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*Unspoken Pain: Evaluation and Management of Pelvic Pain from a Physical Therapy Lens*



# Unspoken Pain: Evaluation and Management of Pelvic Pain from a Physical Therapy Lens

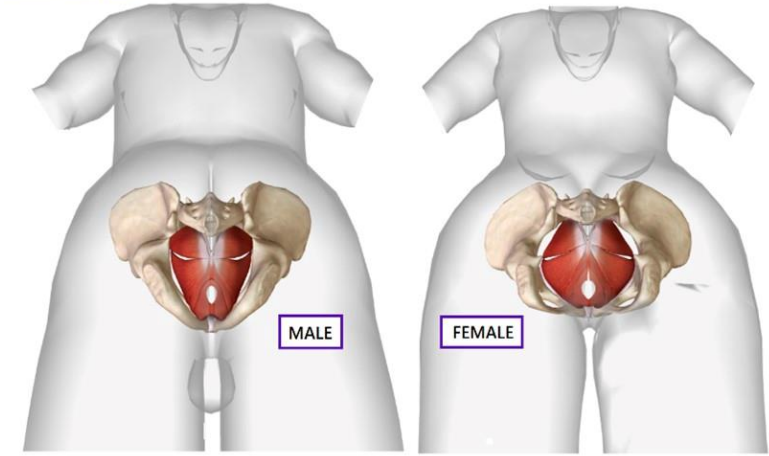
Meghan Z. Markowski, PT, DPT, WCS, BCB-PMD

Rebecca G. Stephenson, PT, DPT, MS, WCS

# Disclosures

Image created using:  
BioDigital  
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Pelvic floor muscles within the pelvic canal.



View from behind. Tilted forward.

- Dr. Stephenson- GWHI.org non profit that funds PT projects improving women’s health nationally & internationally
- Dr. Markowski- no disclosures
- Note:
  - When referencing “female” and “male” in this presentation, this is referring to natal anatomy
    - Data collected in the literature refers to natal anatomy
    - This is NOT a reference to gender - the authors respect and treat individuals of all gender identities

# Objectives

1. Introduce the anatomy and physiology of the pelvic floor muscles, genitourinary and gastrointestinal system, and sexual organs in males and females
2. Discuss normative bladder, bowel, and sexual function - a systems approach
4. Review the role of the musculoskeletal system in the following pelvic floor syndromes: urinary and fecal incontinence, constipation, pelvic pain, sexual pain, and sexual dysfunction
5. Provide a clear understanding of the role of the pelvic floor physical therapist in the evaluation and treatment of various pelvic floor conditions
6. Discuss the examination and various pelvic physical therapy treatment options including: bladder and bowel retraining, manual techniques, biofeedback/neuromuscular re-education, therapeutic exercise, and postural re-education
7. Review the current evidence for pelvic physical therapy intervention in pelvic floor related pain syndromes
8. Understand the importance of a multi-modal approach to the treatment of pelvic pain

# Physical Therapists <sup>1</sup>

## Physical Therapy (PT)

- Experts in the musculoskeletal system, doctoring profession
- Most recognized in orthopedics
- Play a large role in the evaluation and treatment of pelvic floor conditions including: pelvic pain, incontinence, and constipation
- Pelvic floor muscles (PFM) are important in continence, elimination, sexual function, and postural control

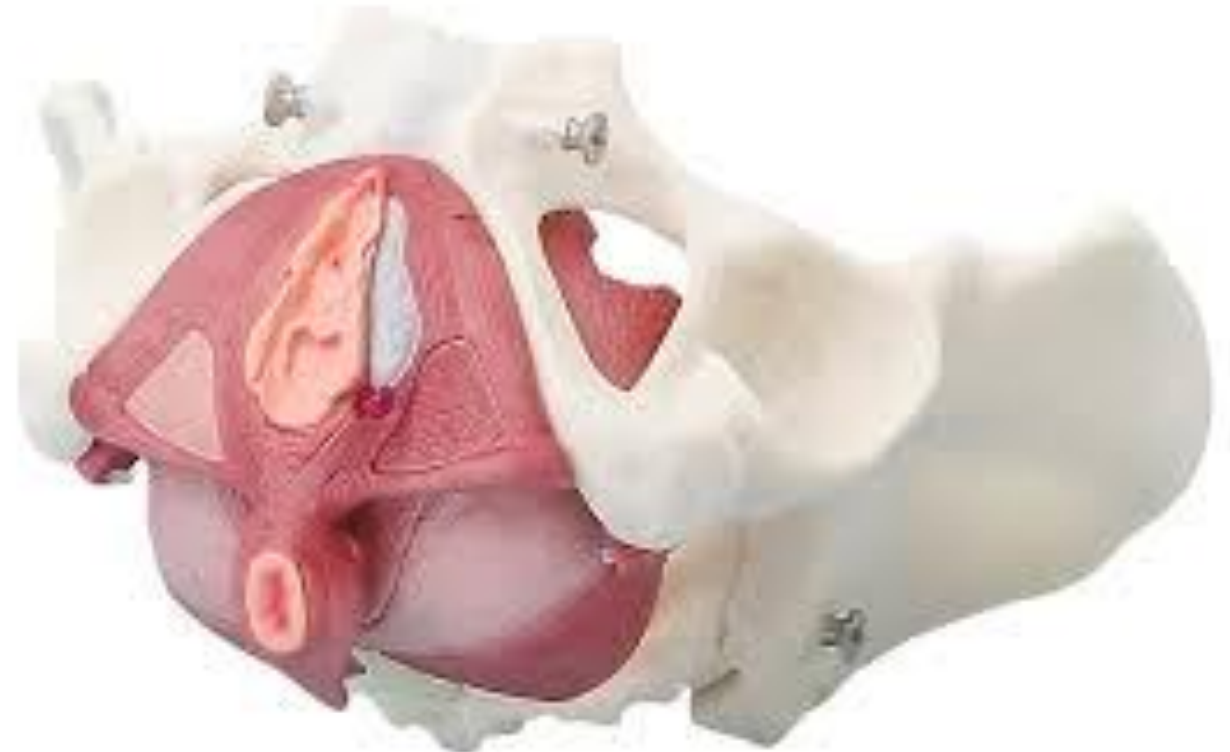
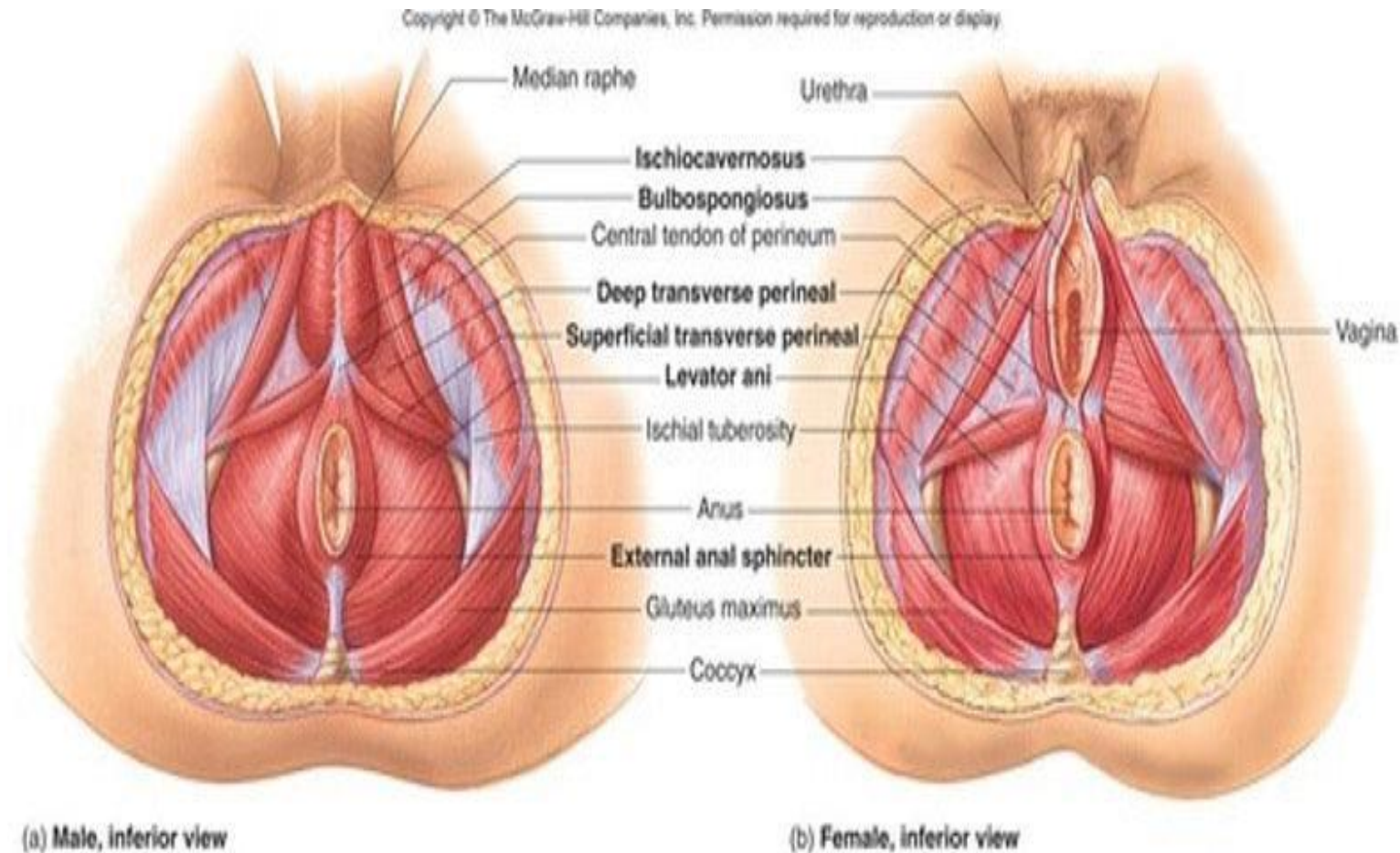


