

# Dr. Jill

Your Functional Medicine Expert®  
Jill Carnahan, MD ABHM, ABOM, IFMCP

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## Podcast:

[#111: Dr. Jill interviews Manual Therapist Gina Tacconi-Moore on Tips to Relieve Chronic Pain](#)

## Text:

### Dr. Jill 00:13

Well, good afternoon, everyone! Welcome to another episode of Dr. Jill Live on this Friday afternoon. I don't know where you are listening in the world. Please pop in the chat and say hello. If you are live with us, tell us where you're from.

### Dr. Jill 00:26

Today here in Boulder, Colorado, it is hot, hot, hot. It's dry and it's above 90 degrees. And I was just telling Gina, full disclosure, I went on a hike this morning. It was amazing, and I had a great time and I crashed. I think that the heat just totally took it out of me. I'm back up and ready to go and I got a little tiny bit of coffee here, some good clean coffee. I'm super excited. I did not want to miss this. And I just say that because I was literally laying flat an hour or two ago and here I am because I am so excited about this guest, Gina Tacconi-Moore.

### Dr. Jill 01:00

We met through a mutual acquaintance that masterfully helps us with marketing and different things. But she said, "You two have some things in common, and you have to meet." So I was super excited. And even in our conversation just in the last few minutes, we found all kinds of fun things that we have in common.

### Dr. Jill 01:17

Let me introduce her, and then I'm going to jump right in. So Gina is a pioneer in the world of manual therapy with knowledge that goes far beyond the four walls that house your primary care physician. She spends her time answering mystery pain. "It's not magic, it's mobility," is one of the things that she goes with. You're going to learn a lot about her, why she's so special and why she's so good at what

she does. I can't wait for you to hear her story. She is an accomplished clinician and businesswoman, running her own practice.

**Dr. Jill 01:50**

I can read all the great accolades that you have, but the things that I think are really special, our mutual acquaintance who introduced us said: "She's one of those people that doesn't even need advertising; it's word of mouth. When someone gets helped by her, they tell people." And you've helped some pretty influential people. So I hope it's okay that I don't read all of the bio because you've got so many accolades to your name. But she still pursues CrossFit, weight training, literature, interior design, and we both decided we love going deep and reading books. I was telling you before we started, "I'm like a secret, closet librarian," because we have an introverted-extrovert inside.

**Dr. Jill 02:20**

So, Gina, welcome, welcome, welcome! Tell us a little bit about your story. First of all, a lot of people are probably like: "What is this? What do you do?" We'll get there. But how did you get to where you are now? What's the story of how you landed here?

**Gina Tacconi-Moore 2:32**

Sure. So first, thanks for having me. It's a pleasure. So the story begins with my shins. In a former life, I was a sprinter—short distances—anything beyond 200 was just not my bailiwick. But I had really, really nasty shin splints for about eight years or so. And then I got it in my mind that I wanted to run a Tough Mudder and knew that I was going to need something a little bit more aggressive than the yoga that I was doing in order to prepare me for that. And so I found CrossFit. And I had a very adept trainer who was really on point with his recommendations and stuff, very conservative as far as CrossFit goes. But I was constantly subbing in for anything else besides running because it just hurt. And he said: "Look, you're going to run 12.1 miles with obstacles and stuff. But you're going to need to get your body fixed before you go and do this because you can't row and you can't airdyne your way through every time; it's not going to work." So I said, 'Okay.'

**Gina Tacconi-Moore 3:39**

So I went on his recommendation to this gentleman who did active release techniques. So there's a lot of familiarity, I think, in this space with that technique. And I gave him what was going on, and three or four fairly uncomfortable sessions

later, I was about 80% resolved. And that was the first time that had happened because, in high school, they would stick me in a whirlpool bath and kind of tape up my shins like a racehorse, and that was the end of it. So it was like a little Band-Aid on the problem. And the change was so profound with those visits that I was like, "I have to figure out how to do this for other people. This is crazy!" So I found out that I just needed a license to touch. So I pursued a course in massage therapy. And as soon as I got accepted to the massage school, I started signing up for Active Release Techniques seminars. Before I graduated with my license, I was full-body certified in ART.

**Dr. Jill 4:50**

You were clear on your journey, right? You were like: "This works, I want to do this! I'm licensed." That's really good. That's amazing. I love it!

**Gina Tacconi-Moore 4:56**

I mean, I don't do well with waiting when I find something that I really want. So it seemed like a natural progression to me, and I knew that I wanted to do something with a clinical focus that was going to be under the umbrella of wanting to help specific issues. So I give a lot of credit to folks who are in the space providing therapeutic massage for stress and reduction because that's absolutely required, and it's really, really needed. But the stuff that I do is much more individual outcome-focused. How much can we reduce your pain? How much can we improve your range of motion so that you can get out there on the 12.1-mile course and run the Tough Mudder?—or whatever it happens to be.

