True Sports Podcast transcript

Guys, we got an interesting one today. Uh, today I interviewed Dr. Philippe

0:05

Schafer. He is a male pelvic floor specialist operating his own clinic,

0:10

Schafer Physical Therapy in Union Square of Manhattan. He actually interviewed with me a long time ago when

0:16

he was doing far more sports stuff. Um, and he really does a great job of diving into what the sports PT needs to

0:23

consider as it pertains to male pelvic floor health. I learned a ton. He

0:28

definitely made me blush. a bunch of times, but I persevered so you guys could learn. You can find him on

0:34

Instagram, P. Schafer 3. That's P S C H A F E R the number three. He graduated

0:40

from the University of Maryland with his doctor in physical therapy. He also spent time as a strength coach for

0:47

Georgetown University. And we get into it also a little bit. Has a background in stand-up comedy. Without further ado,

0:53

here's Dr. Phipe Schaefer. Welcome back to the True Sports Physical Therapy podcast. Today's guest is an old

0:59

acquaintance of mine. We kind of ran into each other um when you were first looking for a job. Um I loved your

1:06

background and then we kind of got connected around what you're doing now in the male pelvic floor space. So Dr.

1:12

Philipe Schaefer, super excited to dive into what you got going on. Welcome to the party. Thank you. Thank you so much for having

1:18

me. I really appreciate you having me on. Yeah, absolutely. Okay, so you're up in New York.

1:23

I am. Yeah, in Manhattan. I own a clinic, Schaefer Physical Therapy, in Union Square in Manhattan.

1:30

And big time. That is big time, dude. So, so let's pause there. Ready? Like, how, you

1:36

know, I met you however many years ago. Just walk me through your process in going from um you're a University of

1:43

Maryland grad. How'd you get up there? How did you open the practice? And what shocked you about that process?

1:50

Uh, let's see. Um, I guess I'll give a little bit just just my background in

1:55

general. Um, I started, I think like a lot of physical therapists, I started off as an athlete. Um, played a lot of

2:02

sports growing up. Uh, track and field was my main sport. I started running when I was six. Um, ended up I was, uh,

2:09

I guess lucky enough to run for the University of Maryland. And after that,

2:15

uh, I, so actually my first job out of school, I was an industrial engineer.

2:20

And then I kind of it was just a little too much sitting around for me. So I started as a personal trainer and

2:27

strength and conditioning coach. And before I went to PT school, I uh I

2:33

worked as a strength and conditioning coach at Georgetown University. And then just wanted to learn more. Like

2:39

athletes, they're they're always hurt like all the time. And I felt like I I

2:44

feel like I should be able to fix you, but I can't. And I don't I don't know how. Um, so went to the University of

2:51

Maryland and got my doctorate of physical therapy and afterwards I that's

2:57

when we met I think around 2019. Uh, but I ended up working at a a place

3:05

that was more manual therapy focused and did uh just a more education and

3:11

received more education in uh like the biomechanics and manual therapy related

3:16

to each body part. So the neck, the jaw, the shoulder, the hip. Um,

3:22

I did my COOMT, which is like an advanced certification through Nyant. And it was sort of through that that I

3:29

got involved with pelvic floor physical therapy because starting off when I was

3:34

working in Baltimore, uh, not, you know, not only was I doing orthopedics and sports, but I wanted to I wanted to get

3:41

experience with everything that I could. So at the the clinic where I worked, they saw like a little bit of neuro

3:47

cases and they saw a lot of vestibular. So I was like, "Yeah, I can I can do that." Like, you know, I learned it in

3:52

school. Like the best way to do it is just to just take on some patients. And uh the I can I can mention where I

4:00

worked. I don't I don't think they're like a direct competitor to you guys. No, we don't have those. So go ahead. We don't have Oh, sure. I work at Spine

4:07

and Sports Rehabilitation with Josh Renzy and JC Mativier. And they're they're very knowledgeable. they have a lot of experience and you know JC was an

4:14

expert in vestibular cases and Josh Renzy like knows everything. So I

4:19

learned a lot from those guys. So I started off with vestibular and I did TMJ which I still do now uh patients

4:25

with TMJ pain and I started also seeing pelvic floor for men. Um

4:33

yeah and then so I essentially I started seeing cases there and then I moved to

4:39

New York because my wife is from Queens so most of her family is here. So ended

4:44

up we live on the the Upper East Side New York and I right when I moved here

4:50

is about three years ago. Uh I just started a clinic in Manhattan and just

4:56

specializing in orthopedic sports uh and pelvic floor physical therapy for men.

5:01

And it's been uh definitely an experience. It's different in New York

5:06

because I'm, you know, I'm from Maryland. I'm from outside of DC. So it it is it's it's I guess it's very competitive everywhere, but I I feel

5:12

like there's like a thousand clinics in New York. So many it's so so many PTs. So you kind of gloss over that like, oh, I just

5:18

started a practice. I kind of I kind of know what goes into that. Tell me tell me like what someone listening who's

5:25

considering doing something like that tell me some of the horror stories and tell me some of the upside.

5:31

So I guess I'll just go into So when I I started it uh I'll go step by step. So

5:36

first thing is you want to decide what you want to do. Um you know you I think in New York it's very important that you

5:43

specialize a little bit. Like I like I like seeing everything. I like, you know, male pelvic floor in particular

5:48

because it's, you know, the people that and, you know, we'll talk about that more in a minute. The people that have

5:54

those problems, it's like they they really have a lot of issues. So, when you fix them, they're like they're the most gracious of of patients. Um, so you

6:01

have to decide what you're going to specialize in. And I just threw up a simple website and I found uh a place

6:08

where I could rent out space. And for anyone, I feel like that's a sticking point for some people. they're not sure

6:14

exactly like where, you know, where they're going to rent out space. So, you can go to a gym, you can go to an office. I found like a a

6:21

health care share, which is something that's uh more common in New York, and just started renting out space by the

6:27

hour essentially. And when you start off, you don't like I didn't have any patients. You have to go, you know, how

6:32

do you find patients? There's like a number of ways that you can do that. Um, so I, you know, I put up my website and

6:38

made my Google profile and just started basically knocking on physicians doors. Um, and it

6:46

took, uh, you know, it took, I don't know, four months or something before I got my first patient. And then it's

6:52

like, you know, it's another few months before you get the second patient. And then then it rolls into, oh, I have two

6:59

patients now. And then I have three and then four. And then it was like a progressive thing. I had a part I had a a job at the same time I was doing it. I

7:05

was working in an area that was not really in competition with them. Um, so

7:10

they were in Queens. Uh, I was operating in Manhattan. Um,

7:16

and you you gradually build up a client base. It's not there's not anything

7:21

magical about it. It's you just have to be patient and you have to make sure that each patient you have, you do a really good job. And then each patient

7:28

that comes has a like a physician or somebody somebody who they talk to. They may not have been referred by a

7:34

physician, but you, you know, there's somebody who they, you know, who they that they interface with. And once you

7:39

do a good job with that person, you tell the physician, hey, or you ask the patient, you know, you have them sign a release that you can tell them, can I,

7:44

you know, can I just tell your doctor a little bit what we did and how we fixed you, x, y, and z. Uh, and then you tell uh you tell the

7:53

doctor and then, you know, hopefully they send you some patients. A lot of times they don't. Um, I'm in New York.

