

Myofascial Pelvic Pain and Related Disorders



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KEYWORDS

- Pelvic pain • Myofascial pain • Trigger points • Vulvodynia • Physical therapy
- Bladder pain • Constipation

KEY POINTS

- Myofascial pelvic pain can present as trigger points, taut muscle bands, or generalized muscle pain and may refer to other regions of the pelvis.
- A comprehensive history and physical examination provide the most reliable diagnostic information for patients with suspected myofascial pelvic pain.
- Myofascial pelvic pain is often associated with disorders, such as vulvodynia, constipation, bladder pain syndrome, endometriosis, and anxiety.
- Treatments for myofascial pelvic pain can include physical therapy, oral medications, cognitive-behavioral therapy, and botulinum toxin injections.

DEFINITION AND EPIDEMIOLOGY

Myofascial pelvic pain (MFPP) refers to pain in the pelvic floor muscles (PFMs), the pelvic floor connective tissue, and the surrounding fascia. MFPP can be a syndrome of its own and cause pelvic pain or it can be associated with a host of other abdominopelvic pain disorders. It is characterized by muscular pain, taut bands, and trigger points that refer pain to specific regions when pressure is applied. Trigger points in the PFMs can refer to many areas, including the suprapubic region, the lower abdomen, the posterior and inner thighs, the buttocks, and the low back. Historically, it has been undertreated as a result of being undiagnosed by providers who usually evaluate and treat patients with pelvic pain because detailed PFM examination is not routinely taught in their residency training. In studies assessing training of obstetrics/gynecology residents on diagnosing urogynecologic disorders, there were no questions addressing their knowledge of MFPP disorders.^{1,2} In addition, there are no accepted

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laboratory or imaging tests that establish the diagnosis. In recent years, it is being recognized by practitioners because of studies that have consistently demonstrated its existence as part of other pelvic pain disorders.

A recent study that screened patients with chronic pelvic pain (CPP) for myofascial pelvic floor pain or pelvic floor trigger points via interview and physical examination found that 13.2% had pain that was related to the PFMs.³ The prevalence of PFM tenderness in those with other CPP disorders is much higher though. Prevalence of levator ani pain in a CPP clinic over a 7-year period has been found to be 22%.⁴ In another study of women in a CPP clinic, PFM tenderness was an isolated finding in 15% of these patients but was associated with other CPP disorders in 58.3% of patients versus 4.2% of healthy volunteers. Of the women in the CPP group, 89.0% had tenderness of the levator ani muscle, 50.8% had tenderness of the piriformis muscle, and 31.7% had tenderness of the internal obturator muscle.⁵

ANATOMY

The PFMs are composed of 2 major layers, the superficial PFMs, which are part of the urogenital (UG) diaphragm, and the deep PFMs (also called the pelvic diaphragm). The superficial muscles include the bulbospongiosus, ischiocavernosus, and superficial and deep transverse perineal muscles. In addition, the external urethral sphincter sits within the UG diaphragm. The UG diaphragm also contains fascial layers, which are situated on the muscles and act to form the deep and superficial perineal space. The superficial perineal fascia is the most inferior layer, sitting between the skin and the bulbospongiosus, ischiocavernosus, and superficial perineal muscles. The perineal membrane encompasses the deep transverse perineal muscle on its inferior and superior aspects. Beyond this rests the inferior pelvic fascia behind which the levator ani muscles sit. The muscles that compose the pelvic diaphragm and act to support the abdominopelvic cavity and viscera by closing the inferior aperture of the pelvis are the levator ani muscle and coccygeus muscle. The levator ani muscle is made of 3 individual muscles: the puborectalis, pubococcygeus, and the iliococcygeus. The muscles are bordered superiorly by the superior pelvic fascia. The coccygeus muscle is also a deep PFM located posteriorly, arising from the ischial spine and moving medially to the midline sacrococcygeal joint. Also located posteriorly is the piriformis muscle, originating from the sacrum and inserting onto the greater trochanter. Lastly, the obturator internus sits laterally above the arcus tendinous, attaching to the pelvic surface of the obturator foramen and exiting the pelvis around the ischial tuberosity to insert on the greater trochanter. Each of the PFMs can contribute to pelvic pain, as a primary source, as a referred source, or as component of a more widespread pelvic pain disorder.

HISTORY

A comprehensive history must be taken from patients with MFPP, with a particular focus on medical and surgical history involving the abdominopelvic organs and region. Patients must also be screened for a past history of physical, sexual, and emotional abuse given the high instance of MFPP in this population. A typical set of paramount questions regarding pain are asked, such as alleviating and aggravating factors, quality, severity, associated symptoms, and areas it radiates to. Pain may be constant or intermittent, at rest or with activity, and is usually described as sore, achy, heavy, and deep. Pain at the introitus with intercourse is often described as burning or sharp. It is also crucial to take an in-depth review of systems regarding urinary, bowel, and sexual dysfunction as patients with MFPP often have comorbid disorders of these organ

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