**Gina Tacconi-Moore 5:52**

So in the midst of that, I was also opening my CrossFit gym, CrossFit Lowell, which I founded 10 years ago, and has since moved on. But it's still functioning, so if you're in Massachusetts, check out CrossFit Lowell. And so I found that being a CrossFit coach and being a bodyworker, a manual therapist—whatever you want to call it—was really complimentary because I could see biomechanically things working out on the gym floor, and then see consequentially what was happening in my clinic. So I did that for a while and had some wonderful mentors along the way, specifically Tom Myers, who wrote Anatomy Trains. And that was really where I got my foot in the door with the dissection work that I do. And so the approach now that I have developed, which is called 'infrastructural release,' is sort of a marriage between all of the work that I've done in the dissection lab, the work that I did as a CrossFit and Olympic weightlifting coach, and just the work that I've done over the past 10 years on thousands of bodies at this point. So it's a culmination of all of that

learning, in addition to, as we were talking about before, standing on the shoulders of giants in this brilliant borrowing thing. So that's what I'm trying to do.

**Dr. Jill** 7:26

And I didn't mention it, but I wanted to make sure people know that you have been a renowned consultant with high-profile sports teams: NFL, MLB, PGA, and other sports people. Again, in this field, you are known. What's neat is that you've really taken your own approach and pulled some things together. It's interesting, ART, because I didn't realize that was one of the bases because, probably 20 years ago, when I first started running, I didn't know anything about what I was doing. And I was like, "Oh, this barefoot running sounds cool!" So I got myself a pair of five fingers and I went out. I had no idea I was totally a heel striker. I got a stress fracture in my calcaneus. So I clearly was not running right. And ART was the thing that actually helped me back then. And so I remember a chiropractor who did it nearby. And it was like, "Okay, there's something really different here." So I totally know the power of that personally. And that was decades ago. I wouldn't have been able to hardly walk for months were it not for that technique at that time. So you've taken that and made it your own. And then you just briefly mentioned the dissection. But this is what's so unique about you. Tell us more. You are an expert—what do you even call that? And forgive me for not—

**Gina Tacconi-Moore** 8:42

Dissector, I guess, is fine. So again, in studying with Tom, I think that he really attempts to take a holistic look at the body. And in doing so I've likened my job, the job of the manual therapist in general, to hearing a terrible noise in your car, driving it to the mechanic, and saying: "Okay, I've got this terrible noise in my car, and I need you to fix it. But I don't want you to put it up on the lift, and you definitely can't look under the hood." And so, that's part of what we have to do. Being able to get into the dissection lab was a way to look under the hood. And having those images that are not computer generated, that are not out of a textbook, that are behind my eyelids at any given moment, has given me an atlas that I can utilize anytime I have a patient under my hands, which is really awesome.

**Gina Tacconi-Moore** 9:47

And particularly where the method that I've developed relies on the separation of tissues at the borders and margins and things like that, having a really solid idea of what the topography of the inside of the body is makes the work that much easier, honestly. So that got parlayed. I did a bunch of labs with Tom. I did a few labs independently as well. And then I was invited to be part of the dissection team at

the Plastinarium that was creating the world's first fascially-focused plastic model. So she's in existence now. Her name is Freya. She's over at the Body Worlds exhibit in Berlin. And we had these major non-reality-based dreams when we were starting. Everybody wanted to be able to essentially disarticulate the fascia from the musculature completely. The plastination process is a fairly brutal one on tissue and things like that. And so we compromised by starting with various areas and showing how those are fascially encased or whatever. So it's not quite the full ghost body that we're hoping for yet, but give us 7-10 years and we'll get there.

**Dr. Jill** 11:17

Unbelievable! So is this a model? Is it just a model, like a man-made model? Or is it actually preserved tissue?

**Gina Tacconi-Moore** 11:27

It is preserved tissue. So it's a full-body cadaver. And like I said, the process of plastination is years long. We started this process about four years ago, and like I said, she's finally done.

**Dr. Jill** 11:45

Wow, that's fascinating! I was loving this so much. And I can see how that totally gives you the ability to see or feel. And you mentioned just before we started too, this movement and the smoothness, it's almost like there's a tear or a rub. Tell us more, because just like a well-oiled hip, or a cog in a wheel, or whatever, you're going to have that smooth motion or this creaky greasy sound. So can you actually tell with the tissues on the exterior that things are not moving like they should? And again, I don't know the vocabulary very well.