7:59

It's it's very difficult to be a at least if you're in Manhattan, it's very difficult to be uh a practice that

8:07

accepts insurance because a you know, a lot of the clinics up here, they'll they see six, seven, eight patients at a

8:12

time. Yep. So, there's there's a very wide range of options that you get in New York as far

8:19

as like the patient experience. There's, you know, I know a lady on the west side who she does take insurance and she sees

8:25

a patient once every 30 minutes, but she also owns the gym that she works in.

8:31

Yeah. What's that? It offsets it. So, so that she's able to do that. Yep. Exactly. So, you you can have a

8:39

situation like that which is hard to grow into like a clear I don't know her whole backstory, but it's hard to own a gym in New York also like uh there's a

8:46

lot of competition for that. up by you. So if you're just taking insurance and you're just like a normal office,

8:52

you're seeing three, four, five, six patients at a time and a lot of people don't do that. I don't. So since pelvic

8:59

floor physical therapy, you can't I I find it ridiculous that people would even attempt that while seeing

9:05

Do people do that? Do do people they run a How do you do that? How do you run a pelvic floor shot? Okay,

9:11

I get patients that I get patients that complain about that and I was like, I don't how do they do that? They're like, "Oh, well, they were seeing for the I

9:18

think when you do you, of course, if you do any internal work, it's private." Yep. But I do like exit the room. I don't

9:25

know. Just logistically, it seems very difficult. Yeah, I I'd imagine. Although I mean

9:30

that's true for many orthopedic conditions, right? Like I I worked in Midtown Manhattan my last rotation. Um

9:36

Yeah, dude. I don't even think they had appointments where I worked. like that elevator door would open and people

9:42

would just like come off in droves and then we would go two hours with no patients and then five more walk in at

9:48

the same time. It was crazy. But like if you're dealing with a neck, how do you deal with someone outside the room doing exercise or across the room or whatever?

9:55

It it just becomes a juggling game. So how do you keep Yeah, it's ridiculous. How do you keep the lights on being in network doing one?

10:01

I'm not I'm not in network. Okay, you're genius. Okay, I'm out of network with all insurance

10:06

plans. It's it's a very reasonable path to take in Manhattan because

10:12

people just don't want to see six or seven patients at once. And I have a very varied varied

10:18

background and deep background in you know each joint. And then my background as a strength and conditioning coach. So

10:23

they come in I have advanced knowledge on the biomechanics of everything just whatever they they need. And then I say

10:29

look I'm also a trainer strength and conditioning coach. This is like a one-stop shop for pretty much everything

10:35

you need, including pelvic floor. Yep. Yeah. I That's a hell of a sales pitch. And that's that's awesome that

10:41

you can do that. The truth is like from what I understand about the New York market is if you're using your insurance

10:47

as in network, you are going to a mill. I can think of maybe one example where

10:52

that's somewhat not the case. Otherwise, it like the the patient population has

10:57

just been educated if I want one-on-one care, I have to pay out of pocket. I think it's different in other areas of

11:03

the country where there are therapists like ourselves that are in network and see a patient every 45 minutes. Um so so

11:11

and and the market kind of reacts to that like they know that I have this option. I don't need to pay 150 bucks or

11:17

whatever per session 200 bucks because um I have a reasonable option. So I think it's just different markets. I

11:23

think that's worthwhile to anyone listening like where you're thinking about opening shop to think about what

11:28

is the market dictating as to what I can charge how much time I can spend with patients what's my overhead like right

11:34

like great idea to use a health share healthc care share um which doesn't exist necessarily in Maryland at least

11:41

to where you can get like affordable rates to it's a great way to start also I'll tell you what I heard in that story

11:47

which is not new uh not unique to you Philipe no offense When you get a

11:53

practice up and running, it takes grind. You're working in Queens. You're hopping on a train. You're getting into

11:59

Manhattan. You're seeing a patient. Dude, you probably just saw 15 patients that day already. It's a many days easy 12-h hour workday

12:08

on top of I got to go. I've probably I've probably talked to gone to 70 or 80

12:14

doctor's offices just going in. And you know, you go and if you want to do that,

12:19

you go, I would advise going in before they start seeing patients, like 8:30. Be super polite. Um, because when I

12:26

start off, I try to emailing people like starting off, nobody answers your emails. Uh, now they do because now I

12:32

have Google reviews and my my website is it's kind of filling out a little bit and they look and they're like, "Oh, this is a real clinic. Look at that."

12:37

But it wasn't it wasn't like that when I started. So, I had to you just go in, you say very

12:42

polite, "I'm sorry. Sorry, I know everyone's busy, but you know, I just opened up down the street and you know, I specialize in uh TMJ or male pelvic

12:51

health physical therapy. I was wondering if I could just talk to the doctor. It'll take two minutes. Really, all it takes is like two minutes. Yep.

