MOMS

Montana Obstetrics & Maternal Support

Pelvic Health Physical Therapy

Sari Stahl, PT, DPT, CSCS

MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

Billings Clinic Foundation

Project ECHO

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $10MM designed to improve maternal health outcomes. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.

Conflicts of Interest

I have no conflict of interest nor ownership/business association with Billings Clinic.

Objectives

- Identify diagnoses that can benefit from physical therapy.
- Have interventional knowledge in order to educate the patient regarding the reasoning and benefits of physical therapy in order to decrease the client's anxiety about initiating PT.
- Understand the benefits of an interdisciplinary approach to pelvic health.

Prevalence of Pelvic Floor Dysfunction

- Incontinence: 45/100 (Melville, 2005)
- Vaginismus: No substantiated study but estimated at 5-17/100 (Lahaie, 2010)
- Dyspareunia: 7.5/100 (Mitchell, 2017)
- Endometriosis: 10-15/100 (Parasar, 2017)
- SI joint dysfunction
- Pudendal Neuralgia
- Constipation
- Prolapse

- WHAT IS THE POINT??? Of the four diagnoses that I listed prevalence rates, 84/100 women are affected. Open the door to conversation and ask the right questions. These women are coached and trained since they are young that this is “just part of being a woman,” “you’ve had a child, so you are going to leak,” and “you’re just getting older.” We have to ask the questions to know if they are affected by pelvic health impairments.

Incontinence

- According to Melville, 2005, the population-based prevalence of UI with n=3536 was 45%.
  - 30-39 year old female prevalence was 28%
  - 80-90 year old female prevalence was 55%
  - The prevalence of severe UI also increased notably with age; higher BMI, greater medical comorbidity, current major depression, a history of hysterectomy, and parity
  - Research has demonstrated that young female athletes participating in high-impact sports may be at higher risk for urinary incontinence. Using a modified Bristol Female Lower Urinary Tract Symptoms Questionnaire, a group of young adult female athletes was surveyed in Central Illinois to identify the prevalence of stress incontinence and assess education needs. Results indicated that more than 25% of those completing surveys experienced incontinence and that more than 90% had never told anyone about their problem and had no knowledge of preventive measures; 16% reported incontinence negatively impacted their quality of life. (Carls, 2007)
- Urge vs Stress Incontinence