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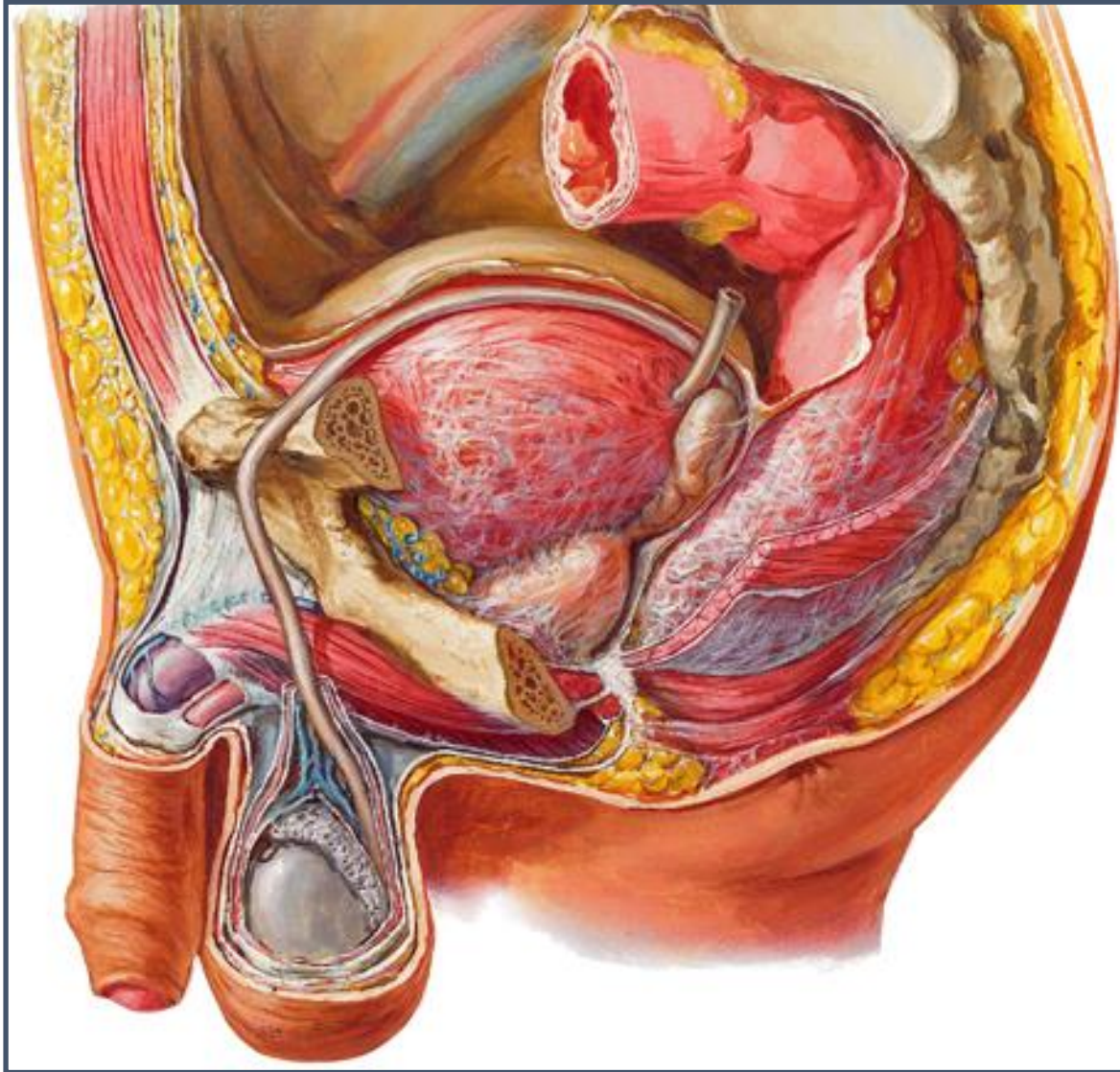
# The Pelvic Floor <sup>1</sup>

- All visceral, neurovascular, and myofascial structures contained in the bony pelvis
- Two layers of muscles, perineum, genitals, fascial layers, and connective tissue
- Three Main Functions:
  1. Supportive
    - Of internal organs
    - Of lumbar spine
  2. Sphincteric
    - Closure of urethra, anus, and vagina
  3. Sexual appreciation





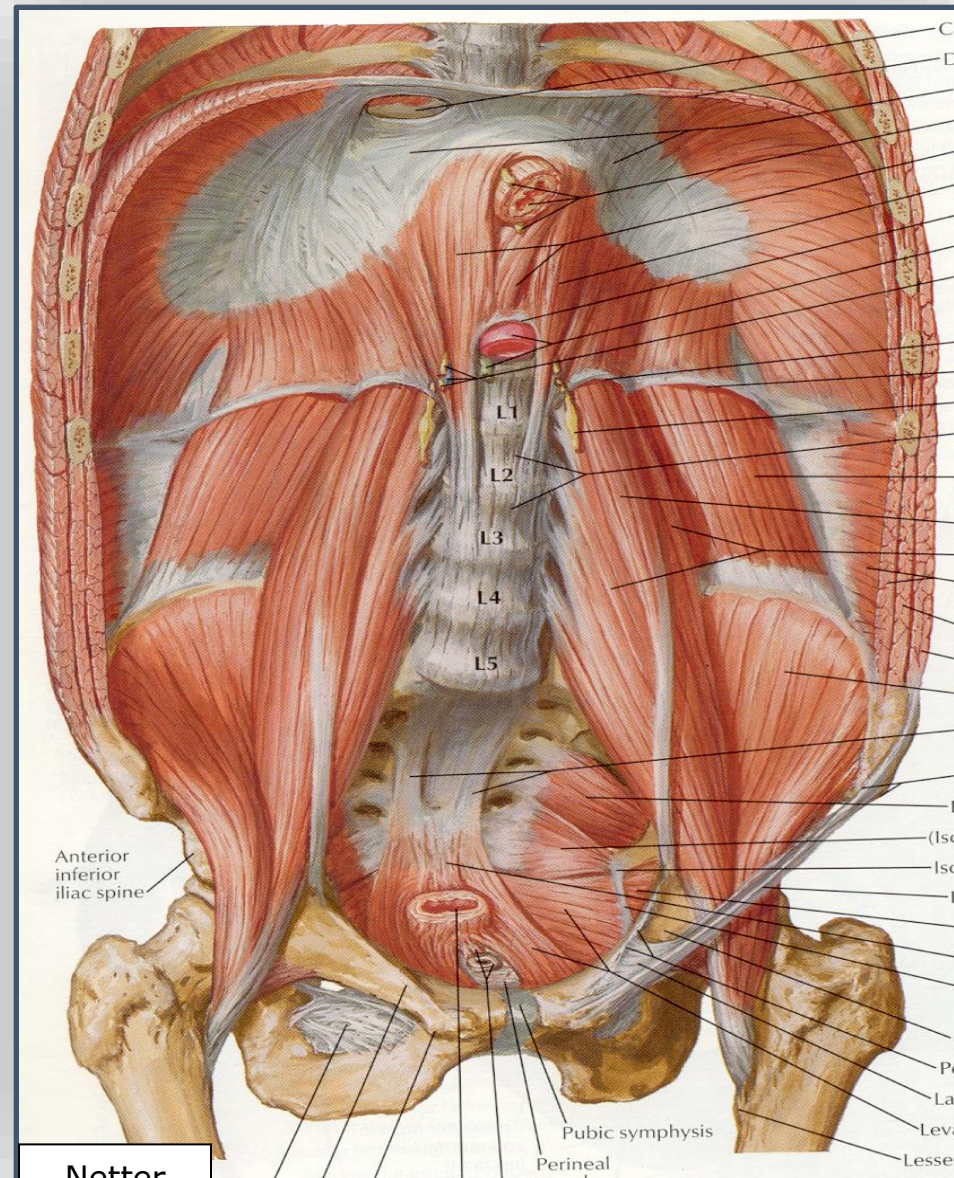
# Male / Female Pelvic Floor Muscles





# Posterior Abdominal Wall

- Respiratory Diaphragm
- Quadratus lumborum
- Psoas (major & minor)
- Transversus abdominis
- Iliacus
- Piriformis
- Pelvic floor diaphragm

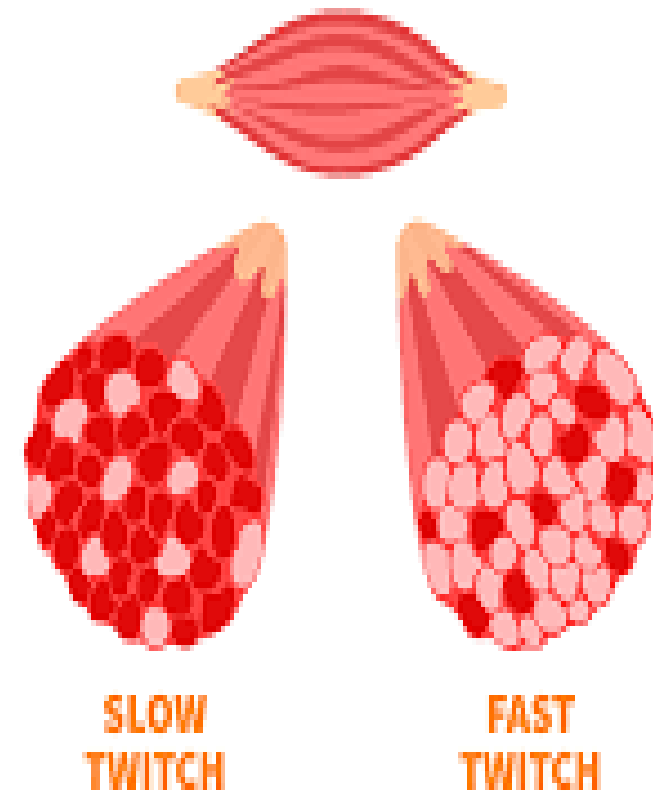




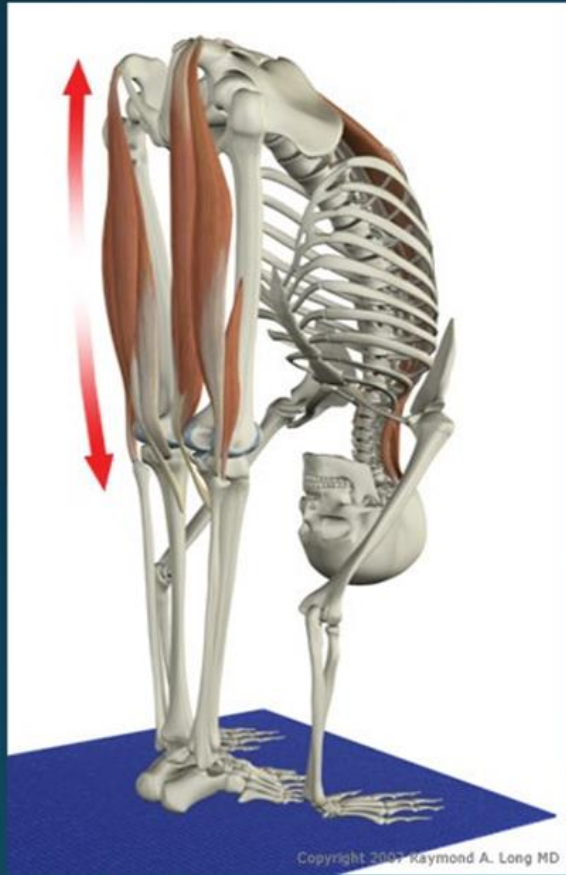
# Pelvic Floor Physiology- Slow and Fast Twitch