12:56

And you have your marketing materials, you have a card, and you have a pamphlet. You say, "Here's my stuff. Nice to meet you." Uh, and then you just

13:03

pray that they send you patients. Yeah. Yeah, you do. And and then you probably have to follow up. So, one is

13:08

great. Two is customer service. like you said it when you get that first patient, you have to be able to turn that patient

13:14

into four patients like in referrals and that means that patient has to have an awesome customer experience. So, you

13:20

have to be great at just the care we're providing. And you should have a differentiator, which Philipe, you

13:26

really do with with your special niche. Even if it's not male pelvic floor, it's

13:32

um extensive manual therapy. It's, hey, I also do strength and conditioning. By the way, I used to be a stand-up comic. Like, there are million things that play

13:39

into how this patient is then going to tell their friends and how you can hit the road uh hit the ground running. So,

13:45

um I think it's a great lesson. I'm glad we got into that. Let's get into male pelvic floor. Words that I never thought

13:50

I would say. Sure. Um, when I think about pelvic floor, my head

13:56

goes immediately to postpartum women. Sure. You you have a practice that specializes

14:03

in male pelvic floor. So, tell me what the biggest thing the rehab and strength

14:08

world is completely missing about the pelvic floor and how potentially it's actually sabotaging the performance of

14:15

the male athlete. I think the main so I see my case load you know depending on the month it's

14:22

like 50 to 70% male pelvic floor. I think the most important thing to

14:27

consider you know if I was going to convince a you know like a sports PT to

14:32

maybe look into like a pelvic floor course for men and they weren't because you know most sports PTs maybe they want

14:39

to completely avoid uh the pelvic floor but I I first that's there you go

14:45

convince me otherwise. So, uh, I first, uh, when I was coaching at Georgetown,

14:51

there was a book I read about posture that mentioned, oh, the pelvic floor, if you're sitting and you're slumped over like I am now, like if you start

14:57

squeezing the pelvic floor, you sit, you start to sit upright. And that was just the first time I was exposed to it. And

15:02

then when I went to PT school, I would say the University of Maryland does a pretty decent job of they bring in a

15:09

bunch of people. They they give many lectures on it and you know and they discuss how the core is it's like you

15:17

know they they talk about how it's the canister you know the diaphragm on top and then the abs and the obliques and

15:22

then the multifidi and then the pelvic floor is at the bottom and of course when I was coming into PT school I was

15:29

my background was mostly sports and of course sports you're always talking about the core and how to make it

15:35

stronger and and all this I was like oh this is this is the bottom of the core this is obviously ly important like it

15:41

should be it should be strong right but they don't really go into detail you know they talk about key goals they

15:48

um uh I can't you know I can't specifically remember the lecture I have like vague uh recollections but they

15:55

don't go into too much detail but moving forward to why

16:00

part of the reason I got into it is you could have a patient who comes in and they're like my hip or my groin hurts

16:07

and then you you know you do all the things that you know you do the full evaluation you know uh you look at I

16:13

look at for for pelvic floor I look at everything from the base of the neck down to the feet there there are a few

16:19

isolated uh there are a few cases if you have a really bad cervical herniated disc or if you have a spinal cord injury

16:24

or I had a guy with a C7 L1 fusion that had uh pelvic floor issues you do need

16:30

to look at the neck but if you're looking at the the groin or the hip you know you look at the spine and you look at the hip and then you look at the

16:36

thigh a little bit and the strength and you don't consider that the pelvic floor might be involved. So, I've had a few

16:44

cases where somebody it was exactly that. They come in for their groin or their hip and it's not resolving how I

16:50

want it to resolve and then uh I say, you know what, there's this thing that I

16:55

can do. I can look at your pelvic floor and I tell them, look, it's a little invasive. What you have is not resolving

17:02

like I should. there's a muscle like the opterator internis connects directly from the hip to the pelvic floor. If

17:09

something is wrong with the pelvic floor or the hip like vice versa, whatever. And let's say it's this muscle that's

17:15

really tight, this could be the thing that resolves it. So, uh I have a guy

17:22

who's finishing up now. It was exactly that. He came in for groin pain. It was bothering him for years. He came in and

17:28

we did all the things. I don't suggest it right off the bat because it's very invasive and people think it's weird and

17:34

they don't they don't come and they they don't think that that's going to be I

17:40

wouldn't advise if it is a situation like that I wouldn't advise doing it on the first evaluation you have to do everything first and then say look it's

17:47

not resolving how it should maybe we should maybe we should try this uh and it's exactly what I said he was open to

17:53

it and that was the thing that really made him turn the corner really reduced the pain dramatically because it was a

17:59

pelvic for partially a pelvic floor issue. And it was the same thing for me when I

18:05

first learned and I took the Herman and Wallace class and you you have to do have the internal

18:11

work done on yourself so you know what it feels like. At the time I had pinching in the front of my hip when I was squatting and I did

18:18

all sorts of things. This is after PT school. Um I had uh one of my colleagues

18:24

look at it at at clinic. Nothing was really resolving it. It was when I would go deep into my squat. I had this

18:30

pinching in my hip and nothing was really really working. And then I had an

18:35

internal mobe done and it was gone. And I was like, "Oh, so maybe there's this is like something that would work on

18:42

people that are not necessarily coming in for pelvic health issues." Yeah. Yeah. You know, that was kind of

18:48

like my eye opening moment with dry needling. Um where I I thought it was just a bunch of garbage. I'm like, you

18:54

know, I got a sister-in-law that's an acupuncturist and dude that uh there's no way in hell that works. Um and then

19:02

like as I'm working on my spinal manipulation stuff or I'm doing like a C-spine manip

19:09

following a very simple dry needling um intervention and how the muscles totally

19:15

uh downregulated allowed me to manipulate joints with far less force. I'm like, "Hey, I think there's

19:20

something here. sounds pretty similar where you try everything else you realize that this one little um

19:26

intervention little in the case of uh needling um I think I think um opterator mobs are

19:33

different but it can it can be a gamecher so um I totally understand like that eyeopening piece um tell me about

19:42

like when I think pelvic floor like I said postpartum woman but also uh don't forget to like teach them kles what else

19:48

am I missing there. It's so I'll just I'll run through an evaluation because like I said, normal

19:54

person, it's the base of the neck down to the feet. The the thoracic spine is very important on a number of levels.

