

Incontinence & Pelvic Pain

Women's health PTs should know how to manage these two different but related conditions

Whereas five or 10 years ago many physicians were unaware of PTs' role in helping patients restore continence, physical therapy is now recognized as the standard of care for this population. Today, physicians, gynecologists and other specialists are much more likely to refer patients with incontinence to a therapist before relying on surgical or medical management. Strengthening exercises and sEMG biofeedback, coupled with patient education, are among the non-invasive techniques PTs use to keep patients dry. ▶



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incontinence

As a result, therapists who treat this population may find that their referring physicians are also sending them patients with pelvic pain, a condition that afflicts similar anatomy but is unrelated to incontinence. "These patients could have associated back pain or fullness in the pelvic region, but most patients with incontinence don't have pain," explained Janet Shelley, PT, of Vaughn, Buchanan, Shelley

Whereas managing incontinence is a matter of patient education and home exercise, the treatment of pelvic pain usually requires a more hands-on approach.

(VBS) and Associates Inc., a physical therapy practice with multiple locations in South Carolina, and state representative for the Section on Women's Health of the APTA. "However, since we've treated incontinence for a long time, physicians are increasingly looking to PTs to assist them with patients who have pelvic pain." Therapists who treat patients with incontinence should also know the basics of pelvic pain.

Pelvic Pain and Assessment

Prior to being referred for therapy, patients with pelvic pain typically undergo a number of tests to diagnose the condition.

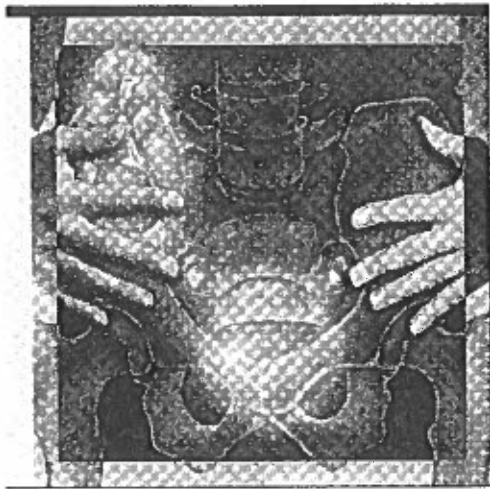
Those patients who are referred to PT, Shelley said, usually fall into one of two broad categories: Having either too much or not enough muscle tone. "Hypertonicity is often due to trauma, such as surgery, childbirth, trauma, adhesions, sexual abuse or pelvic fractures. [Those conditions] can cause tightness in the muscles that results in spasms and pain," she said. Postural dysfunctions, such as a malalignment of the joints in the lower back and sacrum, may also manifest themselves as pelvic pain.

On the other hand, a lack of muscular strength in the pelvis may also cause pain. This may be due to stretch weakness of tissues with vaginal delivery, hormone imbalances in pregnancy and menopause or chronic constipation, Shelley said. "The pelvic floor is used for support of many internal organs, and weakness in [that region] is often associated with back pain, pelvic pressure and frequent urinary tract infections." Patients with a lack of muscle tone in the pelvic floor, more so than hypertonicity, may also have either fecal or urinary incontinence. In addition, disease conditions and abnormal mobility of the pelvic organs such as endometriosis and irritable bowel syndrome can lead to pain and dysfunction, she said.

Although patients often come to the clinic with a clear diagnosis, therapists should start by conducting their own evaluation, to confirm the physician's findings and to quantify patients' current level of function. The cornerstone of a thorough evaluation, Shelley said, is a detailed patient history, including a description of the symptoms, other treatments they've tried, and medications that might make the situation worse. A history of other possible causes, such as sexual abuse, or previous surgery, should also be included.

Following the history, PTs should perform a thorough postural evaluation, including assessment of pelvic musculature both internally and

externally. PTs should also try to quantify the activity of the pelvic floor muscle. "You can actually baseline the strength of the pelvic floor muscles using biofeedback assessment by inserting a probe vaginally and asking the patient to contract," Shelley explained. PTs



can back these findings up with a postural assessment and functional assessments. For patients with incontinence, for example, PTs might count the number of jumping jacks a patient can perform without leaking. This kind of quick, functional assessment can augment sEMG findings and act as a baseline for patients' progress later on in rehab.

Treatment Options

While some patients will present with both incontinence and pelvic pain, and referring physicians often associate the two, treatment for the conditions is entirely different. The most important part of incontinence management, Shelley said, is educating patients on Kegel exercises that can help strengthen the pelvic floor muscles to cut off the flow of urine. A typical Kegel exercise involves contracting the pelvic floor muscles for three seconds, then relaxing those muscles for three seconds, 12 to 15 times in a row; PTs usually recommend patients do this at least three to six times throughout each day. As patients develop strength, they can make the exercises more challenging by doing them in different positions (seated, standing or lying down) or while coughing, lifting a heavy item or performing another stressful activity.

The most challenging part for patients is knowing when they are activating the correct muscles forcefully enough. Shelley said that the literature shows verbal instruction of Kegel exercises aren't very effective, so patients may be contracting the wrong muscles or not contracting them at the proper intensity. For this reason, sEMG biofeedback plays a big role in educating patients. "With sEMG the patient can see when they're using the right muscles,

so they'll develop correlation between 'seeing' the muscle contraction [on the biofeedback screen] and the feeling of contracting it," she said. "And patients also need to know the intensity at which they should exercise so that they don't just 'flicker' the muscle but actually draw the perineum up and in."

Whereas managing incontinence is a matter of patient education and home exercise, the treatment of pelvic pain usually requires a more hands-on approach. PTs often try to ease pain and spasms with stretching and exercise, and modalities such as heat and electrical stimulation may also figure prominently in treatment. "E-stim has been used for years to reduce pain and spasm in other muscle groups, so as odd as it may seem to apply it either vaginally or rectally, it's actually very comfortable," Shelley said.

Although education, biofeedback and in some cases passive modalities make up the "core" of treatment for incontinence and pelvic pain, Shelley noted that manual therapy also plays a role. For example, some patients may have pelvic pain following an episiotomy, a common surgical incision made in a woman's perineum to enlarge her vaginal opening for delivery. In this case, PTs may rely more on scar mobilization and strengthening of the entire muscle group to relieve pain. Myofascial Release, visceral mobilization, strain/counterstrain and joint mobilizations are techniques that figure prominently in the management of pelvic pain. "There are many different causes of pelvic pain and we'd treat them all differently," Shelley concluded. "Sometimes we can resolve the pain completely and sometimes it's management, showing the patient how to cope with the pain and adjust to it posturally." ■

Mike Le Postollec is on staff at ADVANCE and can be reached at mlepostollec@merion.com.