**Gina Tacconi-Moore** 12:19

Yes, absolutely. So basically, what I've said to my students and to patients as well is that healthy, well-circulated solid tissue feels like a freshly set bowl of jello. That's the secret. Anything that feels anything other than that is what I go after. So I'll say that and people are like, "Well, surely, it can't be that simple." It is because otherwise you can really get lost in the sauce—in the analysis paralysis realm of things—if you start thinking much more complicated than that. So the idea of this whole method is that somebody comes in with an initial complaint—and it can be anything from carpal tunnel to plantar fasciitis to chronic lower back pain, all of that I would label under the more common things that I see, to pelvic floor dysfunction, incontinence, temporomandibular joint disorder, chronic headaches and things of that nature as well—and say, "it's this," "it's my shoulder," "it's my back," "it's my... " whatever. And so

I'll start at that area, but rarely do I stay in that area. One of the sort of guiding tenets of this is that it's the victim that cries out, not the perpetrator, right? So the thing that hurts is not necessarily always going to be the source of your problem. It's certainly the source of what's causing you to not sleep or have to change your posture or whatever. But what is maintaining that pain? And that, ultimately, is what my job is: to find the source of that pain and attempt to resolve it.

**Dr. Jill** 14:17

Wow. So often, like you said, knees are coming from hips, ankles are coming from hips or elbows, lateral epicondylitis is coming from... So that's manual therapy. Fascinating. And I love how you've combined that. And the thing that I hear too, is that you've got, obviously, an incredibly analytical mind and you love to go deep and study, but you've also clearly developed this tactile sense that's probably extraordinary compared to the average person because that's what you do. And I always admired those people [for this] because that's like the right brain, left brain stuff, right? You've got the tactile intuitive sense that you probably trust; just like you said, if you think too hard... And I do that in medicine too. It's interesting because I used to be purely analytical, but over time and with experience, I'll often have a gut feeling and then I'll prove it with the science. But it feels like to me—'feels like,' literally—you're actually getting very good clues from your fingers, from your touch, from your tactile sense, and then thinking through where it comes from. But that had to be developed over time. How many years have you been doing this?

**Gina Tacconi-Moore** 15:22

So 10 years at this point. And there is a funny story related to the tactile sense, actually. So, as I said, I started in massage school, and we really launch into things right away. So within the first week, we had hands on each other in the class because ultimately, with a massage therapist or manual therapist, it's that haptic sense, it's that perception that is really what sets us apart as well from other folks who are doing good work in this field. In chiropractic school, in physical therapy school, and places like that, there just isn't the emphasis that there is in massage school with developing these as your primary tools of assessment. [showing her hands] Because truly, in a traditional massage school setting, you aren't getting a huge amount of education about orthopedic tests or anything like that. So you really are taught to rely on these very portable tools that you have with you at all times.

**Gina Tacconi-Moore** 16:29



So it's the second week of my time at the massage school, and we're working on finding the point of physical innervation at the trap up here. Some people might call them 'trigger points.' So I've got my partner down, and I'm working, and I'm working, working. And the teacher is saying: "These are pretty obvious. You're going to find them [with] no problem." And I'm like, "Oh, my gosh, I can't find these anywhere!" And so I wave her down. She just comes gliding across the room. She's talking to another student, and literally just puts her hand out and lands directly on my partner's shoulder, and she goes, "Ow, that's it!" I said: "Oh, my gosh. I'm never going to be that good. How did you do that? That is remarkable!" So that was a little bit of humble pie right out of the gate. But it's like anything over time, when you get used to using a tool in a certain way, you become adept with it. My tools just happened to occur at the end of my wrists.

**Gina Tacconi-Moore** 17:32

It's funny because I was having a discussion with my husband not too long ago just about perception and stuff [about] the hands. He was working on me—that's what it was—he was working on me. And I was like, "Gosh, you're so pointy. I taught you better than that! Pull up and start again." And he's like, "Well, but I can really only feel at the very tips of my fingers." And I was like, "Really?" Because my point of contact—and this is why I have nails—when I work with someone is right along the side of my finger, or sort of right in through here. [pointing to the midpoint of the index finger] I didn't even realize that that was the point with the most sensation in my hands until a couple of weeks ago when I was talking about it.

**Dr. Jill** 18:13

In college, I did a course in reflexology for a short time. I did that for a little extra on the side. And I remember very clearly that we really targeted this little section of the thumb on the side where you can get more pressure but also feel. Again, I'm no expert, but I remember that a little bit. And I'm like, "Oh, yes, that makes total sense."

**Dr. Jill** 18:31

So let's talk about patients. It sounds like a lot of people come to you. That's the commonality with us too. Our mutual acquaintance was like: "You both are like these medical mystery people who [treat] people [who] have been everywhere, tried everything, and they haven't gotten the help they need." So I can totally relate. But tell us about a situation where maybe they were getting ready for surgery, or maybe they were post-surgery and they felt like they were unhealable.