- **Type II** Slow-twitch fibers rely on aerobic respiration for contractions, while fast-twitch fibers rely on anaerobic respiration to fuel muscle contractions. Quick sphincter closure- 70%
- **Type I** fibers are perfect for long-term endurance exercises. Chronic tone maintained throughout the day -30%
- We lose fast twitch fibers with age

## MUSCLE FIBER TYPES

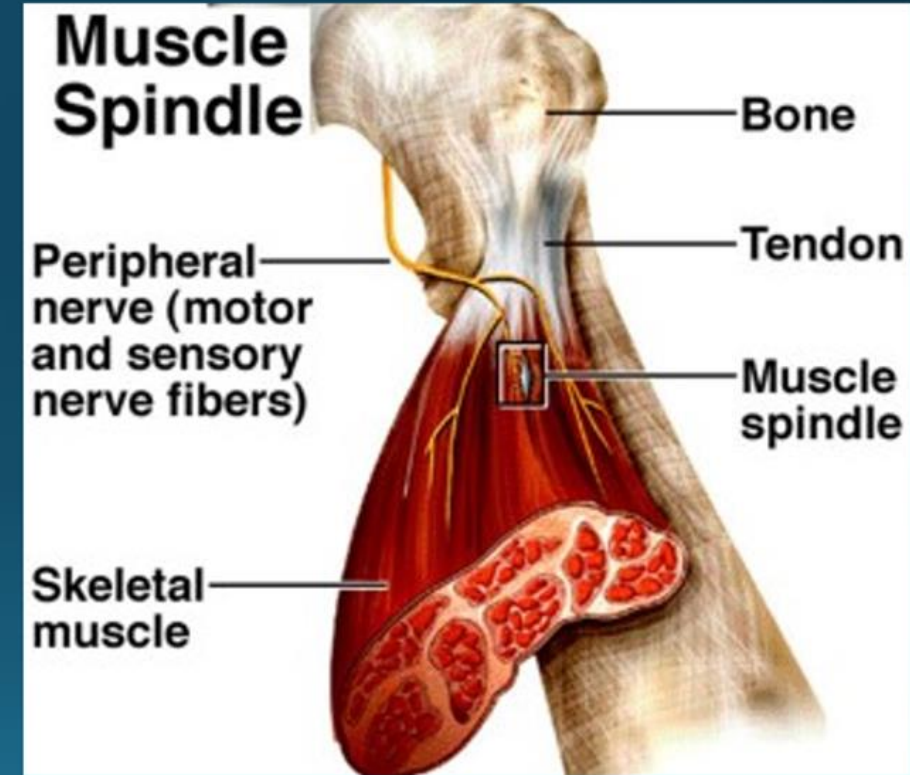


# Muscle Spindle Mechanism



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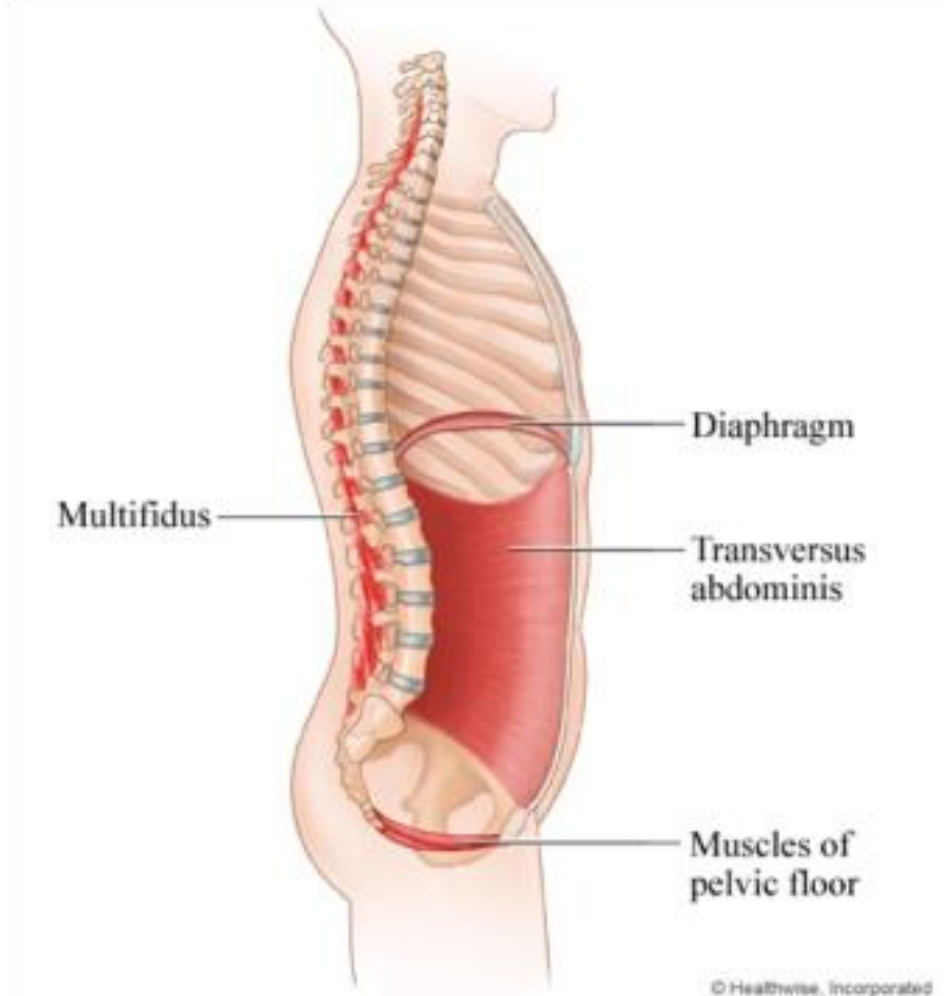
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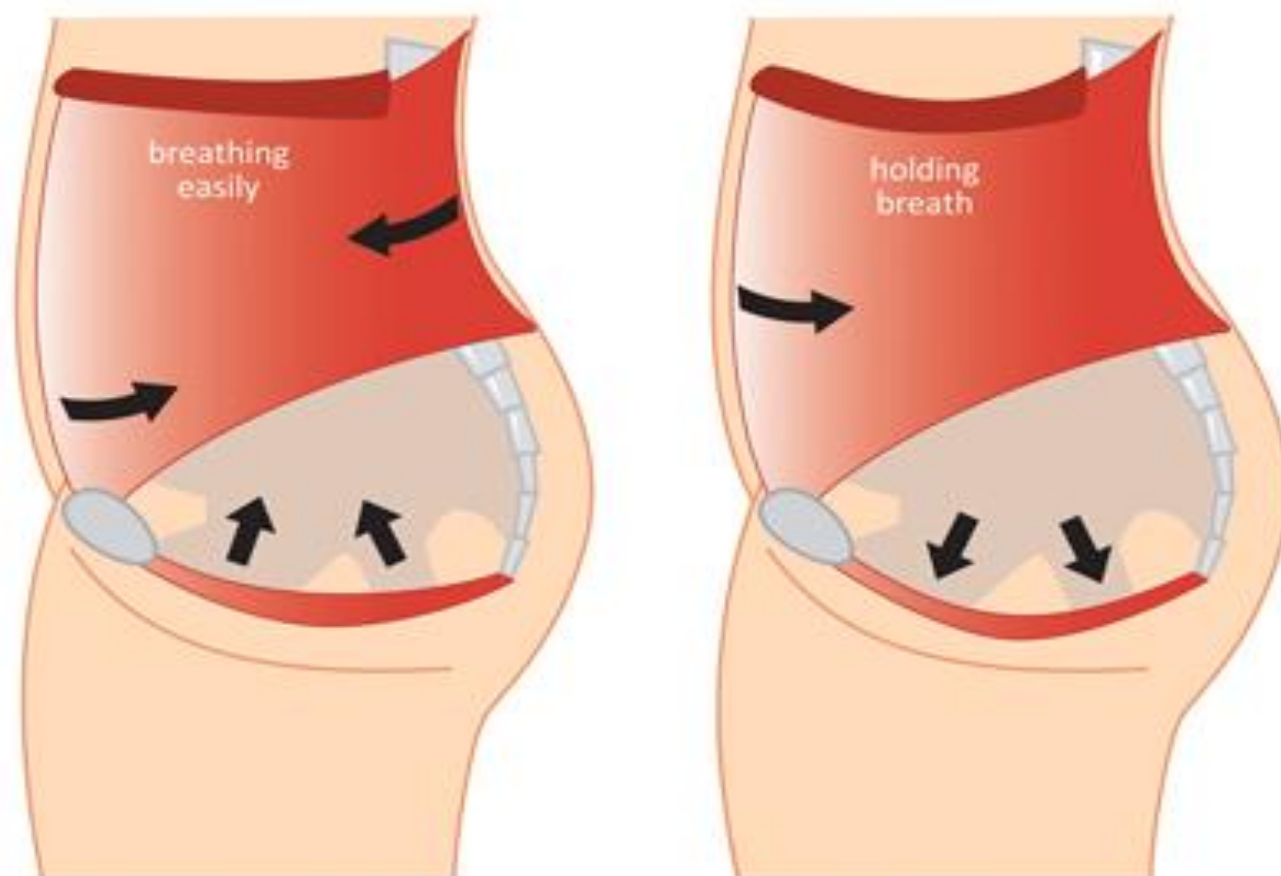
# PFM Trunk Stabilizer Role <sup>1</sup>