20:02

So, breathing is very important. There's a number of people that come in, they just don't they don't know how to breathe. Um, people who are athletes

20:09

kind of take it for granted because if you're doing intense exercise, you kind of learn breathing. There's also like a

20:15

a wide variety of patterns and you know things that you can do but they don't you know if you're doing intense

20:20

exercise you just kind of learn uh you know breathe in through your nose out through your mouth you take deep breaths

20:26

otherwise you're going to pass out when you're doing sprints so you get but a lot of people if you were not a serious

20:31

athlete they sometimes they don't take deep breaths and sometimes that's because the thoracic spine or your ribs

20:37

are really stiff and if you don't take a deep breath if you're not good at breathing during breathing the pelvic

20:42

floor expands downwards So, if you have if you have a tight pelvic floor and you're not breathing well, that could be

20:48

one of the the things that is causing your issues. Like if you have or or you're not or like you're not

20:54

you're not breathing well, so your pelvic floor doesn't loosen, doesn't uh descend, if you will. Okay. So, um Okay,

21:01

that makes a lot of sense. So, you're looking at T-spine, you're looking at breathing patterns, then where do you

21:07

go? Then you go to the lumbar spine. there's uh you know anything that connects to

21:14

the pelvis could be fair grain like if it's if it's pure more purely a biomechanical issue uh like I see a lot

21:21

of runners a lot of guys that that ran the marathon that have pelvic floor issues now maybe they have some weakness

21:26

somewhere um you have to check for one of the things that is missed very often

21:32

is I have a a lot of patients with very distinct

21:38

lumbar ridiculopathy I think I have I don't know many three

21:43

or four right now that also have weakness in their dorsif flexors. Uh like we're talking pretty significant.

21:49

So I don't uh I would guess that that maybe the pelvic floor issues are downstream from that just from like the

21:56

weakness in their hip and you know they have numbness in their feet and weakness like I said. So you have to make sure

22:01

that you tease out tease that out from the lumbar spine. Um, then you look at you, you know, you look at the hip, you

22:07

do the scour and the faber and all that stuff. Check the muscles, you know, do like a basic muscle, you know, manual

22:12

muscle test just to see how strong they are. Um, you look at the thighs like hamstrings and the the hip flexors. Um,

22:20

and of course check the feet like for weakness and and stuff like that. And then I do I do the like the internal

22:26

exam towards the end just so like they're more comfortable. And then I do a lot of education on sometimes they

22:32

come from a urologist and the urologist didn't do any internal exam at all. Um so I just show them okay this is what

22:37

we're going to do. It might be a little uncomfortable. It shouldn't be painful. If it hurts we don't have to do it. If you're very uncomfortable we don't have

22:43

to do it at all. But just know that because of the issues that you're coming in for. It's there's a higher likelihood

22:49

that uh there's going to be some tightness or some weakness there. Um not

22:55

everyone does. There's people that come in, they have issues with urinating and stuff like that and it's, you know, they

23:00

can do a keull, they're strong, it's not that tight. Um, like I had a a 60-year-old guy about a year ago who

23:07

had, you know, he couldn't fully empty his bladder. And this is a guy that did like a lot of yoga. His hips were he was

23:12

strong. He had really good flexibility. It's just his his thoracic spine, his lumbar spine uh was like a brick and had

23:20

a lot of tightness in his abs. And we it was like 90% of the treatment was geared

23:27

towards resolving that and that's what fixed his issue. It wasn't like every time you go to a pelvic floor therapist

23:32

it doesn't means that they're going to be like fishing around in there. Uh you just have to make sure you do a full

23:38

evaluation and see because you know with the pelvis a lot of things could be involved. Yeah. Okay. So you you got to like think

23:44

about what are the possible uh contributors to symptoms and then start ticking those off via your test. I

23:51

think, you know, it's no different than than treating the shoulder. So, okay, if we're talking about groin strains or

23:57

groin pain, anterior hip pain like you were mentioning in yourself, right? I I'm doing scour, it's negative. Um, I'm

24:04

doing a deduction testing, they're strong, then I go, uh, okay, well, let's

24:10

check pelvic floor. What does that look like? I almost hesitate to ask. Like, I don't know

24:16

anything about it. So, walk me through. How do you tell if they're weak? How do you tell if they're tight? How do you measure it? And then how do you treat?

24:23

So you I I start with them. If you've looked at the hip and everything, I start them. I

24:29

do the internal. So you do the internal exam and there's the external exam where you look at the like the first layer of

24:35

the the superficial layer of the pelvic floor. So I lie them on their side and I have like a nice little app on my phone

24:41

where I show them the muscles and I say, you know, these are the muscles we're going to look at. There's three layers of the pelvic floor. They are all

24:48

combined. They're about the depth of my index finger and they're they're muscles just like your bicep is is a muscle and

24:54

I explain because most of these patients they don't know anything like they've googled but there's so much information on the internet now. Uh they protect

25:02

your bladder and they help with sexual function and this is because I'm looking at your groin and and your hip and

25:09

everything seems okay. Uh I have a suspicion that it might be the pelvic floor. So the education is a very

25:15

important part to make them feel comfortable because even though they know have they know

25:20

they have an issue with the pelvic floor uh a good percentage of people are very

25:26

uncomfortable with what you're about to do. So I get it. I get it, Phipe. Like it makes that makes sense.

25:32

Yeah. So cover them up and then you go through I just go layer by layer. So you go uh internally in and then you check

25:38

the first layer and I'm just checking for the basics. uh like I'm not going to dwell in there. And then you

25:45

what are you checking for? Oh, you're checking all the muscles in the first layer. So the issioinosis and the bulbos spongiosis uh is and there's

25:53

other muscles that comprise the first layer and you're just going around like a clock just to see uh if they're tight.

25:58

Then you go to the second layer, it's the external anal sphincter. Again, you're just checking if it's tight. And

26:03

then you go to the third layer, the levator ani, the katsugius. Again, you're just checking. you're going

26:09

around, you know, they're all layered around there just to see if it's tight. And then you that's just, you know, it's

26:16

a if it's if it's stiff, some there's some people that you can't you can't even get into the uh the rectum at all.

26:23

Um because the muscles are so tight. And then you don't, you know, if that is the case, I say, "Look, these are really

26:29

tight. We we don't have to force our way in. We're just going to start with some hip stretches and some groin stretches first." Uh because they'll loosen it up

26:36

by by proxy. Um, okay. Let me ask let me ask you a question. Hold on one second. So, I

26:43

if I'm looking at a hamstring and I want to see if this patient's hamstrings are

26:48

tight, I'm not pushing on their hamstring to figure out if their hamstring is tight.

26:54

So, square that for me. Like you are palpating a muscle and you're saying

27:00

Yeah. You're saying this is tight. What What is normal? What is this based on? You're not measuring anything.