**Gina Tacconi-Moore** 18:59

Yes! That's really my bread and butter. So the one that comes to mind is [when] I was working with a first responder in a major city. And this person came to me on a Monday and said: "Okay, here's the deal. I've got surgery scheduled for Friday," the same week.

**Dr. Jill** 19:23

You've got two days!

**Gina Tacconi-Moore** 19:26

No pressure, this is great. He had chronic lower back pain. So what they were recommending was going to be a double laminectomy but on the same side, so it's lateral. And he was like, "I really don't want to do that. I have young kids. I want to continue to be active in my work." So for him, it was his livelihood and also his ability to have a good quality of life with his family.

**Dr. Jill** 20:08

What decade, 20s, 30s, 40s, 50s?

**Gina Tacconi-Moore** 20:11

He was [in his] early 40s. He had tried, according to him, fundamentally every conservative measure under the sun. He'd been to chiropractors and physical therapy, and he'd done all of the cryo treatments. And he's like, "Anything holistic I could think of, I tried." And he'd gone and he'd been to a neurologist and a pain specialist. And the pain specialist basically said, "Look, when are you going to start taking this seriously and actually fix it?" And so that was really what prompted him—bullied him, maybe—into surgery. And so he was like, "You're my last ditch effort before I get cut on and I really don't want to, so what can you do?"

**Gina Tacconi-Moore** 21:03

Starting with the initial area of complaint, which was on the left side of his back, I felt around and there was maybe a little bit of tightness, but certainly nothing I'd write home about. I just followed the tissue down the sciatic path, so I'm in through glute and piriformis, and down through hamstrings, and so forth. And I'm like, "Gosh, I really am not finding anything remarkable in here. Maybe I can't help him." So I sent him home. I was like: "Look, you're going to have some residual soreness. Just get in touch with me in 24 hours, let me know—good, better, and different—how things are going." So in the meantime, I went home, and I'm racking



my brain because I don't like failure. And I'm like, "I can't—I have to figure this out." I like to draw schematics of the patients I'm working with that I can't solve on my whiteboard, draw out the structures that I think are involved, and then look at what I might be missing with my trusty, net, or textbook, or something like that. At any rate, I went home. I thought about it and realized that I had fundamentally skipped over his entire adductor group. So I was like, "Okay, well, that's something that I can check. I've got a little breadcrumb now." Right?

### **Gina Tacconi-Moore** 22:29

When he called me, he's like, "Yes, I'm probably 20% better. I'm not sure." I'm like, "None of that matters. I missed something. So come back in because we checked all the obvious stuff on that path. But I missed the stuff that was maybe secondary or even tertiary." So he comes in—I like to do just a subjective pain scale with folks before we start—and he's like, "Yes, I'm probably at a six right now," which is better than moderate. So I'm like, "Okay, I'm going to just look down into your adductors and see what we've got here." Sure enough, there is a spot in the adductor magnus, which is the big one that's in the middle of the meat of your leg. It's called the adductor hiatus. It's there on purpose. It's basically just a hole that allows nerves and vascular structures to pass through. So I look at that and I'm like, "Man, this thing feels like it's got a zip tie around it!" So I'm like, "Wow, okay, it's a bit of a crapshoot, but let's just see what we can do." So I worked through the hiatus and I felt the neurovascular bundle just like travel all of a sudden. And he went, "Holy crap!" And I went, "Holy crap!" And so I cleaned up a little bit more, just doing due diligence down into the lower compartment of the leg and all of that.

### **Gina Tacconi-Moore** 23:59

I traced my steps back up to the lower back, and I was like, "Okay, get up off the table, see what you think." And he got up and he was like, "It's gone. The pain is gone!" And he's bending and moving and twisting. One of the things that I ask my patients to do most of the time is if I feel like I've gotten to a certain resolution, I'll say, "Okay, try to make it hurt," right? They know what movements they can do to produce the symptoms that they're having. So this guy is all but cartwheeling around my office to try to make it hurt at this point. And he's like, "It's gone. It's absolutely gone!" So I was like: "Okay, so let's not jump the gun. Do me a favor, wait another 24 hours and let's just see if this thing has settled in"; basically [to see] if the body has accepted our suggestion, right? And sure enough, a day later, he called me and he was like, "I canceled my surgery."

### **Dr. Jill** 25:07

I love that so much. And it sounds like—again, with my familiarity—entrapments, isn't it? I mean, I'm sure it's way bigger than that. But at a core level, at times, these things get trapped, and you're releasing them from captivity.

