Treatments for Patients With Pelvic Pain

Elaine Meadows

An overview of the incidence and types of pelvic pain is presented, followed by some practical information concerning the presentation of patients with pelvic pain. Simple physical therapy techniques that are use in treating patients with pelvic pain are also discussed.

Chronic pelvic pain (CPP) is a vague and confusing term that generally refers to noncyclic pain in the abdominal and/or pelvic area, that has been present for 6 months or longer, and that may have a negative impact on activities of daily living and quality of life. CPP affects predominantly women but men may suffer with pelvic and/or rectal pain as well.

Information related to pelvic pain is limited. Two studies published in 1996 presented staggering statistics. Chronic pelvic pain is most common among women 26 to 30 years old and 39% of women of all ages reported having some form of pelvic pain. Irritable bowel syndrome (IBS) was present in 65% to 79% of referrals of women with CPP and 10% to 15% underwent hysterectomy without resolution of their symptoms (Jamieson & Steege, 1996; Mathias, Kupperman, Liberman, Lipschutz, & Steege, 1996). Patient complaints are often unrelated to an identifiable gynecologic or urologic pathology. Despite this, many patients are treated with surgery and/or medications.

There are many different diagnoses associated with CPP including vulvar pain syndromes, interstitial cystitis, levator ani syndrome, piriformis syndrome, vaginismus, anismus, dyspareunia, proctalgia fugax, constipation, pelvic floor tension myalgias, endometriosis, pudendal neuralgia, and/or rectal pain. Many patients seek help for many years until they receive a correct diagnosis and proper treatment.

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Symptoms and Relief

Symptoms associated with CPP include low back pain, heavy feeling in pelvis, radiating leg pain, pain with urination and/or defecation, constipation, diarrhea, coccyx pain, supra pubic pain, abdominal pain, bloating, and/or cramping, irregular menstrual cycles, pain with menstruation, and dyspareunia.

Symptoms are aggravated by many factors that may contradict each other. Some patients report increased pain with sitting, standing, supine, or with changes in position. Working with patients to find a position of comfort is essential (Kendall, McCreary, & Provenance, 1993; King Baker, 1998). Pillows can be used to assist with placement of extremities and trunk for proper positioning in supine and sidelying. In sitting position, use lumbar rolls to facilitate lumbar support and use a footstool for hip and knee flexion. Try to maintain hip flexion greater then 90 degrees to facilitate proper lumbar lordosis. Discuss and monitor patient's workstations, home care areas (kitchen, bathroom, bedroom), car seating, and recreational activities for proper body positioning.

Physical activity often exacerbates pelvic pain and patients may choose not to exercise or be active. Lack of physical activity causes patients to become deconditioned. Educate the patient as to the importance of aerobic exercise for overall fitness and conditioning. Suggest the patient exercise 3 to 6 times a week for 20 to 40 minutes at a time. Walking, swimming, and low-impact aerobic activities may be best. Some patients should avoid running, cycling, and high-impact aerobics since they may aggravate the pelvic girdle musculature. Easy stretching or yoga will lengthen chronically tight muscles and help alleviate muscle pain. A simple home exercise program to perform pelvic stability, abdominal exercises, hip strengthening exercises, and extremity exercises is easily accomplished with theraband, rubber tubing, swiss

ball, or floor exercises. As a patient's muscles regain strength, function follows.

Keeping a bowel and bladder record will help a patient recognize the importance of regular urination and defecation, and identify problems with regularity. Patients should understand the significance of bowel regularity in the control of CPP. Tension in the pelvic floor muscles (PFM), poor intake of fiber and fluid, and lack of physical activity may cause constipation (Whitehead, 1998). Constipation may increase complaints of CPP. A bowel and bladder retraining program may also be used. Stress the importance of eating 20 to 30 grams of fiber each day to maintain regular and easy bowel movements.

Many patients with painful bladder conditions will limit their daily fluid intake in an attempt to alleviate symptoms, a practice known to worsen symptoms. Teach the patient about proper fluid intake levels and timed voiding intervals. Many people do not consume enough water and are frequently drinking bladder irritants (caffeinated products, acidic fruit juice, spicy foods). Have handouts available with lists of bladder irritants and help patients understand the importance of making choices in their diet and fluid intake. The best fluid for patients to drink is water, especially if they are constipated or have a painful bladder.

Dyspareunia (painful intercourse) is a common complaint of patients with chronic pelvic pain and a frank, open discussion with your patients regarding their sexual function and fulfillment is beneficial. Many patients have not been thoroughly interviewed prior to their referral and may be embarrassed by a discussion regarding their sexual activity. This information is helpful in understanding the nature of their pain and in documenting pelvic muscle dysfunction. Ask questions regarding positioning, use of lubrication, areas of pain, ability to achieve orgasm, type of stimulation needed for orgasm, description of pain during and after sexual activity, and frequency of activity. Offer practical suggestions such as positioning to avoid excessive weightbearing on sensitive tissue, and reading material to facilitate alternative sexual fulfillment.