27:06

It's just it's based on feel. I mean, you can you can palpate the hamstring also. I mean, there's no there's there's

27:13

not really like a a straight leg raise for the like the pelvic floor. You can,

27:19

you know, you can palpate the, you know, the opterator internist while the hip is moving. Um, but you are doing it based

27:26

on feel. Um, the you also ask them like you asked about muscle strength and you

27:32

ask them to contract the muscles. So there's there's two types of contractions with the pelvic floor. So

27:37

there's the concentric like a kele and then a reverse keigle which is a bearing

27:43

down motion which is like the same as if you know if you're trying to do a bowel movement. So for each layer you have

27:48

them do both and then you can have it you have them do just for a few seconds

27:54

then you have it you have them do it for multiple seconds just to see if they have good endurance uh with the pelvic

28:00

floor uh or with with each individual muscle. Uh, and during the first evaluation, I'm just getting a sense

28:06

just to see if, you know, how strong or how weak they are. It's pretty obvious if they don't there there's some people

28:13

that, you know, there's a lot of compensation and you say, you know, just do a little squeeze for me and they

28:20

squeeze their adductors or they they squeeze their glutes or something like that. And then there's people that have

28:25

really good, you know, they've never done a like a kele or a pelvic floor squeeze in their life and they have a

28:31

like it feels exactly how it should feel. Okay. Okay. So, it's it just sounds like

28:38

there's a lot of art that transpires here, right? It's like dependent on the therapist how good their palpation

28:44

skills are. Um whether they're actually in the right place and then you're just feeling whether the patient can turn the

28:50

muscle on or um does it feel tight? Is there tunicity there? And that's just based upon your

28:57

subjective uh experience and knowhow to see whether that's the case. Are

29:02

there any ways to objectify it? Uh not. I'm I'm sure there's instruments

29:08

you could use, but I do it all I do it all manually. Um I combine it with uh

29:14

you know I'm not I have I have my own critiques of manual muscle testing also like glute me and the glute max and

29:20

yep testing it on the t like you know it's it's you're you're getting a sense of how strong it is. You know I look at the

29:26

whole picture of you know if it's a runner can they do can they do double leg squats? Can they do single leg

29:32

squats? How how strong is the glute lead? How strong is the glute max? how how good is their pelvic floor squeeze

29:38

on the first layer, the second layer, the third layer, and so on. And then you just get a holistic kind of view of

29:43

everything. Yeah. Okay. So, now put your strength and conditioning hat on. How do you

29:49

train these muscles? Like where do you start? How do you progress? So, it uh it largely depends on the

29:57

person. Realistically, there's not many people, you know, the question you asked was, okay, let's say you're looking at the hip and they don't have anything.

30:05

Uh, it's okay. That almost I'm trying to think if I don't know if I've ever had a

30:12

situation like that. Usually before you get to the pelvic floor, like there's something. Um, so if

30:21

I do the full evaluation, I just determine on what I find. I start with the the the greatest outlier first. So,

30:28

like I said, the that man that Oh, so we'll do strength and conditioning. So, uh if there's a runner, I did have a

30:34

runner that that came in uh very recently and he was very like the

30:40

tenacity was very significant. So, I and then in addition, he did not have good

30:46

glute max strength uh behind his body. And this was a marathoner who ran he ran something like 240 in the New York City

30:53

Marathon like very fast uh very stiff thoracic spine. you know, when you're

30:59

running, um, uh, there's a lot of things that are going on. And if, if you do have a very stiff thoracic spine, you're

31:05

not rotating at the, you know, at your thoracic spine. When you're running, that's something that you have to take a

31:10

look at because in addition to the breathing, like I said before, there's there's two muscles at the bottom of the

31:15

thoracic spine at L1, L2, or not two muscles, two nerves that go down to the the genital region. So, if you know, if

31:23

there's some sort of inflammation there or some what's going on like that could be like a contributing factor. So you have to look at biomechanically

31:30

what does this you know with regards to their sport what does this person have to do uh to loosen everything up. So you know

31:38

uh loosening up the thoracic spine like I use for the example of the older gentleman that could be something that

31:44

uh that would be significant for this runner. Um, so you I like to start with at least for

31:52

the first couple of visits, I start with the individual joints or the individual

31:58

uh segments first and then I progress to stuff like single leg squats or single leg sit to stands like that. So I'll

32:05

start with like the first couple of visits we do most of my visits are structured 30 minutes manual therapy, 30

32:12

minutes of exercises and then it kind of it kind of progresses from there with what we do. So start with the thoracic

32:18

spine. I look at uh lumbar lumbar core stability. And then one of the things I

32:24

educate people on especially the athletes or or really everybody is for core strength you want to make sure that

32:31

you have that you're doing exercises in the three major planes. So like sagittal front to back um uh side to side and

32:40

then rotation. And even people who are like even this guy who was uh a pretty

32:46

experienced runner was doing largely only sagittal plane exercises. So we introduce you know I give him uh just

32:53

dumbbell uh side crunches and then various rotation exercises. You know I have some that I like. Um and then once

33:01

we he had significant pelvic floor Yeah. Give me give me the strength and

33:06

conditioning approach to the pelvic floor. it. I I combine it's so I do the like I

33:17

said the segmental stuff first and then I look at like with him like single leg strength and

33:23

single leg system I I can't remember exactly the progression what I did with this guy but essentially single leg strength or like Bulgarian split squats

33:30

and then one it's based on subjective you know how does your pelvic floor feel when you do it and then two do we have

33:38

to like if you're doing squats uh almost everybody I start with like a hinge or a squat squat during the squat and during

33:44

the hinge. I want you to bear down and bear down during like I like to do single uh sumo squats with a lot of

33:50

people because it's wide squat and then when you go down to the bottom your pelvic floor is stretching at the

33:56

bottom. So you at the bottom you do a bear down motion just so you're

34:01

stretching out and you know not very hard because you don't want to strain the muscles and then when you come up you do the the squeeze just to make sure

34:07

that your pelvic floor is sinking with everything. the the basic things that you have to keep in mind with those

34:12

motions is the breathing and the contraction of the pelvic floor. So if

34:18

if it's somebody who's who's not breathing well during those motions or they say, "Oh, it still feels very stiff

34:24

when I'm doing a sumo squat," you might need to palpate the pelvic floor when they're breathing like at the bottom

34:30

like in the hole or even palpate the the muscles when you're down there also because it could be, you know, when

34:36

they're lying on the table and they're doing squeezes is different from when they're they're standing up and doing stuff.

34:41

Yeah. Yeah. So I I I had Phipe, sorry to cut you off. I had a uh I had a women's

34:47

pelvic floor sports specialist on the pod and my head almost exploded when she was

34:52

talking about Okay. So, we palpate um internally while the patient is doing

34:58

the move. That is a normal thing is what you're telling me. Yeah. I have not done and I have done

35:04

the first layer. I haven't done internally because I don't know.