- “Cylinder Concept” of trunk stability
  - Bottom of cylinder = pelvic floor muscles (PFM)
- Mobility versus Stability Concept
  - Organs and outlets of the pelvic floor need to have mobility
  - Too much mobility = weakness
    - Presents as incontinence or prolapse
  - Too much stability = overactivity
    - Presents as pain or constipation





## PELVIC FLOOR MUSCLE CONTRACTION



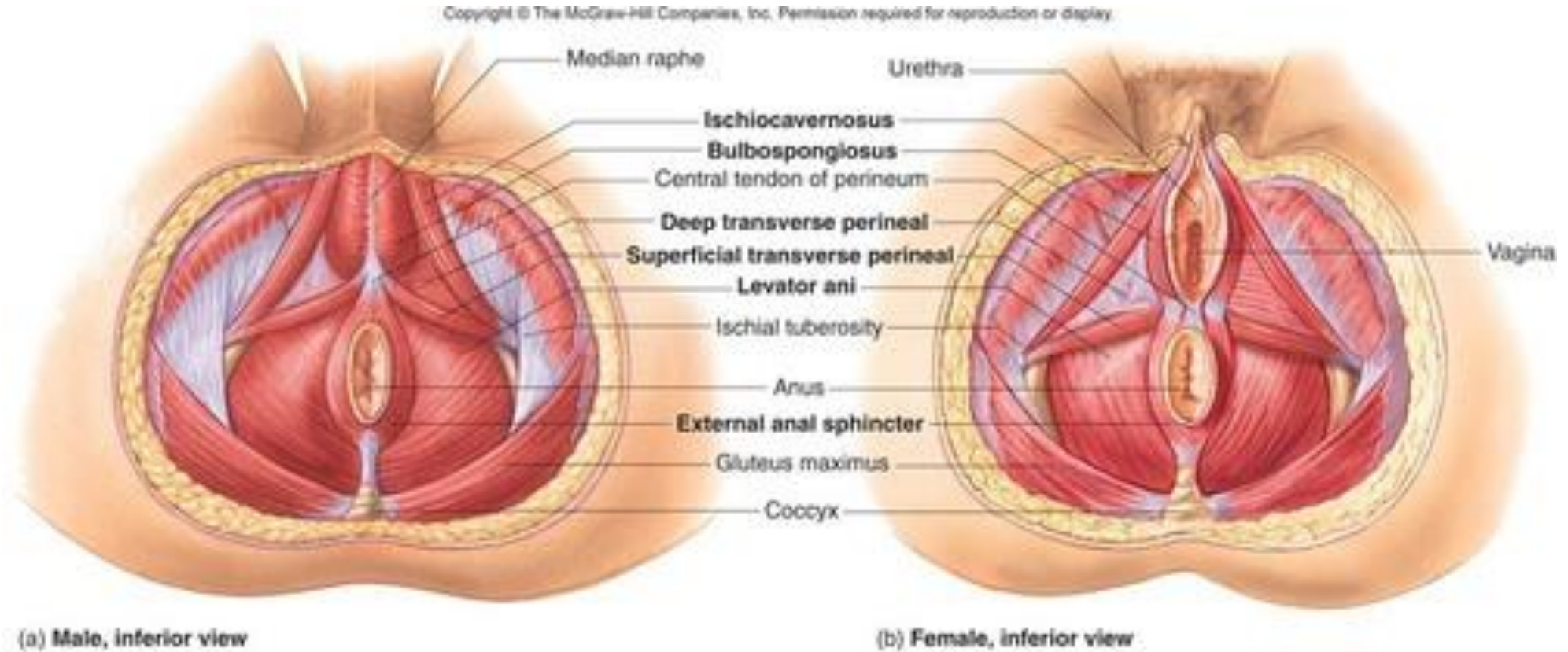
### **Correct action**

The pelvic floor lifts, the deep abdominals draw in and there is no change in breathing

### **Incorrect action**

Pulling the belly button in towards the backbone and holding your breath can cause bearing-down on pelvic floor

# PFM Function Bladder/Bowel/Sexual Roles



# Review: Pelvic Floor Muscles Function <sup>1</sup>

- **Trunk Support**

- Allows fixation of trunk with strong movement of upper extremities

- **Pelvic Organ Support**

- Allows increased PFM closure during increases in intra-abdominal pressure (IAP)

- **Sphincteric**

- Closes urethra, anus, and vagina

- **Sexual**

- Provides tone and support to the genitals

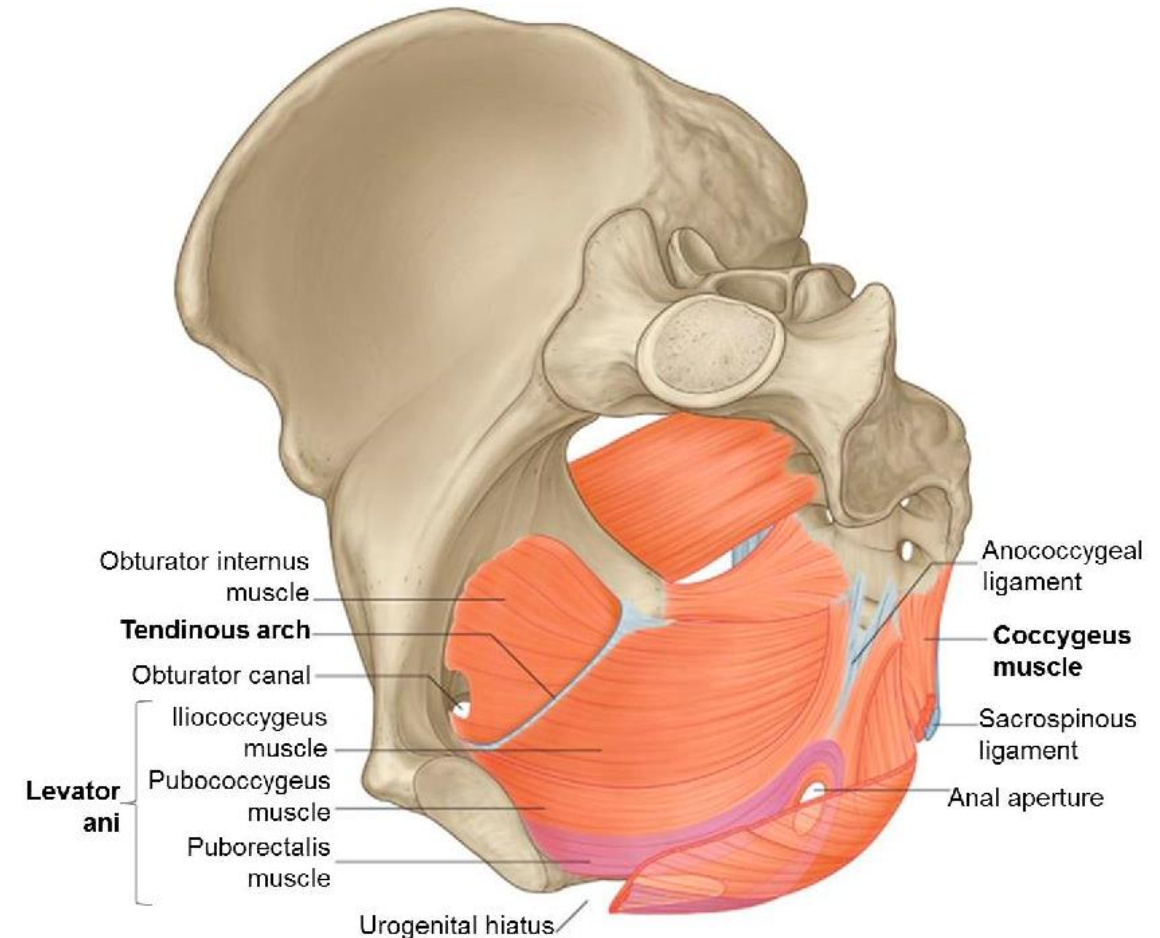
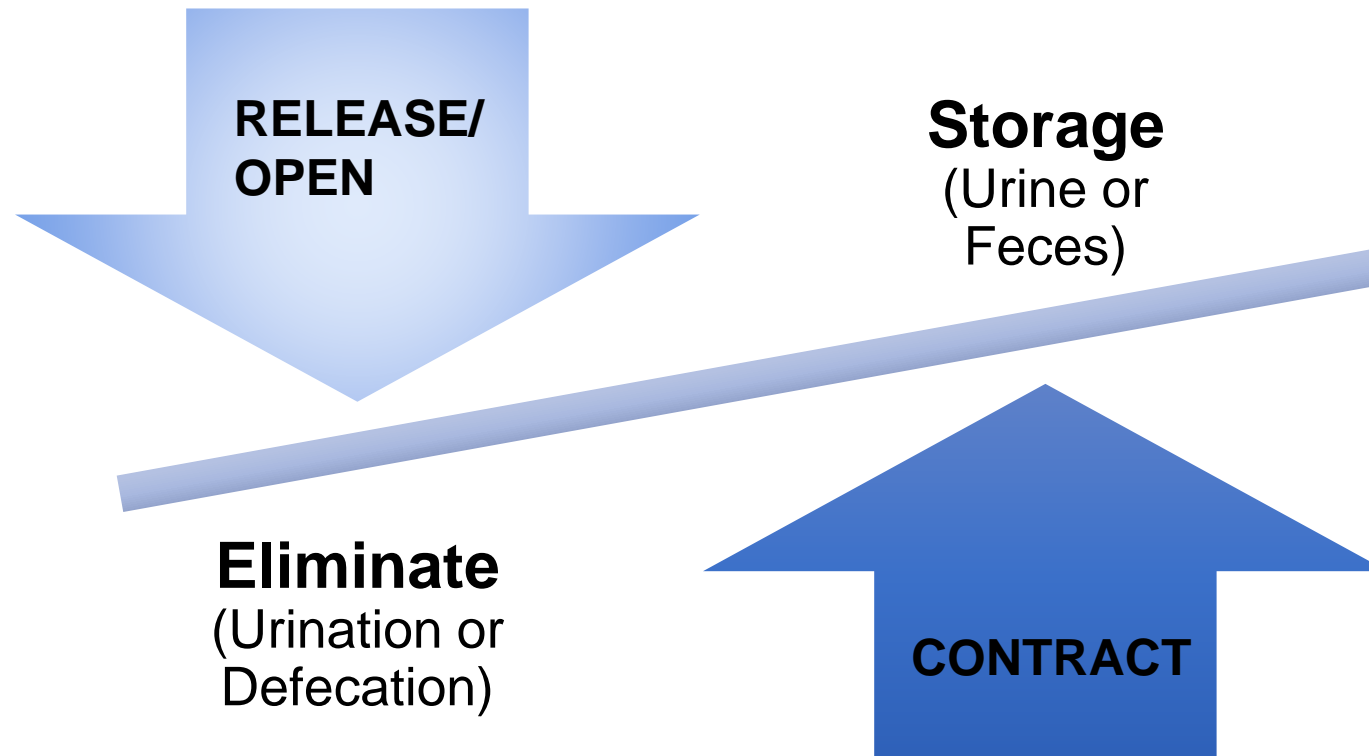


