CoverStory

In Support of the Pelvic Floor: *My Story*

DON'T SUFFER SILENTLY, GET TO THE BOTTOM OF INCONTINENCE PROBLEMS

By Linda McGerr, PT

I usually sleep very well. In fact, when we had children I was able to sleep through their crying at 2 o'clock in the morning. My husband had to push me out of the bed to tend to my feedings. I guess that is where my story starts, with the birth of our first child. I feel compelled to educate other women about a problem that I quietly lived with for nine years before seeking help.

You see, like many of my female predecessors and millions of other women today, I have been "floored" by incontinence. It is a problem that magically appeared after the birth of my first child, although it did not magically go away. I guess I thought it was "one of those things" that comes with childbearing, like stretch marks and wide hips.

This problem did not occur because I didn't do my Kegels during pregnancy, because I did. I probably didn't do them long enough or frequently enough, and never thought to incorporate them into activities such as coughing, lifting or running. I may not have correctly isolated the muscles with exercise, a common problem with the pelvic floor.

Factors that can aggravate stress incontinence, such as being overweight or poorly fit, did not apply to me. From high school through my third trimester of pregnancy at age 26, I was an avid distance runner. But I was ignorant about what function could be expected of a "normal" pelvic floor both during and after pregnancy.

I should refrain from the use of the word "ignorant." After

all, even though I was a physical therapist who had treated many women. I never received education in the anatomy, causes or treatment of incontinence. For the sake of all women living with incontinence who have not sought treatment yet, I will identify the primary problem as a lack of education, not ignorance.

So, I asked myself, "How can I make a difference for others living with incontinence?" Women need to be informed of this condition, which is rarely discussed among close personal friends much less in the medical establishments or in public circles.

By sharing my experience, I can answer that question. I have already shared it with my family and friends to some degree, plus it's good therapy to put my experience down on paper.

Incontinence can have a variety of causes and it can affect men as well as women. It probably affects people's lives and attitudes in as many different ways as there are people affected. Though experiences may be similar, no two reactions or responses to incontinence are the same. That's OK.

Shortly after my son was born I had trouble holding my urine when I sneezed. It hadn't bothered me during my pregnancy, though some women are. I started using panty shields full time, generally one per day, sometimes more. I never considered my experience "abnormal." I never thought to talk to anyone about it or to question my doctors, and they never asked me about bladder control.

My first bad experience with incontinence brought the problem to a conscious level. It occurred when my son was about a year old. My twin sister came for a visit. She told me she had been running a couple of miles on a daily basis. I was impressed. I was always the runner in the family and she was the tennis star.

Feeling like some friendly competition, I asked my twin if she would be interested in a one-mile race at the track across the street. She took me up on the challenge. The run felt great! That old competitive adrenaline was churning as we came to the last 440 yards. I was ready to pour on my stuff, that kick at the end of a race that leaves your opponent in the dust, when I sensed something else pouring out. I slowed down as she passed me and tried to hold onto my urine and my pride.

I concluded from my experience that I should avoid fast running and all stressful activities that could lead to bladder control problems. I lived with my secret and modified my activities to suit my weakened pelvic floor.

Three years later, after the birth of my my second child, I decided to seek medical advice for my problem. I read articles in physical therapy journals and magazines and a colleague loaned me Jo Laycock seminar audio tapes on incontinence. Laycock's frank British humor made me feel comfortable verbalizing my problem.

In the meantime, my frustration increased because allergies made me sneeze. I tried going to the bathroom more frequently, thinking that would help the leak, but it didn't. I continued exercising regularly by walking, running and doing video aerobics (limited bouncing and no jumping jacks). I re-instated my Kegels. General fitness helped, but incontinence remained a problem and I kept buying those pads.

My readings taught me that my bladder problem was "stress incontinence." I asked my physician for a physical therapy referral. He agree to the therapy and said he would send me to a urologist if therapy did not help.

My physical therapist familiarized me with my own pelvic floor anatomy and performed some simple evaluation techniques. Next she hooked me up to a formal biofeedback machine, complete with a computer screen for strong visual reinforcement of correct and incorrect isolation of my pelvic floor muscles.

Through examination of the muscles and the use of biofeedback, she assessed that I had good strength in the fast-twitch muscles of my pelvic floor, however, I needed to learn to better isolate this muscle group in order to use it effectively. She was also able to see that the slow-twitch muscles were far less impressive, which was why I had more problems with incontinence when I ran or sneezed at the end of the day. My muscles were too fatigued to keep up with the added stress or pressure.

