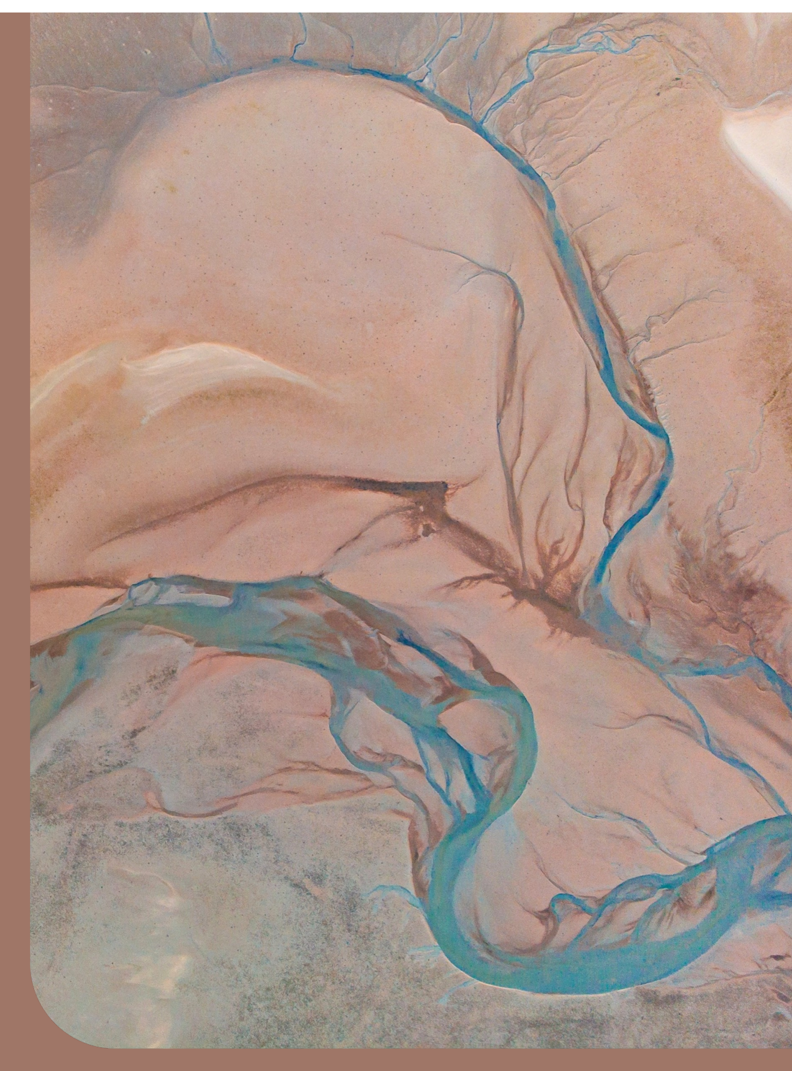
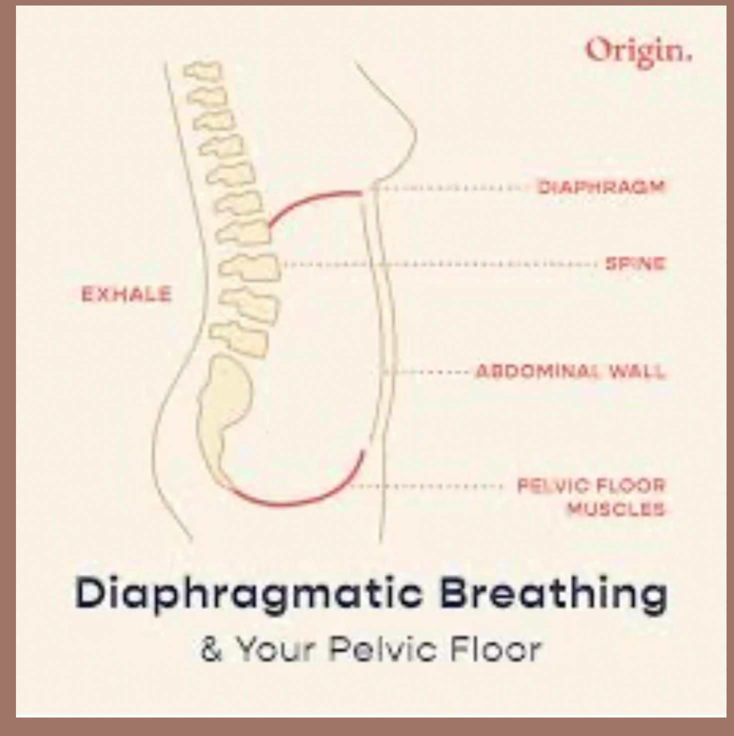
PELVIC FLOOR THERAPY



Katerina Renusch, SPT

BACKGROUND[1, 2, 3, 4]



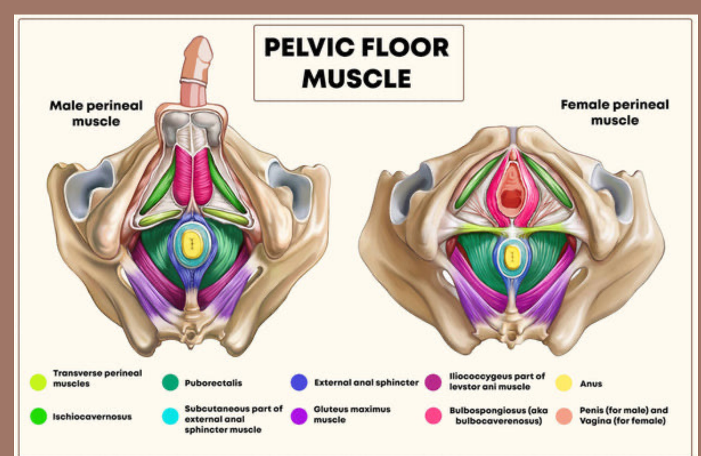
BACKGROUND[1, 2, 3, 4]