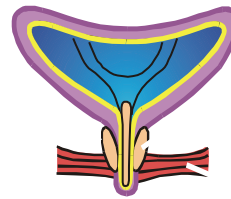
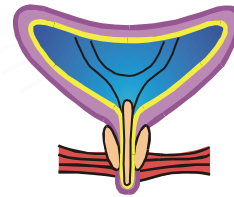
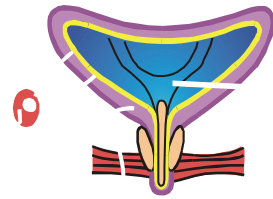
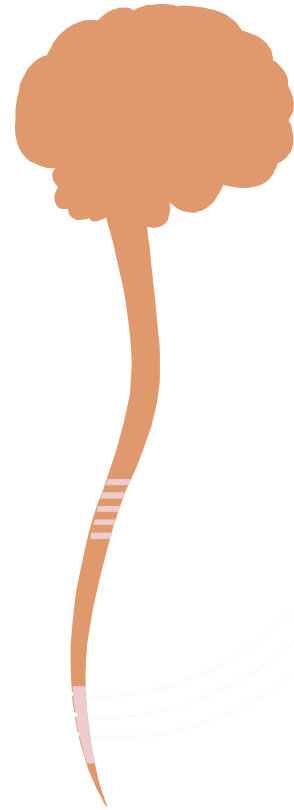
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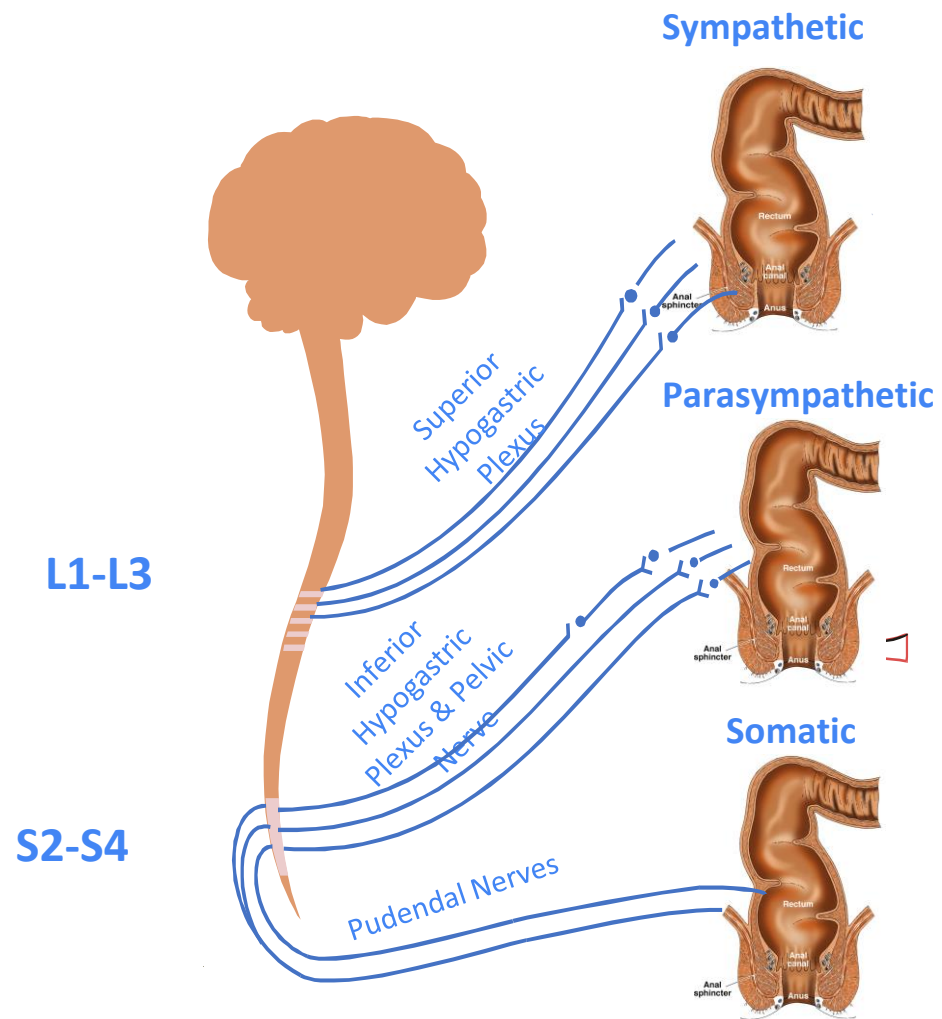


# The Role of the PFM Regarding Continence <sup>1,6</sup>

- PFM assist in urinary and fecal continence by increasing pressure through sphincteric control of the urethra and anorectal angle of the rectum









# Pelvic Organ Support <sup>3</sup>

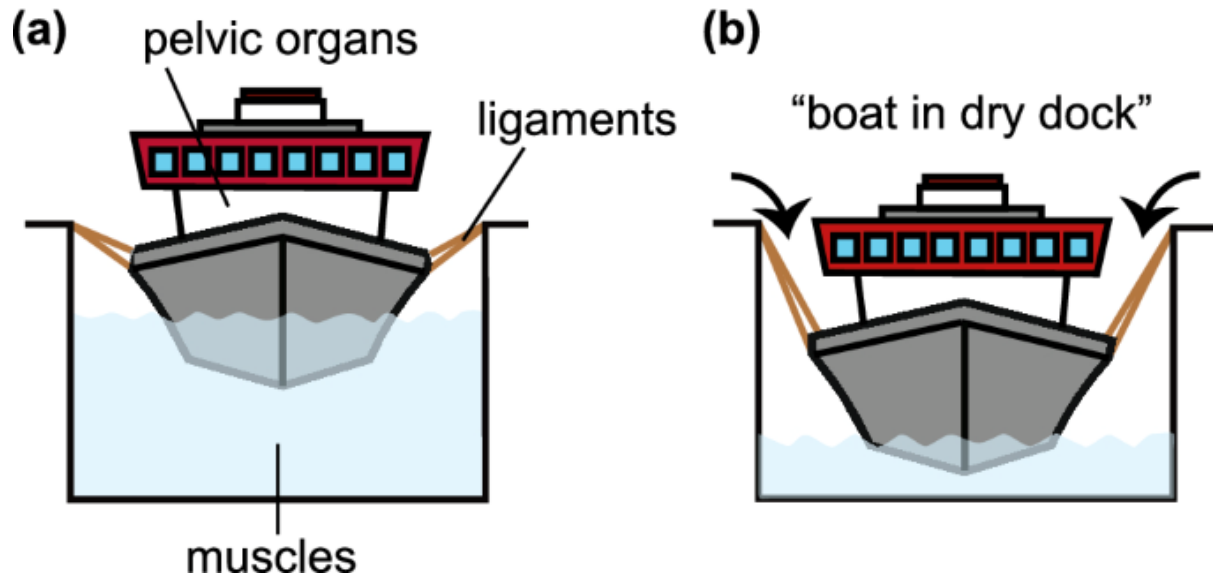


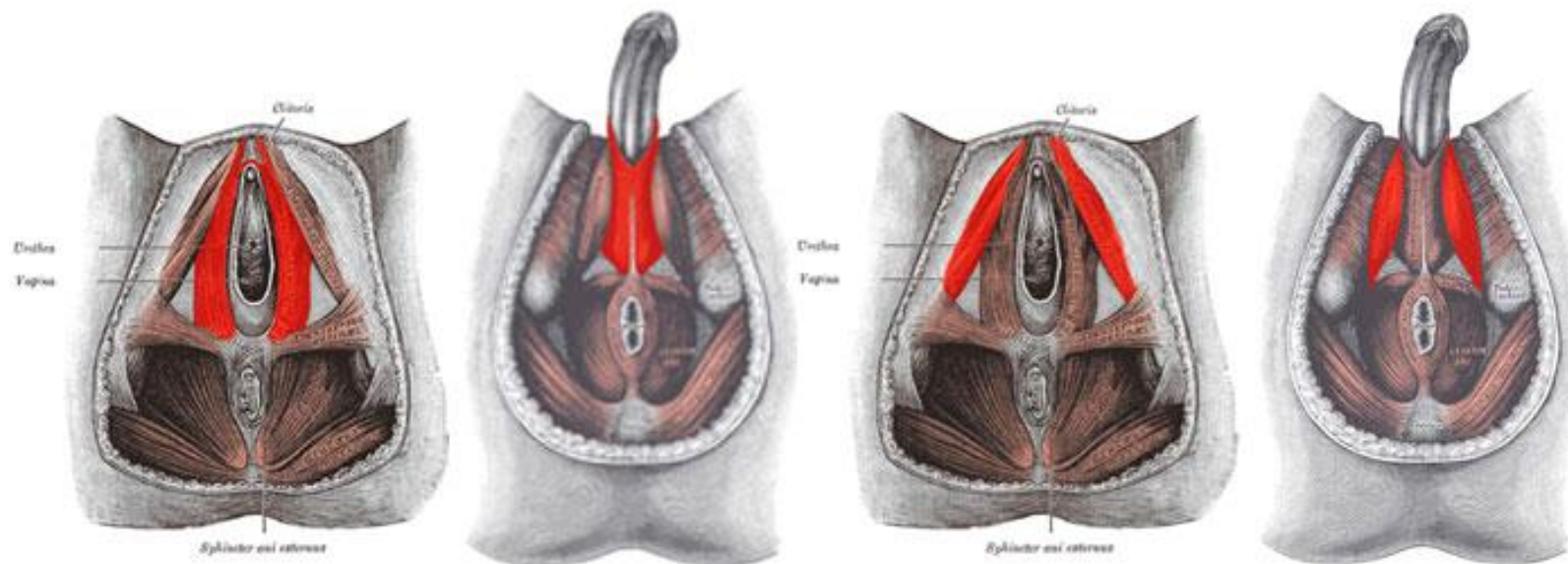
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## Boat in Dry Dock