My therapist also taught me to drink the right amounts and kinds of fluids. She had me keep a diary of my voiding and liquid consumption along with the frequency and

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amount of incontinence that I experienced. This information was helpful, and it was also encouraging because I was able to keep track of my successes later on.

Part of therapy included an exercise routine that was designed to re-activate/ strengthen the slow twitch muscles of my pelvic floor. These muscles had been essentially off the job for the last nine years. I began doing isolated Kegels holding for five to 10 seconds through five repetitions, five times a day. I spend a lot of time driving, so I made a habit of doing my exercises in my car. I also did them in the shower every morning. I focused on setting my pelvic floor and exhaling whenever I performed lift tasks. Once I got good at isolating my muscles, I incorporated Kegels into my running.

There is help available. Incontinence is not "normal." And education is power!

My second visit to the therapist was reassuring. I showed positive changes in pelvic floor endurance. The most dramatic change in my pelvic floor function came four to six months later. I could sneeze with confidence. I could run down hills, slow or fast, and at the end of a work day! I could do 40 legitimate jumping jacks without a dribble. Best of all, I tossed the daily panty shields

In addition, I ran my first five-mile distance run in nine years. It was not a race, just an intimate run in the cool morning air of my ninth Mother's Day. What a fitting day to celebrate my continence with a run, I thought to myself as I picked up my pace coming down the home stretch. No panty shields or pads required!

Now I am destined to spread the good news to other women: There is help available. Incontinence is not "normal." And education is power! I continue to educate myself and interested colleagues to provide treatment to those who can benefit from conservative measures.

The following is a list of terms for patients with pelvic floor dysfunction:

Evaluation . . . .

We evaluate musculoskeletal pelvic floor function both externally and internally as appropriate to determine treatment options and to educate.

Education . . . .

This begins the moment a patient seeks help in treatment of pelvic floor dysfunction. We educate in anatomy and its relevance to function, in good voiding habits, in the findings of our evaluation, and in conservative treatment measures.

Motivation . . . .

This occurs once a patient understands that they have the resources to alleviate their dysfunction. When they begin to see measurable improvements in their function, participation is positively reinforced.

Isolation . . . .

Recruiting the right muscles to act in the right fashion is a good start to achieving success with pelvic floor treatment. Good isolation of muscle function can be achieved with biofeedback.

Elevation . . . .

This word describes how the pelvic floor moves when it contracts. It also reveals the supportive function of the pelvic floor. Good strength and tone is essential to healthy muscle groups. Electrical stimulation for very weak muscles and even weight training can be utilized in appropriate cases to improve pelvic floor elevation.

Relaxation . . . .

A muscle that can find a normal resting position will be subject to less weakness and fatigue than one that is always at work. Relaxation can be an important goal for some pelvic pain problems. Biofeedback and other standard physical therapy modalities can be helpful in achieving muscle relaxation.

Coordination . . . .

Controlled voiding is a learned behavior. It depends on an intricately balanced system to allow coordination of muscle contraction and relaxation at the appropriate times. Bladder instability can be aided by electrical stimulation to restore balance and coordination.

Elongation . . . .

Those tight muscles that promote postural shortening once again strike in the pelvic floor arena. Scar tissue secondary to pelvic and abdominal trauma or surgeries can be factors in pain and dysfunction. Trigger point techniques, scar massage, soft tissue and joint mobilization, muscle energy techniques, and postural stretching are all commonly used physical therapy regimes for tissue elongation.

Integration . . . .

The final phase of any therapy treatment is to incorporate good movement patterns, strength, relaxation, etc. into normal functional activities. Integration of pelvic floor awareness and exercise with healthy voiding habits, work and leisure activities, fitness routines, and postural function is the ultimate way to achieve success.

As you can see, the techniques utilized by physical therapists in treatment of the pelvic floor are those we consistently utilize in treating other aspects of musculoskeletal dysfunction. They are well within our scope of practice and our expertise. There is a whole population of individuals who can benefit from this type of education and regain a better quality of life.

— Linda McGerr is a physical therapist with 13 years of experience serving people through acute hospital rehab, outpatient therapy and home care outreach. Since writing this article, McGerr has attended a four-day course titled "Female Pelvic Floor Dysfunction and Treatment" presented by Hollis Herman, MS, PT, OCS and Kathe Wallace, PT. McGerr highly recommends the course to all physical therapists who want to serve their female clients more completely. She is currently a lead physical therapist at Ridgeview Medical Center in Waconia, Minn., where she treats a variety of patients, including those with pelvic floor dysfunction.