35:10

I understand that completely and I think I would do it if it was necessary, but I don't know how normal like if I just

35:15

think if you're going to do a squat with somebody's finger in there, it's not going to be the normal way that you contract muscles. I agree. Okay. So, we see eye to eye on

35:22

that. But I don't you know, there's a reason why you would maybe do everything, but I don't um

35:30

I don't know if I would do that. It's like I get you get a sense. Is it okay? Is it bearing down correctly? Is it squeezing correctly on the way up? Okay,

35:35

good. It feels great. Okay, then you then you progress to Bulgarian split squats and single leg sit to stands. And

35:43

if I liken it to uh um you know, it's

35:49

you know, it's a group of muscles that I would say are more it's hard to say a group of muscles is more important than another group of muscles, but it's sort

35:55

of like the foot intrinsic muscles. Um, like I've done a lot of teaching just

36:01

from all the high school athletes and the college athletes I've coached. I've done a lot of okay I'm basic this is how

36:07

you squat. This is how you front squat. This is how you bench. I've done a lot of that. I don't start people off with

36:12

foot intrinsic exercise and I don't start people off with keigull. If they get to the point where they're doing a

36:19

normal squat, like a front squat or a sumo squat or a single leg sit to stand and they either feel it's tight or uh

36:27

you can tell or they say that their core just does not their trunk just does not feel strong and it's not stiff while

36:34

you're doing the motion, then it's something that I would take a look at because especially with the pelvic floor, it's 100%. If you're doing a a

36:40

front squat and for some reason you can't stay upright and it it seems like that everything is strong that it might

36:46

be the pelvic floor might be the thing that you need to to do to get that person strong. Uh because

36:51

like I said, there are people who who are seemingly strong and they're seemingly fit and they're not great at

36:57

contracting those those muscles. Yeah. I mean I I mean that makes a lot of sense. That's no different than um

37:03

the the weightlifter who seems very strong, but you isolate a a specific cuff muscle and you know they look like

37:09

a little kid. So um I'm not surprised, right? Yeah, I'm not I'm not surprised by that. So Okay. But what's your intro to

37:16

strengthening just the pelvic floor? Like do you give them three three sets of 10 of of bearing down and like walk

37:25

me through that? Yep. Yeah. It's it's you do uh I tend to

37:31

go with now I'll go straight to the squeeze and the bearing down and let's let's just say let's go past if they the

37:37

the neuromuscular component where if they can even do it. You start with three sets of 10. Um there's there's a very wide variety

37:45

of opinions on how many you should do. I've seen people say like oh you should do three or 500 in a day. And the

37:52

rationale is because when you're walking around it's an endurance muscle. uh you know like the pubo rectalis pub or the

37:59

the third layer is largely it's at slow twitch muscles which makes a lot of sense obviously but I think just

38:05

realistically um I don't know if I want somebody doing that and I don't know how

38:10

effective it is I think like 30 or 40 or 50 a day is a is a good component then I

38:16

tend to progress with how long you can hold it uh so three sets of 10 uh I have

38:22

a I have a lot of success with just three sets of And then you hold it for 5

38:27

seconds or you hold it for 10 seconds. Uh and then pretty quickly I'll progress to bridges.

38:33

Okay. How do h how do they know they're doing it right? uh just through so palpation just

38:40

through me or I teach them how to do it and it's it's based on okay do you feel that that is how it should that's how it

38:48

should feel and do you feel the uh when you're doing like okay so if you're

38:53

doing the first layer like underneath like underneath the testicles is the most superficial layer a lot of times

38:59

people can feel that they're also contracting their adductors at the same time so which is probably um I tell

39:06

people you It's not the worst thing. If you're doing a squat or if you're running, you probably are going to contract them at the same time, but just for the sake of you knowing how to do it

39:13

and knowing that you shouldn't contract your adductors. This is how it should feel. So, it's

39:18

like not necessarily wrong, but we want to make sure that you know how to do it. Um, so that's how they do it. And then

39:25

you pro you progress. You know, I do table exercises first bridges and then you put the band like the band on the bridges then you can do it with weight

39:31

or you know prone hip extensions or standing hip extensions with you know uh

39:38

like this this marathon runner who was not getting good hip extension uh during his stride. You want to make sure that

39:44

you do pelvic floor exercises along with the hip extensions while standing and

39:49

then you progress to like adductor strengthening is really important. A lot of people have chronically weak adductors. Um, and then

39:57

I progressed from just doing the pelvic floor to the table to just more complex standing exercises to like I said, sumo

40:05

squats, single leg squats, single leg sit to stand, stuff like that. Yeah. Okay. So, I I think to like sum

40:10

that that little piece up is you want to educate the patient on how

40:16

to fire that muscle. You then want to make sure that they have the endurance side of it so that

40:21

they can hold it for a long period of time. Then you just start layering on load, different motions, and then

40:28

eventually getting to sports specificity. It's really no different than any other muscle. That makes a lot of sense. I think the only struggle is

40:35

it can be hard for the athlete to know, am I firing this muscle conccommittantly? Like is it on at the

40:42

same time? And I think that comes with education. You ever use um EMG or any BOF feedback to to tell them, hey, this

40:49

is on? I do not. Okay. I I remember it's a thing. It's a thing.

40:54

I It's It is a thing. I don't know if it's It's used a lot with uh I think

41:02

it's very important for maybe I don't really I don't I've never treated anybody under the age of 18. Um but with

41:08

kid, you know, kids who are like 10 or 11 that, you know, they're having trouble with going to the bathroom. I

41:13

think that's very important because they have like video games attached to it and stuff like that. But it's

41:20

um I use it like I can tell and I think it's just easier to just teach the patient how then you teach the patient

41:26

how to do it. Uh because you know they're not going to have an EMG at home or anything like that. I don't it's I don't think it's that difficult

41:33

of a thing to to teach and to I've I have not needed it.

41:39

Okay. Okay, that makes sense. Um so that's around the strengthening side, right? Getting it stronger um endurance.