- Boat = pelvic organs
- Water = PFM
- Rope (moorings) = ligaments and fascia
- If PFM function normally, there is proper support and the ligaments and fascia are under normal tension
- If the PFM cannot actively support the organs, over time the connective tissue will become stretched and damaged

# PFM in Sexual Function <sup>6</sup>

- Muscle strength to maintain blood flow in erectile structures - clitoris or penis
- Muscle length to release/open the anus or vagina for penetration without pain
- Muscle coordination to return muscles to resting baseline after orgasm



# Pelvic Floor Muscle Dysfunction & Pelvic Pain Pathophysiology



# Two Main Categories of PFM Dysfunction <sup>1</sup>

## • Decreased Tone/Underactive PFM

- Incontinence
  - Urinary Incontinence
    - Stress UI
    - Urge UI
    - Mixed UI
    - Functional UI
  - Anal/Fecal Incontinence
    - Passive
    - Urge
- Pelvic organ prolapse (POP)

## • Increased Tone/Overactive PFM

- Dyssynergic defecation/Constipation
- **Pain diagnoses:**
  - Vulvodynia
  - Vulvar vestibulitis/ Vestibulodynia
  - Vaginismus
  - Dyspareunia
  - Prostatitis/Chronic Pelvic Pain Syndrome
  - Coccygodynia

# Increased Tone/Overactive Pelvic Floor Muscles <sup>1</sup>

## **PAIN Diagnoses**

1. Vulvodynia
2. Vulvar vestibulitis/ Vestibulodynia
3. Vaginismus
4. Dyspareunia
5. Prostatitis/Chronic Pelvic Pain Syndrome
6. Coccygodynia
7. Dyssynergic Defecation\*
8. Constipation\*
9. Overactive Bladder\*



Increased Tone/Overactivity

Muscles <sup>1</sup>

- PFM Overactivity  
**PROTECTS**  
to pain

- Continued overactivity  
generates **Pain**



pixtastock.com - 79302229

# Chronic Pain 53, 54

- Central nervous system **changes** with chronic pain:
  - Central changes in the reception, processing and output
  - Dorsal horn changes at the spinal levels
  - Peripheral changes
    - Abnormal impulse generating sites (AIGS) in the peripheral nerves
- Immune response changes
  - Modulating factors resulting in increased nociceptive activity include:
    - Increased inflammatory response
    - Increased tissue temperature
    - Decreased blood flow

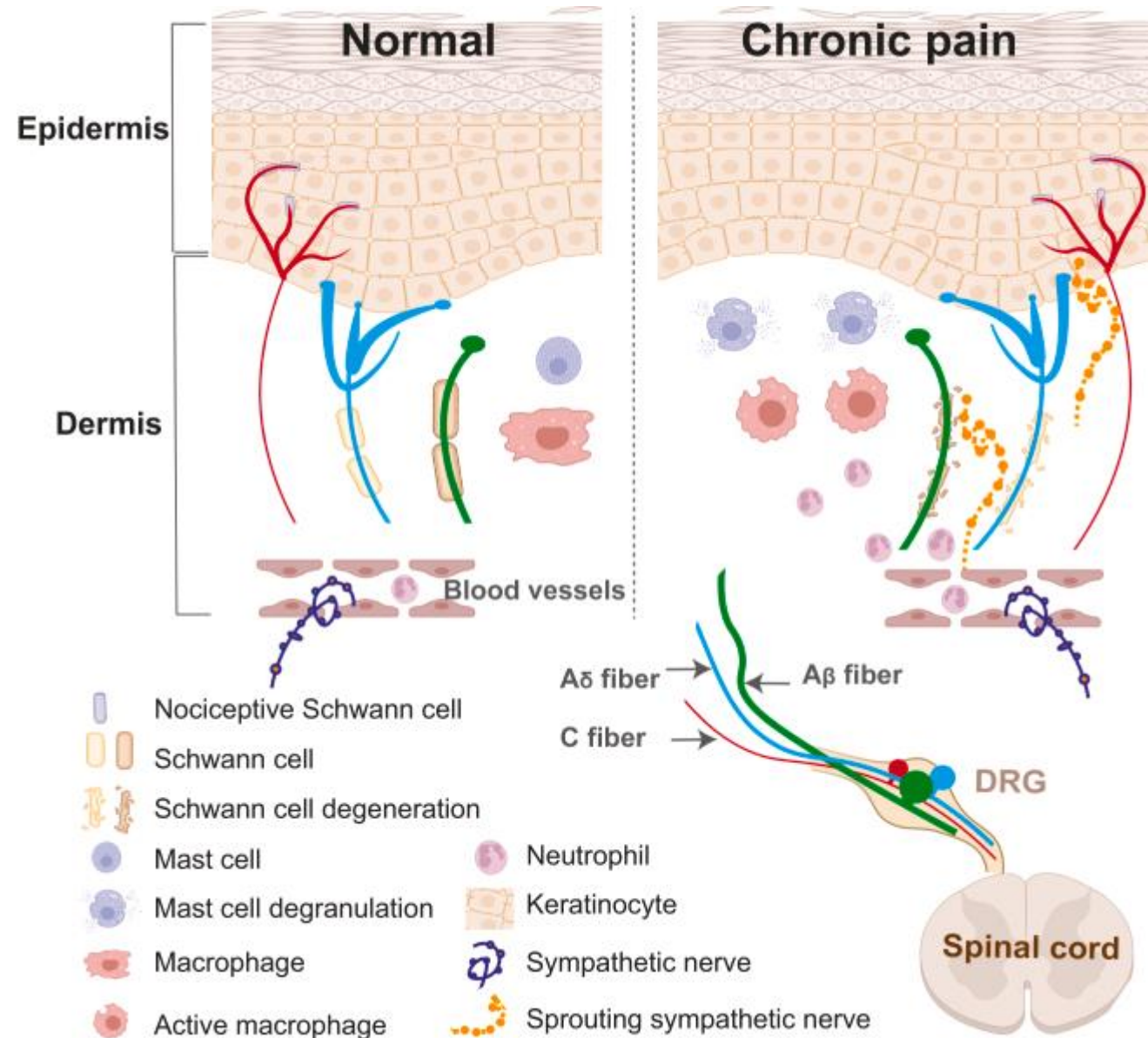


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# Chronic Pain <sup>56,57</sup>

- Cortical changes occur in the primary sensory and motor cortices as pain persists = *Smudging*
  - Motor control and sensation of that body part is distorted
    - These changes become part of the problem
- “Sensitized Nervous System”
- “Centralized” pain

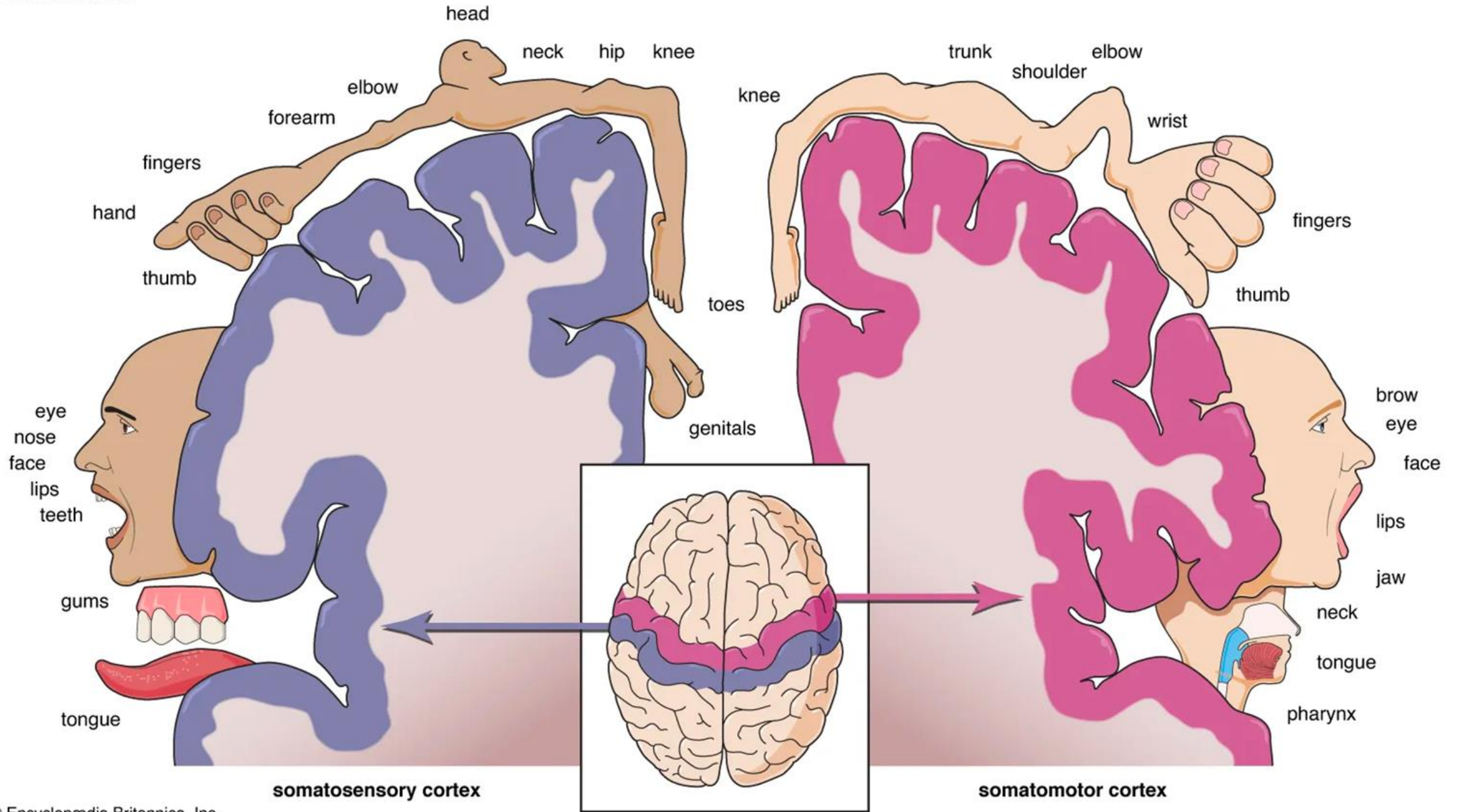
**Lorimer Mosley’s Ted Talk:**

<https://www.youtube.com/watch?v=gwd-wLdIHjs>



Photo available at: <http://www.specialistpainphysio.com/complex-regional-pain-syndrome-it-feels-weird/>

