there. I can't remember offhand what it is, but it's just it is it is safe and effective for pretty much every single woman.

Even if you have a history of breast cancer, even if you are currently being treated for breast cancer. Now, I am not a doctor. Please go do your own research.

But people like Doctor careen men. Yes you are. That she is. She is a breast cancer survivor herself and very

much an advocate for access to beneficial therapies like natural estrogen.

Oh, yeah. I mean, I've been working with women with breast cancer for 23 years and actively not just vaginal, but actual estrogen, progesterone, testosterone, like when it's done safely and you understand what you're doing, it actually increases survival, prevents recurrence.

It's something that, you know, you just get it. No. It's so absolutely. And it is such a big one for, UTIs. So yeah. Off I saw that study and so excited about that.

Yeah. Any last words of wisdom? Because you've just been dropping it. Yeah. A few things. I would say that a lot of people don't necessarily associate with their pelvic health would be how much water you drink.

So I always recommend 2 to 3l of water. And people who have been leaking or who have urgency are often afraid. And often they are not drinking enough water because they're afraid of leaking or because or afraid of having the urges, and then they end up creating constipation.

Challenges. And constipation is one of the biggest contributors to pelvic floor dysfunction. So you want to make sure that you are pooping like a champ every day, and being hydrated is a part of that.

Use a squatty potty. Make sure you're optimizing your your, all the other parts of your health so that you have a really good bowel movement. And then the last piece I would say is, is footwear.

A lot of people will, not necessarily know that the shoes that they are wearing can contribute to pelvic floor dysfunction by narrowing the base of the support.

So things that have a narrow toe box and shoes that have a positive heel. So even a lot of the mainstream running shoes, the heel is higher than the toes, which then translates up the chain to shorter cab, shorter hamstrings, and pulls our pelvis into a posterior tilt, which can contribute to tension.

So transitioning and I emphasize the word transition, to minimal footwear walking barefoot, transitioning to minimal footwear can really make a big difference in your pelvic health as well.

Oh, I'm always barefoot, so awesome. Wow. Well, where can they learn more about your programs and new and all the things? Yeah, my website is Vagina coach.

Practical Tips and Where to Learn More

com and you can learn about all of my I like all my books and my programs are all listed there. And, I have a blog. I also have a podcast between two lips.

All my social channels are at Vagina Coach and my signature. I have a membership called, the Bluff Muff method, and you can find that at Vagina Coach.

You can also go to bluff Nasscom. I love, well, your work is so aligned with what I do and helping women, and I am so excited to know you and connect with you.

And just, we have we have a new clinic opening in Scottsdale. We have a 7000 square foot clinic. That's amazing. Really. Fall and I, I go to Germany a lot to study.

And when I was there last year, I actually purchased and it's it's coming when the clinic opens a pelvic power, chair, which is a magnetic field chair.

Yeah, yeah. Or so now, after talking to you, I'm like, I guess I gotta find a pelvic floor physic physical therapist to come. Yes. Office? Yes. Thank you.

Yes. Yeah, I that would be. That's. I love when there is an integrative approach and lots of different therapists that are working together in a, in a space.

I just think that's amazing. So yeah, I would totally out of pelvic PT to your team. Cuzuh. Well, such a great interview is so much information. So whether you're suffering ladies or you're not, like like me, but we're going to now be preventative.

So we're going to. Yes. Do the and even just taking your course right. Preventatively don't feel like you're suffering. So find a pelvic floor therapist.

Go check out her course. How long is the course? If people start, can start with the best month method, which is very, it's it's like an hour and a half content.

And then it's up to you to be doing the, the exercises once people, you know, I show you how to do it in. It's basically a ten minute routine, 10 to 15 minute routine that people can do every single day.

If people want more support and coaching and they want more variety of workouts and that type of thing, that the membership is same structure I just give you, I give you challenges to follow and routines to follow that are again, kind of in that 10 to 15, 20 minute time frame.

So this is not like a three hour ordeal. This is no totally doable. So yes, I hope you, realize there's hope. You know that. Yeah. One of the things I'm taking away from this talk is that there's a lot of help, and you do not need to suffer.

So. Yes. Thank you can for being here. And thank you, everyone for, for, you know, taking your time to come get educated and listen and learn and advocate for yourself.

And now you've got another thing to put on your doctor's notes to do list. So we'll be back with another interview. And thanks for being here. Thanks so much.