

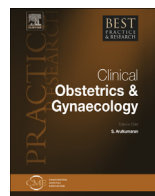


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Chronic pelvic floor dysfunction



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The successful treatment of women with vestibulodynia and its associated chronic pelvic floor dysfunctions requires interventions that address a broad field of possible pain contributors. Pelvic floor muscle hypertonicity was implicated in the mid-1990s as a trigger of major chronic vulvar pain. Painful bladder syndrome, irritable bowel syndrome, fibromyalgia, and temporomandibular jaw disorder are known common comorbidities that can cause a host of associated muscular, visceral, bony, and fascial dysfunctions. It appears that normalizing all of those disorders plays a pivotal role in reducing complaints of chronic vulvar pain and sexual dysfunction. Though the studies have yet to prove a specific protocol, physical therapists trained in pelvic dysfunction are reporting success with restoring tissue normalcy and reducing vulvar and sexual pain. A review of pelvic anatomy and common findings are presented along with suggested physical therapy management.

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Introduction

Chronic pelvic pain (CPP), pelvic floor dysfunction (PFD), and sexual pain are among the most common yet challenging medical conditions that physicians and allied health-care providers face in clinical practice. Provoked vestibulodynia (PVD), a chronic vulvar pain disorder, straddles them all – it is often considered a symptom of CPP (though not related to pelvic organ pathology), it has been correlated with chronic pelvic floor muscle dysfunction (PFMD) [1–4], and it occurs (but not solely)

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with sexual contact [5–7]. The prevalence of female sexual dysfunction resulting from concomitant chronic pelvic and sexual pain was estimated in 2006 to be 26% (range 7–58%) [8].

Unfortunately, many clinicians are not well equipped to assess and diagnose women plagued by the comorbid disorders [9]. Vulvologists, looking primarily at the vulva, work to accurately diagnose and treat PVD, which, by definition according to the International Society for the Study of Vulvovaginal Diseases, has no definable disease or diagnosable cause associated with it [5–7]. Physicians have historically been taught to investigate the pelvic viscera (e.g., bladder, urethra, uterus, ovaries, and bowel) as pain generators when attempting to identify the possible causation of pain [10], yet 28–55% of exploratory laparoscopic surgeries report negative findings [11–14]. When treating women with chronic pain, physicians and other health-care providers (those outside of the psychosexual counseling realm) have struggled to deal with their patients' comorbid sexual dysfunction, with 38% of patients thinking that the problem “will just go away [15].”

Pelvic floor muscle (PFM) disorders are major contributors to a multitude of dysfunctions, with one recent study suggesting that the increase in the demand for care of PFMD (inclusive of all disorders, including incontinence) is predicted to increase by 35% in the next 17 years, with >1.6 million patient visits predicted for the year 2030 [16]. Beginning in the mid-1990s, PFMD was identified as a contributing factor to the pain of vulvodynia and PVD. Hypertonic PFMs were identified and successfully treated using surface electromyography or biofeedback, and complaints of vulvar pain and sexual dysfunction were decreased [2–4,17,18].

Physical therapists, by nature of their training, bring a much broader approach to the management of chronic vulvar and pelvic pain. As specialists, women's health physical therapists (WHPTs) have received extensive education in the treatment of chronic pelvic dysfunction. They have utilized a variety of manual therapy techniques to treat comorbid conditions of PFD, including biofeedback. WHPTs utilize interventions that restore normal function to all systems (musculoskeletal, fascial, and visceral) throughout the body. They have played an integral role in the multidisciplinary team working to decrease pain associated with CPP, PFD, and PVD [1–4,19–39].

A recent multisite, randomized, and blinded trial compared a specific PFM myofascial therapy treatment protocol to nonspecific therapeutic massage in 81 women with interstitial cystitis/painful bladder syndrome (IC/PBS). The results suggested that, of the 78 who completed the 3-month, 10-treatment trial, 59% of those who received myofascial treatment reported improvement (moderate or marked) versus 26% of the massage-only group [32]. Though there is some thought that IC/PBS and PVD may coexist more than reported – though there was no mention of the vulvar pain in the previous study – it may be surmised that the therapy provided might also benefit those with PVD.

Gentilcore-Saulnier et al. compared PFM behavior in women with and without PVD and how those with PVD responded to a physical therapy treatment. The study included eight patient visits with a protocol that included patient education, intervaginal manual therapy, biofeedback, electrical stimulation, use of vaginal dilators, and instruction in a home exercise program that prescribed the use of daily PFM exercises. Their prospective, cross-sectional study suggested that the presence of PVD alters PFM responsiveness to pain, with increased muscle activity (greater in the superficial PFMs than in the deep PFMs) following painful stimuli at the posterior vulvar vestibule. Pelvic floor (PF) physical therapy normalized the overall PFM tone, flexibility, strength, and ability to relax following active contraction. Following WHPT, there was decreased pain responsiveness in the PFM, reduced pressure sensitivity at the vaginal opening with reduced pain at the vulva, and improved tolerance to vaginal penetration [31].

In two retrospective reviews of physical therapy treatment of women with vulvodynia, Bergeron et al. reported a 71% success rate of moderate or great improvement in vulvar pain, as well as decreased pain with intercourse and gynecological exam, and increased intercourse frequency, desire, and arousal [37]. Hartmann reported that 71% of those receiving physical therapy for vulvar pain reported decreased vulvar pain symptoms and 62% reported improved sexual function [42]. Bergeron's protocol included patient education on PFM response to vulvar pain and the importance of muscle control (e.g., relaxation during vaginal insertion), internal and external manual therapy (including myofascial release, trigger-point pressures, and massage), biofeedback, electrical stimulation, and home exercises including use of vaginal dilators, manual stretching of the vaginal tissue, and PFM exercises [37]. Hartmann's protocol included internal and external manual therapy (soft tissue mobilization, myofascial release, and visceral manipulation), internal and external therapeutic exercise, electrical

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