# Homunculus



# Chronic Pain <sup>58</sup>

- All pain is real to those who feel it
- Pain is a subjective and personal experience
- Contributing factors of pain:
  - Physical dysfunction
  - Beliefs
  - Distress
  - Illness behavior
  - Social interactions

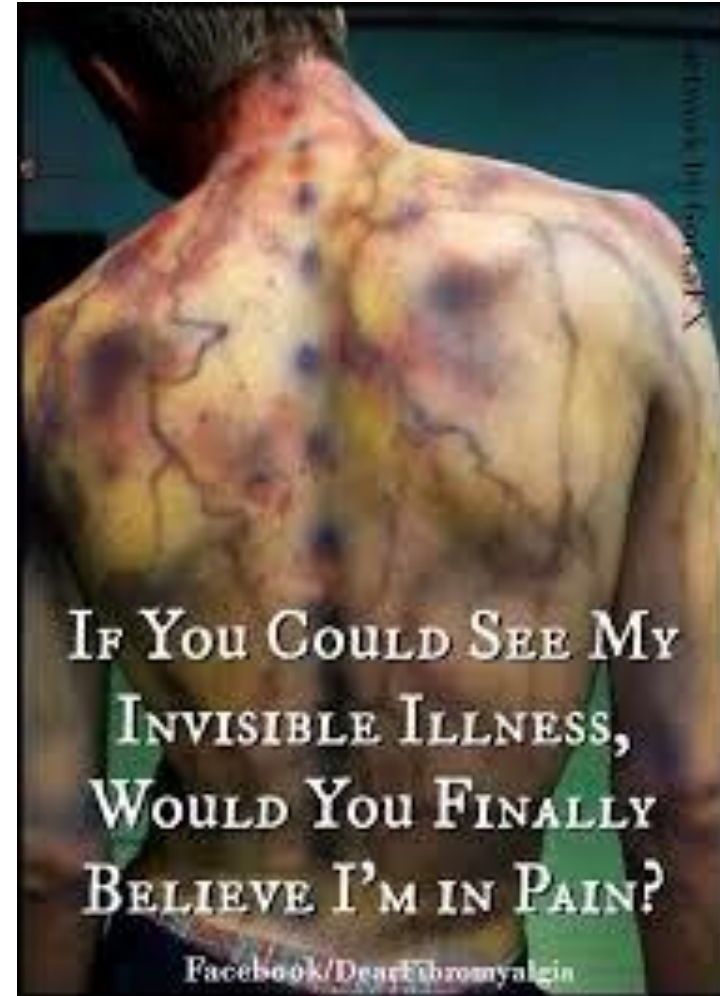


Photo: <https://orkneyfibromyalgiasufferer.com/wp-content/uploads/2017/08/da93389b28dc4d835b2a537e0db95772-chronic-pain-quotes-fibromyalgia-quotes.jpg>

Consider term “*Persistent*” Pain  
instead of “*Chronic*” Pain<sup>10,11</sup>

- Chronic can imply permanence, no chance for improvement
- As providers, we want to provide **HOPE**



# Persistent/Chronic Pain vs Persistent/Chronic **Pelvic** Pain<sup>12</sup>

## Similarities

- Involves CNS
- Creates a stress response
- Can lead to changes within the brain
- Heal similarly

## Differences

- Central location of pelvic pain
  - Where bodies hold stress (GI system)
- Hidden part of the body
- “Private area”
  - Shame / Don’t discuss
- Pelvis can never fully rest
  - Impacts basic ADL’s - toileting, intimacy
- Many providers tend to ignore/dismiss

# Review of Common Pelvic Pain Conditions

# Chronic Pelvic Pain Syndrome/Prostatitis

- Non-malignant pain perceived in structures related to the pelvis, lasting continuously or recurrent for at least 6 months <sup>18</sup>
- Difficult to manage as it is often impossible to identify pathophysiology <sup>52</sup>

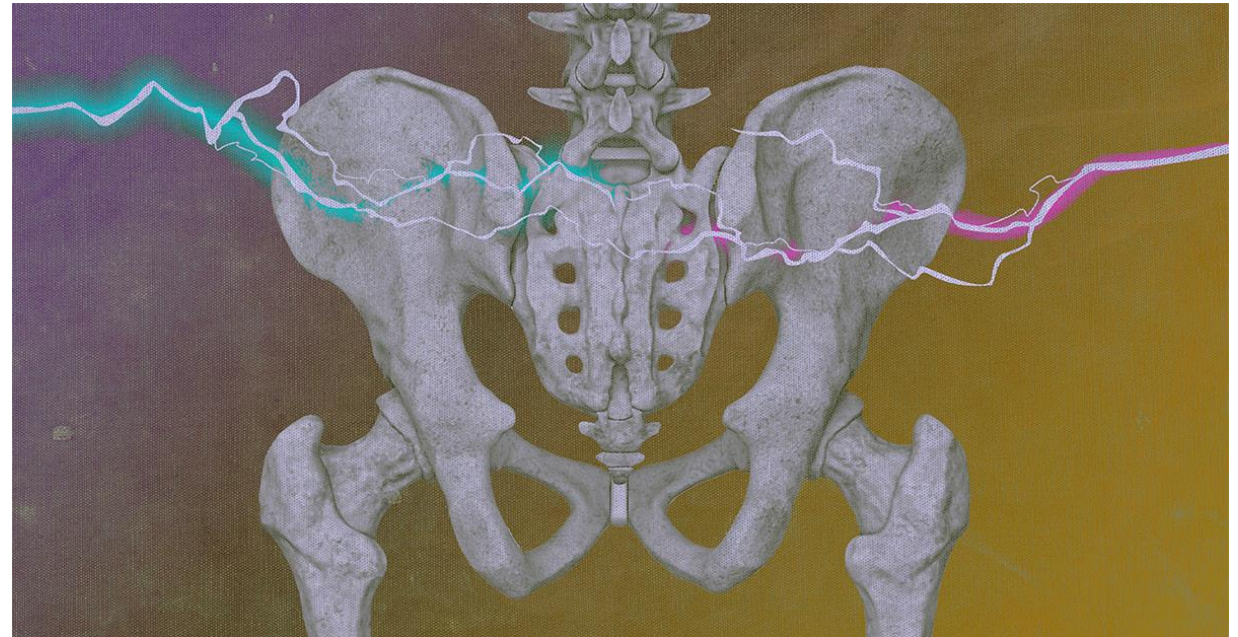


Photo: <https://getmegiddy.com/sites/default/files/2022-12/male-chronic-pelvic-pain-syndrome-social.jpg>