Evaluation

An initial evaluation should include a thorough musculoskeletal assessment. Consider referring to a physical therapist who treats chronic pelvic pain. Musculoskeletal evaluation includes posture assessment, gait and transfer analysis, active range of motion, and strength tests of the extremities and trunk (American Physical Therapy Association, 1997). Patients are also examined for scar tissue on the abdominal wall and flexibility. A pelvic muscle examination should include grading muscle strength and coordination of slow-twitch and fast-twitch fibers, overall muscle tone, tissue sensation and color, location of tender and trigger points, organ descent, perineal movement, and scarring. Surface electromyographic evaluation of the PFM documents baseline resting and contraction ability.

During the musculoskeletal assessment particular attention should concentrate on the hip rotators, hip flexors, hip adductors, hip extensors, sacroiliac joint function, lumbosacral joint function, leg lengths, upper body position, and general movement patterns. A therapeutic exercise program targeting dysfunctions found in these musculoskeletal groups is very helpful. First, consider a stretching program for tight and painful muscles. As the patient progresses add strengthening exercises for all muscle groups especially the pelvic girdle and trunk muscles. Pelvic stability and abdominal strengthening are significant as well. Pelvic floor muscle instruction is important to regain control and coordination of these muscles.

Treatment Options

Biofeedback is useful for monitoring the pelvic floor muscles and accessory muscles for patients with CPP. Biofeedback uses computerized (and other) instruments to relay information to patients about a physiologic activity. Interpreting information about pelvic muscle use through visual displays (such as computer monitors) is very helpful. Biofeedback can be used to strengthen the pelvic floor; facilitate relaxation and reduce resting tone of the pelvic floor; enhance coordination of pelvic muscles; inhibit accessory muscles, which substitute for PFM, to reduce voiding and defecating dysfunctions; and to train for general relaxation techniques (American Physical Therapy Association, 1997; Pauls, 1995). Often, patients with CPP have high resting tone of the pelvic floor muscles and poor ability to properly contract and relax the PFM and accessory muscles. To assist the patient with relaxation techniques, try working with breathing techniques, visualization, massage, and progressive relaxation exercises.

Transcutaneous electrical nerve stimulation (TENS) may be effective for treating patients with chronic pelvic pain. TENS has been used with patients with interstitial cystitis (Kotarinos, 1994). Interferential electrical stimulation is effective in

pelvic floor strengthening but may require frequent visits to the clinic. Neuromuscular electrical stimulation (NMES) is used for pelvic floor strengthening and reflex inhibition with patients with pelvic muscle dysfunction (Laycock, Schussler, Norton, & Stanton, 1994). Try to use a vaginal or anal sensor with NMES and have patients use it before bedtime for assistance with sleeping and relaxation.

Manual therapy is another essential component of the treatment plan for patients with chronic pelvic pain. Manual therapy may include visceral mobilization of the pelvic organs and supporting structures, soft tissue massage or myofascial techniques to pelvic girdle musculature, scar tissue massage, internal vaginal and/or anal work to muscles and tissues, and joint mobilization to spine and extremities. Proper training is required to perform these techniques and referral to a skilled physical therapist may be best for your patient. Contact the American Physical Therapy Association Section on Women's Health at (800) 999-APTA, ext. 3237 to locate a regional representative who can refer you to a practitioner in your area.

Written educational materials are beneficial resources to have available for your patients. Maintain a list of professionals who specialize in counseling patients with chronic pain. Many areas have support groups for people with chronic pain that your patient may join. There are several national organizations whose brochures are available to distribute to your patients (see Table 1).

The Internet is a valuable resource for you and your patients to use for education and networking. Several chat rooms are available to patients and families to discuss their problems (see Table 2). Working with patients with chronic pelvic pain can be challenging and rewarding. Be creative and be sincere with your care and treatment plan. Many patients are willing to work with you to improve their conditions and are motivated much more than other patients because of their chronic pain. Document the treatments you perform and monitor for functional outcomes. Most of all, enjoy your work and good luck.

Table 1.
Patient Support and Information Groups

Endometriosis Association
International Headquarters
8585 N. 76th Place
Milwaukee, WI 53223
Phone: 800-992-3636

ICN - Interstitial Cystitis Network
4773 Sonoma Highway #125
Santa Rosa, CA 95409
Voice mail: 707-538-9442
Fax: 707-538-9444

International Foundation for Functional Gastrointestinal Disorders (IFFGD)
PO Box 17864
Milwaukee, WI 53217
Phone: 414-964-1799

International Pelvic Pain Society
Suite 402 Womens Medical Plaza
2006 Brookwood Medical Center Drive
Birmingham, AL 35209
Phone: 205-877-2950

Interstitial Cystitis Association
51 Monroe Street - Suite 1402
Rockville, MD 20850
Phone: 301-610-5300
Fax: 301-610-5308

NVA - National Vulvodynma Association
Executive Director Phyllis Mate
PO Box 4491
Silver Spring, MD 20914-4491
Phone: 301-299-0775
Fax: 301-299-3999

Vulvar Pain Foundation
Post Office Drawer 177
Graham, NC 27253
Phone: 336-226-0704
Fax: 336-226-8518

Table 2.
Chatrooms

vulvodynia.com
incontinet.com
ichelp.com
ic-network.com

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