**Gina Tacconi-Moore** 25:20

Bingo! Exactly. Yes, it's a stickiness thing. The body has 1000s of gliding surfaces. And the key word there is gliding. They're intended to do this on each other. But if the body all of a sudden gets the message, usually from a joint, that there is some cause for alarm—if there's a perception of instability, for instance—then, because the body is smart and adaptable, sometimes to its own detriment, it will step in and start laying down additional layers to wed these things together. [Due to that,] rather than multiple structures moving as multiple independent structures, you have more or less four case sausages wrapped up in saran wrap, and nobody's going anywhere independently.

**Dr. Jill** 26:13

Yes, this one pulls this one with it. Yes, okay. It's so interesting because, again, as a physician, I know anatomy but not like you do and certainly not to the thought process. I mean, I'm not anywhere near anything you do. But I'm so fascinated because I understand the process behind why it works, why it makes sense, and why you're so unique because of your background of intense knowledge about dissection. I bet you're one of the only ones in the world. You've got to be the only person like this. It's amazing! I love it. I'm sure you have many other stories you could tell us like that because that's what happens when you have that unique base. How cool! You said in some of the stuff you gave me that you think there are three unique bodies. What does that mean? And tell us more about when you perceive that, the unique body that a person you see has, or a patient, or a client.

**Gina Tacconi-Moore** 27:05

Yes, so this is sort of extracted from my own time in the field and so forth. So I encounter the fascia body, the fluid body, and the breath body. Those cross every conceivable system that we have. When people say that they're fascia specialists or something like that, well yes, anybody that puts their hands on another human body for therapeutic purposes is a fascia specialist because you can't contact anything without contacting fascia just by proxy. So that's truly a ubiquitous structure in the human body, but then again, so is fluid.

**Gina Tacconi-Moore** 27:53

We've got all of these different highways and so forth, some of them with their own pump like our circulatory systems, and some of them do the brilliant borrowing thing like lymph. And then the breath is one of those things that over the course of time I've just come to realize how critical good breathing techniques are and how bad most people are at this really, really basic life-giving thing.

**Gina Tacconi-Moore** 28:30

When I encounter a particularly difficult case, and this ultimately is where the three-body theory/purview sort of came through, which is that typically I'm starting with fascia because you've got every single cell, every single muscle, every single muscle group, and then your entire body encased in this particular material. It's really easy to start there because you kind of have to. You're contacting it regardless. So that's sort of my first line of defense is the fascia body and the restoration of gliding surfaces, and sometimes that doesn't work. Sometimes that'll get somebody 50% better or 60% better, but not 100%. And so that's where I'll start to look at things in a more granular way. So more of like, "Okay, well, let's check out your fluid exchange. Do you have boggy tissue at your ankles that we need to look at?" That's a really good indicator that maybe your lymphatic flow is not necessarily where it should be. And then after we've checked that box, and if the person is still like 50%-70%, then we'll look at the breath body. And it's like: "Okay, so you are moving fundamentally everything, certainly in your thoracic cavity when you breathe, and a lot of other things go along for that ride. So let's look at how deep you're getting your breath; where you're getting it to. Let's look at your lung expansion. Let's feel how your organs are moving because organs articulate in a very certain way when you breathe."

**Dr. Jill** 30:11

Do you put your hands on them as they're breathing?

**Gina Tacconi-Moore** 30:13

Yes.

**Dr. Jill** 30:14

That makes a ton of sense.

**Gina Tacconi-Moore** 30:20

I tend to leave the breath for last because, really, it's intimate as well. It's very, very rare that people are getting hands-on in that thoracic region. And typically, it's

because something very invasive is about to happen. And so just out of respect for the way that I feel that the treatments should unfold, that's the last thing so that we've already established a rapport and I'm not just like diving into your abdominal cavity uninvited, basically.

**Dr. Jill** 30:56

I love that you say that though, because I have a massage therapist in my clinic who's amazing, and she does abdominal massage. But I've gone to hundreds, maybe 1000s of other massage therapists, and rarely do they ever touch [that region]—which is perfectly okay, I get why—but some things you can't get to except through that cavity. I've always found it profoundly helpful to my... you know. So it is really such an important place and it's pretty much ignored, all of this. And again, it's like the dog; if you put your belly up, this is the most vulnerable part of ourselves, right? So I get why. And I think that's super respectful of how you practice. But it's also like, if you're out there and your massage therapist has never touched your abdomen and you have a great relationship with them, that's a really powerful place to get healing.

**Gina Tacconi-Moore** 31:40

Absolutely! Look, if you're out there, and you have a great massage therapist who you trust, just ask them.