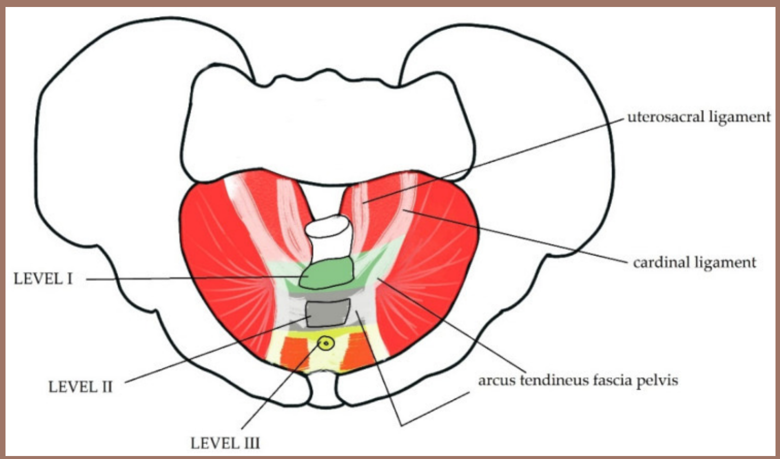
Layers of the Pelvic Floor

Superficial / Perineal
- Bulbospongiosus (Bulbocavernosus)
- Ischiocavernosus
- Superficial transverse perineal
- External anal sphincter

Middle / Urogenital Diaphragm
- Deep transverse perineal
- External urethral sphincter

Deep / Pelvic Diaphragm
- Levator Ani group
  - Pubococcygeus
  - Puborectalis
  - Iliococcygeus
- Coccygeus





WHAT IS A PELVIC FLOOR DYSFUNCTION?[5]

The inability to correctly relax and contract or coordinate the muscles within the pelvis to excrete urine or bowel

COMMON SYMPTOMS

Frequent bathroom visits, straining with BM, constipation, fecal or urinary incontinence, painful urination, unexplained low back pain, ongoing pelvic, genital, or rectal pain with or without BM

CAUSES OF PELVIC FLOOR DYSFUNCTION [1, 5, 6]

Traumatic injuries

Lifestyle

Surgery

Pregnancy and childbirth

Aging

Stress

Anxiety

Connective tissue disorders

ROLE OF PELVIC FLOOR THERAPY [7]

Examination Procedure

Initial evaluation: Subjective, Bladder diary, Bristol Stool Chart, External exam, Patient education

Treatment 1: Internal exam, Strength grade (Oxford Scale), Patient education, Strengthening or down training, coordination training, functional retraining, adjuncts

Bristol Stool Chart

Type 1	Separate hard lumps, like nuts (hard to pass)
Type 2	Sausage-shaped but lumpy
Type 3	Like a sausage but with cracks on its surface
Type 4	Like a sausage or snake, smooth and soft
Type 5	Soft blobs with clear-cut edges (passed easily)
Type 6	Fluffy pieces with ragged edges, a mushy stool
Type 7	Watery, no solid pieces. **Entirely Liquid**

OUTCOMES & STRENGTH

Female NIH – Chronic Prostatitis Symptom Index (NIH-CPSI)

Pelvic Pain Impact Questionnaire (PPIQ)

Pelvic Pain Impact Questionnaire (PPIQ)

DEGREE OF FORCE	MODIFIED OXFORD SCALE
0	Lack of muscle response
1	Flicker of non-sustained contraction
2	Presence of low intensity, but sustained, contraction
3	Moderate contraction, felt like an increase in intravaginal pressure, which compresses the fingers of the examiner with small cranial elevation of the vaginal wall
4	Satisfactory contraction, compressing the fingers of the examiner with elevation of the vaginal wall towards the pubic symphysis
5	Strong contraction, firm compression of the examiner's fingers with positive movement towards the pubic symphysis.

TYPES OF DYSFUNCTIONS X INTERVENTIONS [2]

Underactive (Weak)	Overactive (Tight)	Coordination Dysfunction
Stress urinary incontinence Pelvic organ prolapse	Pelvic pain Constipation Dyspareunia	Dyssynergia - Can't relax to void
Strengthening Functional training	Down training Diaphragmatic breathing Relaxation techniques	ADJUNCTS: Biofeedback NMES Education!!!

SURFACE ELECTRICAL STIMULATION [8]

Hwang et al.

- Randomized controlled trial, women with stress incontinence
- Key findings
  - Improved PF muscle function
  - Decreased incontinence symptoms
  - Improved sexual function
- Limitations
  - Small sample size
  - Short-term outcomes (8 weeks)
  - More research needed for long term effects

- Tight muscles do not mean strong muscles
- Pelvic floor works with the diaphragm and core
- Overactive PF requires relaxation, not strengthening
- Levator ani provides primary support, superficial and middle layers contribute to continence and closure, superficial supports sexual pleasure
- Timing of pelvic floor contraction is as important as strength in preventing incontinence

CLINICAL PEARLS

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