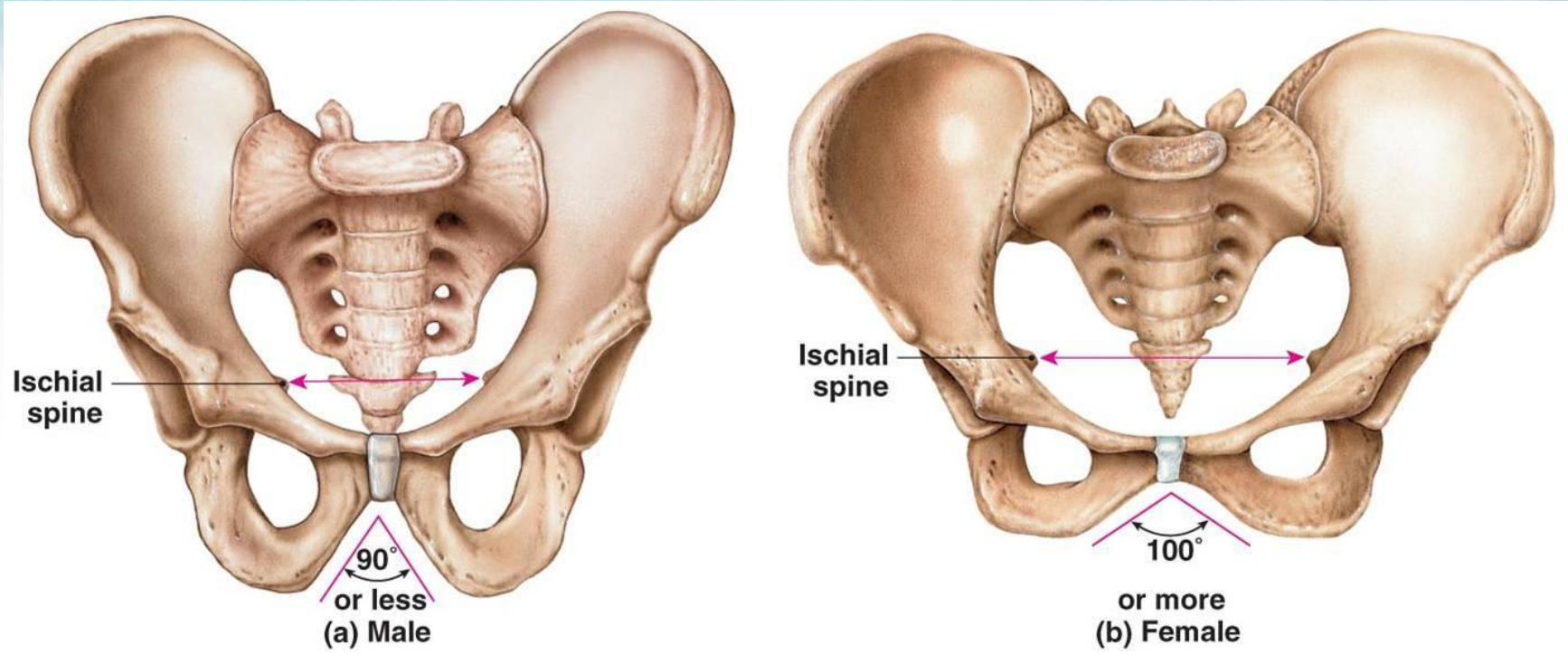
Retraining the Pelvic Floor

- Pelvic floor muscles are made to co-activate with the transverse abdominis, hip adductors, and obturator internus (ER of hip).
- Kegels are a voluntary contraction of the pelvic floor that may help strengthen it somewhat, but not retrain WHEN nor at what amplitude the pelvic floor should contract!
- Hulme found that using Kegels for 6.5 weeks with one group had 48% of the group returned to full continence whereas using hip IR combined with adduction and hip ER combined with abduction for 3.5 weeks had 61% of the group completely continent. (Hulme, 1999)
- What does this mean for rehabilitating the pelvic floor?
- If a woman is incontinent, running and jumping will place her at risk for prolapse!

SI Joint Dysfunction

- Laxity of the SI ligaments and symphasis pubis, especially during pregnancy, post partum, and while nursing due to higher than normal levels of relaxin.
- Pelvic design: women have increased distance between the iliac crests placing them more likely for SI joint dysfunction.
- Average translational displacement of the pubic symphasis with the hip flexed at 90 deg and then maximally abducted showed:
  - 1 mm in males (n=6)
  - 1.3 mm in females. (n=6 nulliparous women)
  - The maximum was 3.1 mm in one of the n=3 multiparous women.
  - (Walheim, 1984)

The Pelvis



Picture taken from Hola.klonec.co

SI Dysfunction Considerations Post Partum

- Abdominals elongated. We must slowly strengthen these!!
- Linea alba: diastasis recti
- Ribs depressed
- Vaginal wall possibly torn, episiotomy/tearing during vaginal birth
- C-section: skin, connective tissue, abdominal wall (abdominal muscles), and uterus are cut. Must allow for tissue healing. Remaining myofascial restrictions or fibrotic tissue can lead to lower abdominal pain especially during active abdominal contractions (all motions).
- Prolapsing (bladder, uterus, rectum)

❖ SI joint dysfunction and coccygeal dysfunction post falls! Be aware.

Pudendal Neuralgia, Dyspareunia, Vaginismus

- Pudendal neuralgia is very complex, especially when the rectal branch is affected.
- PT interventions:
  - Internal pelvic floor soft tissue mobilization.
  - Decompression of the pudendal nerve branches.
  - Activity modification.
  - Stretches, slow/steady progression of strengthening and activity
- Be sensitive to the possibility that sexual abuse, molestation, and rape may be playing a role. Ask questions. Explain palpation. I appreciate a note on the referral of this past history.