**Dr. Jill** 31:47

They know, right? You're trained in it. It's like you said, the intimacy. A lot of people are really nervous or they have the reflex where their rectus abdominis is contracted. They're like: "Don't! Don't go there!" But anyway. And the breath is huge. The thought is coming to my mind as you're talking, so here I am, like in my clinic with these complex chronic [cases of illness], it would be inflammation and infection, toxicity, all those kinds of things. But it's going to manifest in the tissues. And my expertise is using the mind and the testing to do that. I'm not touching the patients as much, but clearly, you are. Can you tell whether it's a post-infection or some inflammatory condition? I'm sure you can actually see and feel the tissue difference there too. So even if you weren't looking at a lab value, say we were working together on the same patient, would you be able to tell me, "Yes, there's a lot of inflammation" because of the feel?

**Gina Tacconi-Moore** 32:36

I'm going to say yes with an asterisk because I operate in shades of gray exclusively; there's no black and white. But yes. As you know, markers of inflammation walk in

lockstep with each other. So if somebody has uterine fibroids and IBS and swollen ankles and chronic lower back pain, "Okay, maybe we need to look at elevated factors of tumor necrosis factor alpha" or something like that, right?—which, by the way, nobody's doing blood tests for those on people with lower back pain, which is insane. But at any rate.

**Dr. Jill** 33:17

I totally agree with you. That's a whole other topic, but I totally agree because I think it's like a structural issue where there's a weak link, right? But then, on top of that, inflammation is what kind of takes people over the edge often. And whether it's infection or toxin, or poor posture, poor breathing or—

**Gina Tacconi-Moore** 33:31

Yes, absolutely. So to answer your original question, there are some cases [where] the markers of inflammation in the body are palpable, things like heat, if things feel particularly baggy, and if things are especially stubborn. An interesting thing that I've discovered over time in this field is that working on people who are chronic smokers is very, very difficult for a number of reasons, not the least of which is that, firstly, their muscle tissue globally tends to feel very much like beef jerky, I guess. And with that also, even when I do restore some circulation to tissues like that, it doesn't stick. So for people who are active, well hydrated, and good breathers, I see them maybe four or five times, and then they're off my caseload. But for people who have inflammation markers or are heavy users of intoxicants or nicotine or stuff like that, what I found is that the quality of the tissue is just that much worse and it won't take the same way that it would in a body that is otherwise well hydrated and not using intoxicants.

**Dr. Jill** 34:56

So I love that you mentioned smoking because of my one experience in medical school. Of course, we had cadaver lab for six months, and we each had our own cadaver that we worked with the whole time. That was with formaldehyde, not like the difference with you [handling] the fresh [tissue]. It's a very different tissue you're talking about too. But the one I remember is that we had a smoker in his 50s who died of a heart attack. I remember that compared to my colleagues' cadavers, the heart was just one big, very, very thick, non-pliable muscle. In the lungs were these chunks of black and our colleagues had non-smokers' [organs that] were still soft and pliable. [It was] very, very different. And then [with] all the arteries we dissected, it was so clear, they were like plastic tubes. I was like, "I remember." And I've never smoked a day in my life, but it was so visual that I was like, "I will never

ever be susceptible to cigarettes because I can see how big a deal [it is]. And I think what you're describing too is that hypoxia happens, and we see that with other infections too. But when you have tissues that aren't getting good oxygenation, it's going to absolutely affect all of these things, right?—and especially pain, because the oxygen [not only] delivers nutrients but also takes away debris, junk, and garbage.

**Gina Tacconi-Moore** 36:04

That's right, absolutely. And one of the labs that I was at, we were here in this country, so we didn't get a medical history, just based on the Body Donor Program. But I mean, that became part of the intrigue of that particular lab, because we had one cadaver that I would put probably in the mid-to late 60s or so. But we were all convinced that this was a COPD patient because he had the massive barrel chest. The heart filled and then overflowed both hands, which is not normal.

**Dr. Jill** 36:51

No. Cardiomyopathy, obviously. It's funny because, for young men who are using steroids or whatever, I've seen a number of young 30–40 [year olds] where there's massive hypertrophy. And people think, "Oh, these muscles are great," right? But you get hypertrophy in your heart and it can't pump anymore.

**Gina Tacconi-Moore** 37:08

That's right. The other thing that you were asking about: can I kind of feel the inflammation? And it's interesting that you brought up steroid use because I can absolutely feel a steroid user because their muscle feels literally inflated. It's like squeezing a beach ball as opposed to squeezing somebody who has 'earned it' the traditional way. So yes, there are definitely people who might be pulling the wool over the eyes of folks at the beach, but not when you get into manual therapy.

**Dr. Jill** 37:40

One other thing I found really interesting in your bio, and some of the info you gave me, are some things that you wouldn't think a manual therapist [would treat] like erectile dysfunction, incontinence, constipation, and for my patient population, small bowel overgrowth, bacterial overgrowth, SIBO, or something with a mild, obstructive pattern where there are adhesions and stuff. Tell us about those cases. It sounds like for those, you can often get them in and out in three, four, or five sessions and have success.



