LETTER TO THE EDITOR EDİTÖRE MEKTUP

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From Dysfunction to Relief: Rethinking Coccydynia Through a Muscular Lens

Disfonksiyondan Rahatlamaya: Koksidiniyi Kas Odaklı Bir Mercekten Yeniden Düşünmek

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Dear Editor,

We read with great interest the article titled "Efficacy of Radiofrequency Thermocoagulation Treatment in Patients with Chronic Coccydynia" and appreciate the authors' efforts in addressing the challenging management of this condition.[1] Chronic coccydynia significantly impairs patients' quality of life, and interventional approaches such as radiofrequency thermocoagulation and ganglion impar blocks provide valuable options for pain relief. We believe that an important and often overlooked aspect of coccydynia pathogenesis is its potential muscular origins, which could offer new insights into comprehensive pain management strategies.

Coccydynia is often attributed to coccygeal joint instability, trauma, or inflammation, but emerging evidence underscores the critical role of soft tissue structures, particularly muscles, in contributing to pain in the coccygeal region.[2] Myofascial dysfunction of the pelvic floor muscles, including the levator ani and coccygeus, has been shown to cause significant pain in coccydynia due to muscle hypertonia, trigger points, and myofascial pain syndromes.[3] Studies have demonstrated that addressing these muscular contributions through physical therapy or myofascial release can yield substantial improvements in pain and function in patients with coccydynia.[3] This myofascial perspective represents a paradigm shift, moving beyond structural interventi-

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ons to consider the broader role of muscular and fascial dysfunction in chronic coccydynia.

The levator ani muscle group (ie, pubococcygeus, puborectalis, and iliococcygeus muscles) supports the pelvic floor and helps maintain pelvic stability. If these muscles become functionally disabled, they can become hypertonic and create soft trigger points that can produce coccygeal pain.[2] Also, the coccygeus muscle, from the ischial spine to the coccyx, is critical in maintaining the integrity of the tailbone unprotecting against external pressures.[2] When this muscle is tight or has myofascial trigger points, however, it can add too much tension to the coccyx, worsening pain symptoms. Additionally, the gluteus maximus, which inserts into the coccyx, may also contribute to coccydynia.[4] Being an effective hip extensor, dysfunction or hyperactivity in this muscle may exert excessive traction forces on the coccyx, which can cause localized pain and discomfort.

More recently, pelvic floor dysfunction has also been associated with coccygeal pain. Hyperactive pelvic floor muscle patients frequently complain of referred coccyx pain and symptoms of difficulty in sitting or transitioning from sitting to standing.[3] This highlights the need for a thorough musculoskeletal examination in all individuals presenting with coccydynia, as an involuntary mechanism whereby myofascial treatment can be beneficial when solely relied on interventional-based techniques may not be adequate. Furthermore, an increasing number of studies have underscored the effectiveness of pelvic floor physical therapy in treating coccydynia. Techniques such as diaphragmatic breathing, stretching, and manual therapy for myofascial trigger points have been shown to reduce coccyx pain and improve function.[2,4]

In conclusion, acknowledging the muscular contributions to coccydynia underscores the need for research on muscle-targeted therapies to enhance comprehensive treatment strategies.

Conflict of Interest

No conflicts of interest between the authors and / or family members of the scientific and medical committee members or members of the potential conflicts of interest, counseling, expertise, working conditions, share holding and similar situations in any firm.

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