Abdominal Pain Syndromes or Dysfunction

- Endometriosis
  - Often also entails hypertonicity of the abdominals and therefore the pelvic floor.
    - This then leads to the pain-spasm-pain cycle
  - Decreased blood flow when there is mm guarding setting up a system for fibrotic tissue and poor healing.
  - Most women also experience with psoas overuse syndrome in this case. Since this presents as deep abdominal pain, the woman typically associates this with her ovaries.
  - PT interventions can improve connective tissue mobility, decrease mm guarding, and retrain correct mm activation. As psoas overuse syndrome resolves, their abdominal pain decreases significantly.
- Constipation or Diarrhea: PT focuses on interventions to correct duration of transit of feces with dietary changes.
- Diastasis Recti: Retraining the transverse abdominis; stability exercises

Collaboration is Key

An interdisciplinary approach is best for the client. These can be very complex cases to solve!

- We all have different pieces of knowledge, and put together, the puzzle can become complete for the patient's benefit.
- PT, FNP, MD, ND, OB/GYN, Urogynecology, PA, mental health therapy, etc can reason through the case together.
- I often call upon the referral source when I am not seeing progress that I would expect. We can than look into co-treating options such as vaginal suppositories for pain, further tests, etc to improve the progress.
- What is helpful from a PT standpoint? I typically sent eval, progress, and DC notes to referral source to keep in contact and reach out if needing more support.
- Don't be afraid to call, email, text, fax, etc. The more the team knows, the better.

What can you do to help?

- Educate the client at their appointment:
  - Why are you referring to PT?
  - Tell them that their diagnosis is real and validate their journey. Let them know that PT does treat their issue.
  - Reach out the PT to get something to hand to the client. I worked with local physicians regarding ways to improve the client calling and attending their PT eval. We found that having handout from the PT clinic that can fit in their purse showing a picture of the PT with diagnoses listed helps them understand that we do treat their issue.

What can you do to help? (cont.)

- Educate the client at their appointment (cont):
  - Send a referral with the patient's demographics so the PT office can reach out to the client.
  - There is a lot of anxiety about attending PT for pelvic health. "What are they going to do? I don't want to go through another pelvic exam."
    - For incontinence, I do not do an internal pelvic exam. I have them focus on a HEP that progresses weekly. I have them come every 2 weeks to give the next progressions.
    - For pelvic pain, I do spinal, pelvic, lower extremity movement pattern assessments as well as an internal pelvic exam. Treatment involves soft tissue mobilization vaginally.

Other Considerations to Ponder

- MALES!!! They can have many of these diagnoses including incontinence (especially post prostatectomy, pudendal neuralgia, as well as penile/scrotal pain.
- Low back pain, SI joint dysfunction, etc during pregnancy
- Menopausal changes affect the tissues of the body.
- Bottom line:
  - Prevention is key!
  - Early intervention is second best.
  - Focusing on pelvic core stability and activation patterns during pregnancy will decrease the risk of incontinence post partum.
  - All women can benefit from PT throughout their lifespan.

Works Cited

- Carls, C. The prevalence of stress urinary incontinence in high school and college-age female athletes in the Midwest: implications for education and prevention. UrolNurs. 2007; 27(1): 21-24, 39.
- Hulme J, Nevin G. Comparison of traditional kegel exercises with obturator internus exercise protocol for treating bladder incontinence. APTA CSM Feb 3-7, 1999. Seattle WA.
- Lahaie MA, Boyer S, Amsel R, et al. Vaginismus: a review on the literature on the classification/diagnosis, etiology and treatment. Sage Journal 2010; https://doi.org/10.2217%2FWHE.10.46.
- Melville J, Katon W, Delaney K, et al. Urinary incontinence in US women. JAMA. 2005; 165(5): 537-542.
- Mitchell KR, Geary R, et al. Painful sex (dyspareunia) in women: prevalence and associated factors in British population survey. BJOG. 2017; https://dx.doi.org/10.1111%2F1471-0528.14518.
- Parasar P, Ozcan P, et al. Endometriosis: Epidemiology, Diagnosis and Clinic Management. Curr Obstet Gynecol Rep, 2017; https://dx.doi.org/10.1007%2Fs13669-017-0187-1.

MOMS
Montana Obstetrics & Maternal Support

FOR MORE INFORMATION

Amanda Eby
MOMS Program Coordinator
DPHHS
amanda.eby@mt.gov
406-444-7034

Stephanie Fitch
MOMS Program Coordinator
Billings Clinic
sfitch@billingsclinic.org 406-435-8833