**Gina Tacconi-Moore** 38:08

That's right, yes. So right now, I really love working on visceral stuff. And you may find that in your practice there are seasons of things that show up where you're like, "Okay, it's raining," like, "left wrists this week" or something like that. And so, in the past 18 months, the focus has really been on pelvic floor dysfunction, which would include—I'm going to umbrella that to include BD to include incontinence—bowel issues like constipation, for instance. So the easiest way to be able to figure out what's going on with somebody with some sort of gastrointestinal upset that is mechanical and not chemical or disease-related in nature—so I just want to put that asterisk out there—is that basically, your colon is more or less forming a bit of a rectangle with a chute at the end of it.

**Gina Tacconi-Moore** 39:16

So I'll start just by listening with a stethoscope to just hear what is going on at the cecum, for instance. If you're listening and you're like, "What the heck is that?" That is the gateway between the small and large intestines. And then I will look up into the corner of ascending and transverse, and then to the corner of all of that other stuff, and just see like, "Okay, if I'm getting noise at the cecum," which I typically am, "then where am I not getting noise in response to pressure?" So that's typically where I'll start, more or less, lifting the margins of the colon to see: Is it stuck to the greater omentum? Is it stuck to the peritoneal wall? Is it stuck to itself? Is there an adhesion somewhere internally? And generally speaking, I can find that through palpation and certainly through patient reporting. I'm relying on the person who's under my hands to be able to help and guide me. The cool thing about that—without wandering into a too graphic territory—is that when I've got somebody in front of me who's constipated, I can feel where the blockage is residing. And we can really physically inspire some motility in the large intestine. I've had people get up in the middle of sessions to be like, "Okay, it's right now!"

**Dr. Jill** 41:02

Yes, totally! From a clinical perspective, what I see a ton of is a small intestinal bacterial overgrowth or fungal overgrowth, and it's all of that ileocecal region. Like you said, if that flap is stuck closed or there's no motility there, it's almost like that flow between meals and things where you should get cleansing and that clearing out of the bacteria is not working. What we call the migrating motor complex (MMC) is not working, it's not clearing between meals. But a lot of it has to do with this manual piece of—there's old surgical adhesions or old stickiness from maybe peritonitis or something going on there. Actually, when you manually break up those adhesions and allow for movement, I find clinically I can do all the medications or the herbs or those things, but I would say 50% of the time with the

small bowel or the large bowel issues, it needs some manual therapy. So I see that too. And I think it's so powerful. That stiffness—no medication, no herb—nothing is going to fix it if there's an adhesion where two pieces of the bowel are stuck together and not moving well, right?

**Gina Tacconi-Moore** 42:01

That's right. Exactly. And the piece that you look at is both mobility and motility, so it's an inside-outside thing. So once again, we're back to the fascia body, and to a lesser extent, the fluid body, and to a lesser extent, the breath body, because all of that is sort of wrapped together in healing that particular region. And so we have to make sure that not only are the exterior gliding surfaces of the structures not stuck to other gliding surfaces of other structures, but also that the smooth muscle inside is doing its job as well. And that's where the breath comes in, and so I'll send people home with some rehab stuff to do because your breath really helps to inspire the motility piece that is directly in the smooth muscle tissue of your bowel. And then as far as the pelvic floor stuff goes, my curiosity developed really early with that, and it goes back to my CrossFit gym. At that point in time, there were not a huge amount of female coaches and even fewer female owners. So it was a unique experience to have one of my younger—like [someone in their] early 20s, not a childbearing person—come to my door and say: "Hey, so I just did a heavy deadlift out there and I peed a little, I don't know what that's about." Or it was box jumps, or it was jump rope, or it was—

**Dr. Jill** 43:36

I love that you say that because I bet there are definitely women listening out there that have had that experience. It's so shameful to talk about. I mean, nowadays you talk to your girlfriends or whatever. But it's so common, isn't it?

**Gina Tacconi-Moore** 43:46

Yes! And that's really the drum that I've been beating for so long: that it is super common but not normal, so let's fix it. Let's talk about it first off. Let's demystify it. The fact that I had all of these very fit young women coming to me and saying, "I'm peeing myself on a regular basis" led me just to look at some osteopathic journals to understand better what the pelvic floor was and all of that stuff. What came out of my research was that, fundamentally, the argument in this one paper [is that] there are four conditions that the pelvic floor can be in. So you've got your high and tight, you've got your low and loose, which is what I think most people would associate with pelvic floor dysfunction or incontinence. And that would be the case of women who have borne children, particularly vaginal births, and that kind of thing. And

then you've also got the low-end tight end, high and loose. So you've got all these different conditions that a pelvic floor can be in. And by the way, since reading that article and doing my anecdotal study, there are way more than four. That was sort of a one-size-fits-most model. But it worked well enough for me to start with just a little case study sort of thing with the female athletes in my gym, just knowing what I knew from dissection lab.

