The Most Dreaded Words in GYN… Pelvic Pain

How to recognize, Refer and Manage

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No Disclosures

- We have no financial interest or other conflict of interest in relation to this presentation. - Jeannine and Ashlee

Do GYNs have a sense of humor?

Objectives

- Upon Completion of this presentation:
  - 1.Participant will be able to define chronic pelvic pain.
  - 2. Participant will be able to identify 3 symptoms of pelvic pain
  - 3. Participant will be able to identify 3 contributing factors of pelvic pain
  - 4. Participant will be able to list 3 treatment options
  - 5. Participant will be able to list 3 pain characteristics of chronic pelvic pain
  - 6. Participant will be able to identify the muscles of the pelvic floor
  - 7. Participant will be able to list 3 disciplines that treat causes/symptoms of pelvic pain patients
  - 8. Participant will be able to list Physical Therapy treatment options.

Subjective

- - hurts to sit, stand – can't get comfortable
- - can't do housework pick up anything, travel, do things with my family
- - may have to go to bed for days
- -can't wear anything tight or rough (jeans, fitted or snug clothing, texture)
- -hurts to have sex (difficult penetration, pain during and after)
- - pain after pelvic exam
- -hurts to use tampons
- - bright lights and strong smells bother me
- -have trouble with bowels (defecatory dysfunction ,IBS-D, constipation)
- -pee all the time (frequency, interrupted stream, hesitancy)
- -never feel like I get all of the poop out (rectal pressure, prolapse)

Objective: Things you see with PFD

- Unable to sit flat- (may reposition frequently or lie down)
- Wears loose clothes (no fitted or snug clothing)
- May appear withdrawn or anxious (poor to no eye contact, hyper, pressured speech)
- Pelvic exam: grimacing, verbal ques, tense pelvic floor and hypertonic rectal tone, spasms
- Increased risk of CPP in the obese patient
- Palpable stool in rectal vault or may be noted with vaginal exam
- Elevated PVR (difficulty emptying bladder hesitancy or interrupted flow)
- Increased sensory awareness/ irritation odors, bright lights, textured clothes
- May c/o pain with taking BP, reaction to hot/cold/touch
- Often has 1 or more autoimmune conditions RA, SLE, Sjogren's syndrome, fibromyalgia, migraine headaches, IBS, IC, dysautonomia, EDS, MS

Factors that Contribute to PFD/ PP

- Sexual assault or abuse
- Physical or emotional abuse
- Strict background- military, religious
- Dance, gymnastics, guarding or excessive contraction of PFM
- Type A personality
- IC, IBS, UTI
- Back or hip injury
- Poor posture
- Surgery (bladder, bowel, hysterectomy, back, pelvic /abdominal, hip)
- Mental health problems
- Anal fissure, fistula, hemorrhoid,- and repairs mesh gone wrong
- Painful menses, endometriosis
- Cesarean Section Scar, other abdominal/pelvic scars (hernia) adhesions

Regardless of the initial source of pain
There is increasing awareness that persistence of pain is a risk factor for developing a chronic pain syndrome as a result of CNS changes

Research suggests relative pain output is influenced by genetics and individual previous sensory experiences
ex: volume knob controls output of sound

Symptoms that continue to escalate-even if present in the past -need new evaluation (Tu, 2017)

Preliminary Considerations for Treatment

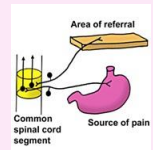
Treatment should be focused on the underlying cause if possible.

Pelvic Pain is often multifactorial and to have optimal results, multiple disciplines are needed to work together to address and treat. A team approach is needed to be effective.

Team members may include physical therapy, urology, GI, GYN, neurology, psychology, pharmacy, alternative medicine, massage therapy, pain clinic , orthopedics

Problems in one organ can influence dysfunction in another area: PBS, endometriosis, IBS and dysmenorrhea

Increased sensitivity to pain is common.



Most important step in caring for your patient is taking a few minutes to listen and reassure her that she is not "crazy". She needs validation that her condition is real.

Treatment Options

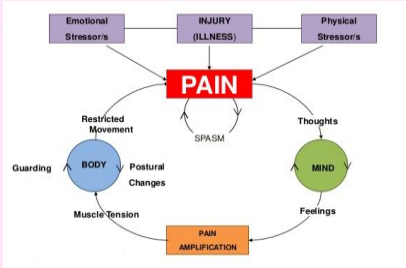
- relaxation techniques, guided imagery, BFB
- Medication (muscle relaxer)-Baclofen, Flexeril, Zanaflex , Gabapentin, Cymbalta, tricyclic antidepressants, Valium supp., compounded supp/creams, anti-inflammatory , antispasmotic IC- Elmiron, marshmallow root IBS/ GI – Bentyl, Imodium
- Pain Clinic (epidural, trigger point injection)
- Alternative Medicine (acupuncture, cupping, massage, meditation, yoga, tai chi, diet)
- Surgery (lap. For endometriosis, adhesions, hyst/BSO, colectomy, mesh removal, prolapse repair
- Bladder instillation and hydrodistention
- Mental health / sex therapist
- PT (Myofascial release, stretches, exercise, dry needling)