41:46

when you talk about the loosening of it, the mobility of it. Um, just walk me

41:53

through that thought process with home exercises and and how you encourage an

41:58

increasing of elasticity. That's the word

42:03

that usually. So, there's a few ways. one, there's a with the pelvic floor

42:08

itself, there's a wand that people can use and people, it's another thing where

42:14

people don't always like using the wand, but I tell them, you know, this is something that could be important and if your symptoms don't resolve, just know

42:21

that this is something that you should probably use. And I have a, you know, I give them instructions and a video and I

42:27

I tell them like, I'm just going to put this in your Google doc just so you know it's there. You don't have to use it.

42:33

But I definitely believe and uh it's definitely true that if you stretch the adductors and you stretch the hamstrings

42:38

or the hip and there's like a lot of different ones that you can do, you're also getting the pelvic floor muscles

42:44

just in addition. So people that are maybe uneven with uneasy with it, you know, I start with supine hamstring

42:51

stretches 30 seconds to a minute. There's people who come in, they're super tight. It's pretty much the norm.

42:57

Like I said, it's it's very uncommon that somebody comes in and their hip is not somehow like they lack mobility in

43:03

their hip. Almost everybody hamstring adductors like pigeon stretches and then you know I start them with 30 seconds to

43:10

a minute and then I tell them a lot of people are not aware of like the low load long duration stretches that if

43:16

they have really tight adductors like like some people do like rocks it's like you know it's okay to do a minute two

43:23

minutes. Don't go straight to five minutes because that can also be sore. Um, and then if they're really tight, I

43:30

tell them stretching is no different really from going to the gym. It's like lowle strengthening. It's like you're

43:36

putting stress on the muscle to conform to a certain way. There's various ways that we can stretch this with weight.

43:43

Like an RDL is stretching the hamstrings with weight. And then once they get past if if they're really not, you know,

43:50

getting to the range that they need, I was like, look, okay, we start with 20 pounds on an RDL. And the goal is not

43:55

hypertrophy or explosiveness. It's okay just, you know, lean deep into the muscle a little bit and stretch it with

44:01

weight. Hold it a little bit longer and that's another way that you can kind of progress past, you know, just like doing 30 seconds on a table.

44:08

Okay. So, when you're is it possible to stretch an adductor to do a pigeon stretch and still and see gains there

44:16

but still have tight pelvic floor? Is that when you go to the wand?

44:22

it it's yeah it's it's typically if they're seeing improvements

44:27

it's like you see a conccom committant kind of improvement in the pelvic floor typically there are there are exceptions

44:33

it's sort of like the same thing is like okay if you stretch yeah if you're stretching your hamstring you can still have knots like in the belly of the

44:40

hamstring it's like there's the manual therapy there's the like the massage component and then there's the the stretch component so I do tell them that

44:47

it's like yeah you can start with this stuff and if it's not you know if it's not resolving like it like try the wand

44:52

and and see there's a you know there's a little bit uh there are yeah especially

44:59

if you're getting the range back it's there's there are people who are still a little bit tight um but it a lot of it

45:06

is also there's like a little bit of trial and error involved as far as like what is really going to improve the like

45:12

the the pelvic floor tenicity. Yeah. Yeah. And and so that begs the next question which is what's the

45:18

duration of care for a lot of these individuals? How quickly do they start seeing results? How long are they come

45:24

in a shape for physical therapy? Uh so of course it depends on the person, but if it's a uh you know main

45:31

thing is a lot of people there's a lot of guys that I have under the age of 30 which is actually a big surprise. I thought when I was first starting to do

45:37

this it was going to be a lot of like postprostate uh type of stuff. So, a guy that's young

45:43

that's exercising, uh, it's the same as anything else. It's like, okay, four,

45:49

six, eight weeks. A lot of people that come in, if they just have a tight pelvic floor and they have a little bit of pain and they don't have any ridicular symptoms, but a lot of people

45:56

do have the ridicular symptoms. I tell them, it's like, look, some people come in the first visit and they see improvements already

46:01

and it's like four to six weeks, sometimes faster if they feel comfortable doing the stuff.

46:08

uh radical prostatctomies uh you know they'll stay for a long time

46:14

like if they have if they really can't contract the muscles and they have they're wearing a diaper and that sort of stuff ridiculopathy I tell them I was

46:21

like look this you know this is probably the main driver of the problem you have to we have to make sure that your hips

46:27

and your your like all the muscles surrounding your lumbar spine are strong before you keep going before before your

46:33

discharge otherwise this might come back um because I don't think I think the pelvic floor was caused by this. So, you

46:41

know, those guys maybe like three months, something like that. Uh it's dependent, but if like it's a if it's a

46:47

simple linear kind of like you're tight. Yep. Pretty fast. Like

46:53

some guys like I had a guy recently was like six visits once a week for six weeks and he was good. And that was and

46:59

that's like a comprehensive like he didn't get discharged when he was like feeling a little bit better. It was like, okay, we did two weeks tacked on

47:06

just to make sure that we're going through like the squats and deadlifts and stuff that this was not a an athlete really, just like a normal guy. But I

47:13

said, this is really important because like in New York, like you're you're walking around getting groceries, you

47:18

it's really important that you're strong, otherwise there's a possibility that this might come back. Yeah. Yeah, that makes sense. Um, okay.

47:25

So, um, what are some of the things that a sports PT should be listening for

47:30

outside of this hip pathology is just sticking around too long that should cue

47:36

me in to think, hey, pelvic floor and then and then what are simple interventions that I can give them to

47:41

try before I send them up to New York to be to to Schaefer? I think uh pain pain. So, you have to

47:49

know to ask these questions because sometimes even even with non- embarrassing questions, you know, people don't think to tell you certain things.

47:55

So, if they're coming with a hip or a groin issue, they don't they don't know like, oh, my testicles hurt or like the

48:01

tip of my penis is numb or something like that. So, of course, anything involving pain in the genitals or a

48:07

little bit of urinary leakage, um, sexual dysfunction, you would have to ask for. It's best to put it on the

48:15

intake form. So you because if you ask again if they're not coming in for that you know they might like why is he

48:20

asking me that and you don't want to turn the patient off. So if you add it to the intake form sexual dysfunction or

48:26

urinary leakage or anything like that uh abdominal pain uh any any uh

48:31

constipation uh constipation is way more common than like fecal incontinence. Uh it's not

48:38

quite as common with you know if you're just like treating athletes but it h you know it happens for sure. Um,

48:45

those are the main ones. Urinary sexual dysfunction. Yeah. Pain in the abdomen, pain in the in the groin or in the in

48:51

the the sex organs. Yeah. And then sexual dysfunction. It's it's a blood flow issue. Pardon my

48:58

anatomical ignorance with this, but it's a blood flow issue because the muscles are too tight.