**Gina Tacconi-Moore** 45:16

Again, if you're a manual therapist, or a bodyworker, or a yoga teacher, or a gym teacher, or a coach, or anything like that, and you can get yourself to a dissection lab, please go and do it because it is going to be so edifying and so life-changing for you. So that's my plug for dissection labs. But at any rate, what I learned in the dissection lab is that we've got muscles that are part of our deep six lateral rotator in the back of the hip that fundamentally, if you picture it like your pelvic floor is a hammock, these are the trees. So if it's the obturator internus and if they're really tight, what will happen is that the trees will fold in and you've got this lower hanging pelvic floor at that point. It doesn't mean the pelvic floor is loose, though, at that stage. Especially if you are bearing down a huge amount, as in weightlifting or whatever, or you're doing something percussive like running or jumping, then you're clenching, basically. And if I put a pencil in your hand and said, "Okay, I'm going to give you \$100 if you don't let me pull this out of your hand." And you're squeezing, squeezing, squeezing, and I pull it out, [then] there's no more strength left in this hand. You want to squeeze more, but you're not going to be able to do it. Why? Because you've already maximized that muscular potential. And so the same is true of pelvic floor incontinence and people who are otherwise not childbearing and very fit. Those muscles are in contracture, and they need to be released.

**Dr. Jill** 46:55

It's the opposite of what you think. It's not more Kegels, it's the opposite.

**Gina Tacconi-Moore** 47:02

Yes. Because particularly at that point in time—and we're going on seven or eight years ago at this point—that's what was available literature-wise.

**Dr. Jill** 47:12

One size fits all, right? I see that clinically too. And I'm not the expert. I always send them to someone like you or a physical therapist. But it's very true. It's not a one-size-fits-all. And a lot of women are really frustrated because they're like:

"Well, I really do my Kegels. I know how to hold the pelvic floor, and I still can't protect [myself] from loss of urine with exertion" or whatever.

**Dr. Jill** 47:34

Oh, my gosh, this is so amazing. I love, love—I could talk to you all day. Any last bits of wisdom? You're so unique. First of all, I'm sure there are a lot of people listening who are going to want to get a hold of you, and you were telling me your website is being built. So that's coming, all the chat and stuff, so we'll make sure people can still find you. And no matter when that happens, we'll make sure that wherever you listen to this, we'll link it up. It's your name, right? Give us your name and spell it for us really quickly so that people can look it up.

**Gina Tacconi-Moore** 48:05

Yes, it'll be [ginatacconimoore.com](http://ginatacconimoore.com). And yes, that'll be where you can find out what I'm doing, book a consult with me, and just generally kind of step into this very nerdy anatomical world.

**Dr. Jill** 48:27

I love this nerdy anatomical world. I love that you encourage anybody listening—doctors, physical therapists, chiropractors, anyone—to think about dissection and anatomy because my experience is [from] 20 years ago and it's pretty rusty. And it's so funny because most people assume that doctors are, you know—but even for me, sometimes I'm like, "What muscle is that, again?" And that's muscles, not nerves and all the other [things]. And of course, I did do all that at one time, so you are encouraging me to go back to that too and make sure that it's all fresh. Any last bits of giving someone hope, parting words of wisdom, or any last little bits of pearls that you want to leave people with?

**Gina Tacconi-Moore** 49:03

Yes, I would say, especially having worked with some populations that have really seen a lot of life—you know, people who have survived catastrophic injury or illness and are still struggling with some of the aftereffects and things like that, all the way to somebody who's like, "Man, I just, all I want to do is be able to control my bladder"—I would just say think outside the box a little bit. Think from an anatomical perspective. To practitioners, please think about things from an anatomical perspective. Oliver Sacks was beating this drum way back in the day and all. He did case studies, and his encouragement was to really bring the patient and their story to the forefront of treatment and prevention. So that would really be the soapbox that I would get on for anybody who is in the business of treating any

human body: put your patient in front of you, keep them in front of you, and if you're smart enough, they will teach you how to treat and cure them.

**Dr. Jill** 50:12

Oh, I couldn't have said it better myself. That is so beautiful! No wonder our mutual acquaintance was like, "You guys have got to meet." Really, truly that listening—and I can hear that. And even the fact of the story you told us where you went home, you drew it out, you were like, "I'm going to figure this out!" Good for you. I know that you're already so successful. You're just going to continue to catapult. What I hope is that you get a chance to continue to teach people and really spread this method and the things you've done. So thank you so much for your time today, Gina. It has been such a pleasure!

**Gina Tacconi-Moore** 50:44

Yes, definitely. It's been great!