APQRST Pain Characteristics

Obtaining this information during a detailed history can assist with determining factors contributing to CPP and possible sources of the pain

- A associated symptoms
- P provocative and palliative factors
- Q quality, sensation , quantify intensity, rate pain
- R radiation ID primary location and where it travels pain map
- S setting r/t menses, nerve irritation, activity
- T temporal (timing)

Pain Cycle



Chronic Pelvic Pain

- Chronic Pelvic Pain (CPP) is a symptom in a specific organ system,
- a chronic pain syndrome or both
- CPP is defined as a non-cyclic pain perceived to be in the pelvic area
- that has persisted for 3-6 months or longer and is unrelated to pregnancy
- New name – "Persistent Pelvic Pain"
- Defined as pain, non-cyclic in nature, in the pelvic region lasting greater than 6 months (Ortiz, 2008)
- Worldwide Female CPP has been reported to affect from 6 to 25% of women of reproductive age
- Comparable to prevalence of Low Back Pain or Asthma (Zondervan, 2011)
- IBS and cystitis were the most common diagnoses of women with pelvic pain across all age groups
- Another study indicates IBS, adhesions, M/S causes and endometriosis (Tu, 2017)

Chronic Pelvic Pain Continued

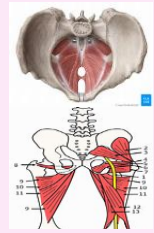
- Only 1/3 of CPP seek medical treatment (Barbieri, 2017)
  -Difficult to treat due to lack of an identifiable pathophysiological cause (Fall, 2010)
- A definitive diagnosis is not given to approximately 60% of women with CPP (Ortiz, 2008)
- Acute injury occurs – healing takes place – but the pain persists OR pain exists in the absence of injury (Malykhina, 2007)
  – Changes are seen in CNS and PNS

PT Examination

- Pelvic Floor Assessment– extra training
  – Observation for Skin Assessment – any lesions, red/raw area, estrogenic/atrophic, etc
  – Sensation to Pelvic Floor (S2-5)
  – Superficial Musculature Palpation for Tenderness
  – Internal Pelvic Floor Muscle Strength
  – Internal Pelvic Floor Muscle Endurance
  – Internal Pelvic Floor Muscle Identification for Pain/Tenderness

Possible Muscle Culprits

- Coccygeus
- Levator Ani
- Obturator Internus
- Adductor Magnus
- Piriformis
- Internal Oblique



Examination Findings

- Overactive pelvic floor muscles
  - Incoordination
  - Poor Relaxation
  - Poor ability to contract involuntarily (i.e. cough/sneeze)
- Weak core/abdominal muscles
- Poor diaphragmatic breathing
- Weak hip/low back muscles

Physical Therapy Goals

- Normalize alignment of bony pelvis/spine
- Restore normal tension/tone to PFM
- Facilitate conscious control of PFM contraction and equal relaxation
- Reduce symptoms: pain/frequency/urgency
- After relaxation, strengthen PFM, if needed

- (Doggweiler-Wiygul 2004)

PT Treatment

- Manual Therapy
  - Myofascial Release
  - Scars, Trigger Points
  - Soft Tissue Massage
  - Joint Mobilizations (Lumbar Spine/Sacroiliac, Hip)
- Functional Dry Needling
- Neuromuscular Re-education
  - Downtraining/Relaxation initially
  - Pelvic Floor Muscle Awareness – Pelvic Floor Checks?
- Calming Autonomic Nervous System
  - Diaphragmatic Breathing
  - Guided Imagery
  - Meditation
- Biofeedback
  - Simple (tactile cues)
  - Surface EMG
- Strengthening
  - Core, Hips Lumbar Spine
  - Pelvic Floor Muscles

Referrals

- **Physical Therapy- Ashlee M. Ellard PT, DPT, CLT at Spain Rehab**
- **If at UAB- order PT in IMPACT and send a message to Spain Rehab Outpatient Therapy Scheduling to have scheduled and have insurance verified**
- **Referrals and appointments UAB - Outpatient Rehabilitation Services 205-975-4922**
- Ashlee may see private insurance as well as BCBS, Viva, Medicare and Medicaid. She will see patients at Spain Rehab.
- **UAB Continence Clinic @ TKC -Urinary and Bowel issues, IC**
- **Appointments for new patients 205-801-8705**

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