49:05

No, it can be. So the if it's an erectile issue, strength of the the bulbos spongiosis and the issio

49:11

cavernosis contributes to solid erections. So it can be a strength

49:16

issue. Uh it can be tightness can impede blood flow. It can be if you're super

49:22

stressed out and we didn't even talk about anxiety which is like a huge uh like a huge component of this. Uh if if

49:31

you're very stressed out and the you know the sympathetic nervous system is also in the ribs. So if you're very

49:36

tight there and you know some people their thoracic spines are like a rock that that will help with sexual

49:42

dysfunction too. Like just get just getting a like a good massage. There's you know like physiological and

49:49

psychological benefits to that. Uh you know it's hard to tease out exactly what is the main cause but

49:55

uh stress is a huge component. You know, if you have somebody I've had somebody who's, you know, a powerlifter who does

50:01

not do aerobic exercise and aerobic exercise helps everything basically like

50:07

your your mood and like going to the bathroom and if you have sexual dysfunction, even though they're an

50:12

athlete, maybe they're not getting, you know, like a pitcher for baseball or something. They're not doing they're not

50:18

doing any jogging or swimming or something like that. That could that could be something that's causing some of the symptoms also.

50:24

Gotcha. Okay. Um All right. Last last question here. What is one exercise that

50:31

we should stop doing immediately because it could be contributing to pelvic floor

50:36

dysfunction? I think the main thing now is is uh the

50:41

main thing is people just know keigull and they don't realize uh like I was I

50:47

was talking to a cardiologist the other day and he said the only you know I guess they got a little bit of education

50:53

in in school or or PTS it's also if you don't know if you haven't taken a a

50:58

class they'll say like oh just try some keull and maybe it'll go away. Do three sets of 10.

51:03

Uh that could potentially make it worse. uh you don't know if the person is you know like I said some people you can't

51:09

even palpate the internal muscles because they're so tight you don't necessarily want that person starting

51:15

with keigull maybe they can try some reverse keigull but also they may not they might be so tight that they can't

51:21

even really do them so the the thing to do there is like to start with stretches so I would not I I don't know if going

51:28

with keigull right off the bat is a good idea because it could make it worse and if that person does have you know if

51:34

they have significant and you know, sexual dysfunction along with whatever they're coming in to see you with, it might make it worse and it, you know,

51:41

might make them pretty uneasy. You kind of freak them out a little bit. Yeah. Rule number one, don't make your patient worse.

51:46

Yeah. Um Okay. Okay. I said last question, but le let's bring it all the way back to to

51:53

something we started with. How do you in such a serious field of pelvic floor

51:58

health? How do you use your standup comedy past

52:04

to influence your interventions?

52:10

There's a few ways I think. Not not what you think. People people would think

52:15

like, "Oh, I'm you know, I'm good at telling jokes. I'm super funny." But it's not.

52:20

I don't know. you you want to be careful with cracking too many jokes when people come in. It depend it depends on the

52:26

person. Yeah, sometimes you do. Um, but I think the the main thing that I I

52:32

bring to the table that maybe people wouldn't realize from standup is when you're doing standup and everyone's looking at you, you cannot lose your

52:38

composure or get upset or get sad that a joke doesn't work or get angry that a

52:44

joke doesn't work. You have to be solid and you are there despite what the

52:49

audience might be doing. And it's the same thing with being a PT. If somebody comes in and they say something, of

52:55

course you want to be congenial and and nice and listen and of course those are like basics, but if somebody says something that's very uncomfortable,

53:02

uh something that's a little weird, you can't you can't even recoil an instance otherwise it's going to turn that person

53:08

off. You have to be totally like you are here to tell me what's wrong with you

53:14

and I'm taking all the information you're telling me and there's no judgment and there's no like there's nothing that's weird. It's like I am

53:20

here and I'm not uh like I don't make a like a disgusted face or anything like that. It's just complete like composure

53:27

I think is the main the main thing that's important there. Dude, that's great advice for any PT in

53:34

whatever we're doing. If you're teaching somebody like an exercise, a hip hinge that a lot of

53:39

people can't get. You you should never get frustrated at all. like you have to

53:44

be you have to have ultimate patience because they're they're insecure about like oh I can't squat I can't I can't do

53:51

this I can't do that whatever it is like they they think that oh I'm not an athlete I'm not I'm not this I'm not that no if like if they're not getting

53:57

it then it is your your fault like get better cues like teach them how to do it better like try something else you

54:04

cannot get upset it's not the patient's fault it's it's your fault you have to explain it better yeah um out that is outstanding advice

54:12

Philipe you taught me a ton Tell everyone listening how they can find you. Tell anyone who needs your services

54:18

where they can come see you. I'm at Union Square and Manhattan Schaefer Physical Therapy www.fippeshafer.com.

54:25

Um I give free 15minute consultation. So even if you're in Maryland, you can still hit me up. Um I'm still licensed

54:31

in Maryland, so if you want to do a video visit, you can do that also. But anyone else watching like in New York,

54:37

uh I give free 15inute uh phone consultation. So you can always call me. I give my patients my my cell phone so

54:44

they can text me. I'm very good at responding just whenever just, you know, people have a lot of questions. So, I

54:49

welcome all questions. Uh, no problem, dude. Awesome. Thanks for being a

54:56

resource. Um, absolutely. Thanks for telling us how important this is. I think it's something that we don't talk about um and it gets kind of brushed

55:02

aside. And just think about everyone listening, just think about all those patients where you're following the

55:07

protocols or you're following um the latest and greatest best evidence interventions and the patient just isn't

55:13

responding. There's always something else you can check. Phipe did a great job today of highlighting. Let's think a

55:18

little bit more about the pelvic floor. Um male or female. Yeah, you did a great job. Everyone listening, thank you so

55:24

much for your support. This is like episode 170. Um the podcast is doing

55:30

awesome. Um, yeah, it's it's awesome. I love the outreach. If you're looking for an awesome place to work, look us up,

55:37

True Sports PT on Instagram. If you're a patient that needs help, find us, too. We're everywhere throughout Maryland,

55:42

Pennsylvania, Delaware. We're coming to Virginia. So, look out for that, guys. Thank you so much for your support.

55:47

Thanks for listening. Bye-bye. Goodbye.