# Chronic Pelvic Pain Syndrome (CPPS)/Prostatitis <sup>59</sup>

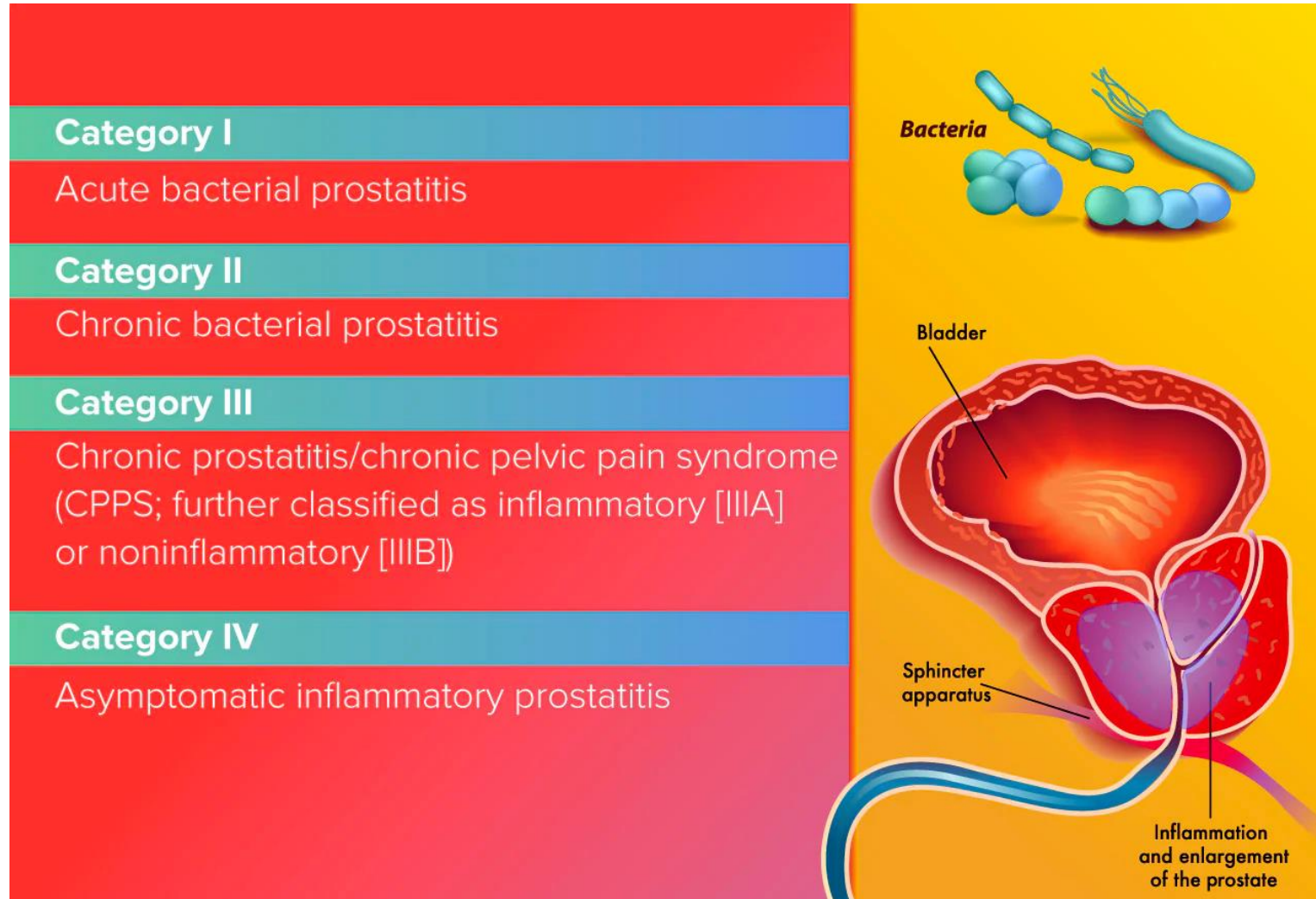
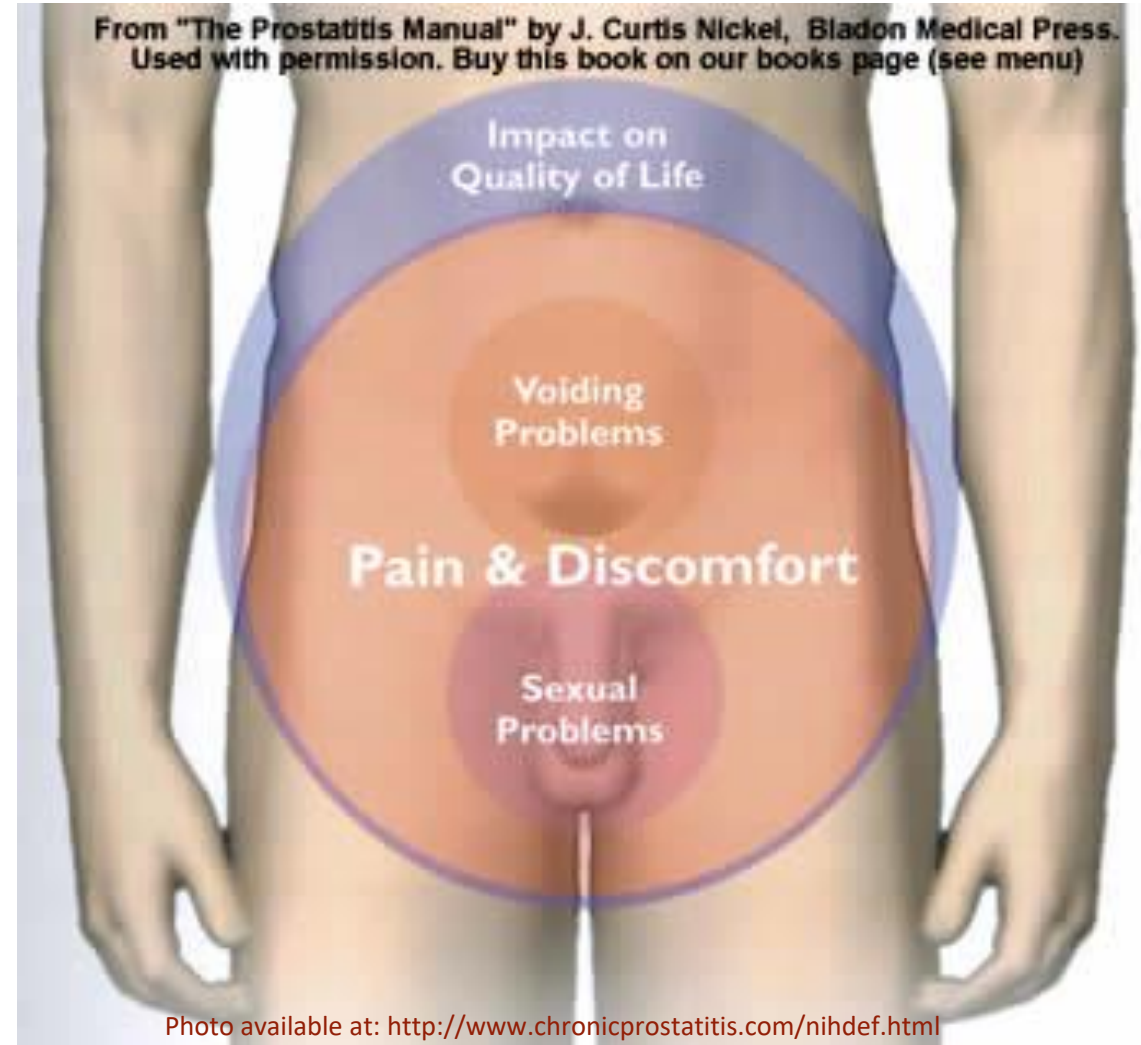


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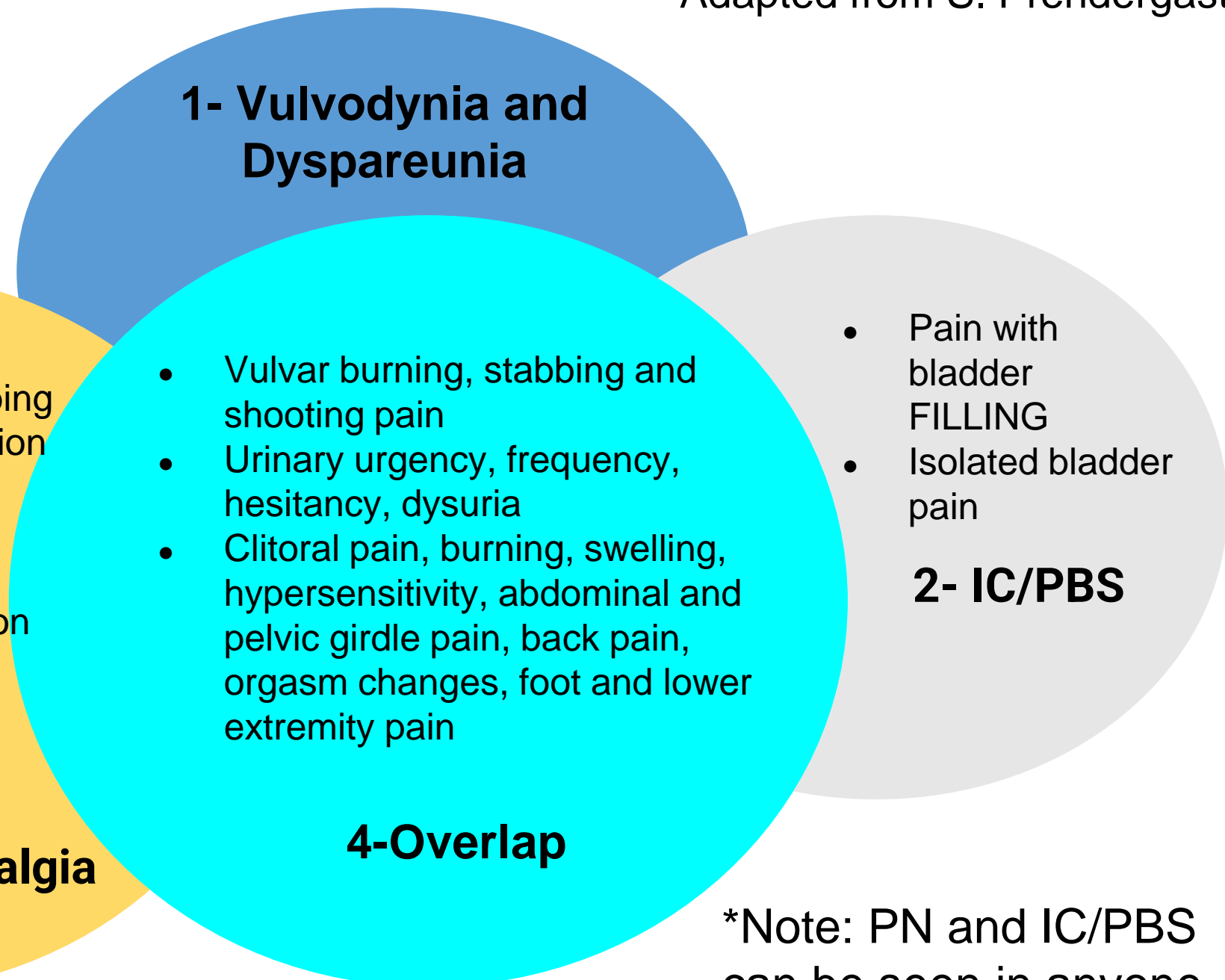


# Category 3: Non-Bacterial Prostatitis<sup>59,60</sup>

- PT related issue
- Symptoms:
  - Pelvic pain
  - Urinary urgency/frequency
  - Pain or burning with urination
  - Post-ejaculation pain
- Pain patterns can vary:
  - Suprapubic
  - Perineal
  - Scrotum
  - Urethra
  - Penis
  - Low back



- 1 Vulvodynia and Dyspareunia
- 2 Interstitial Cystitis(IC) / Painful Bladder Syndrome (PBS)
- 3 Pudendal Neuralgia (PN)
- 4 Vulvodynia, Dyspareunia, IC/PBS, PN combined



### 1- Vulvodynia and Dyspareunia

- Vulvar burning, stabbing and shooting pain
- Urinary urgency, frequency, hesitancy, dysuria
- Clitoral pain, burning, swelling, hypersensitivity, abdominal and pelvic girdle pain, back pain, orgasm changes, foot and lower extremity pain

- Pain with bladder FILLING
- Isolated bladder pain

### 2- IC/PBS

- Burning shooting stabbing pain in the PN distribution
- Primarily unilateral
- Provoked by sitting, trunk or hip flexion, resisted external rotation walking uphill, intercourse, clitoral stimulation, toileting, orgasm

### 3- Pudendal Neuralgia

### 4-Overlap

\*Note: PN and IC/PBS can be seen in anyone

# Example: Pathophysiology of LPV 40-43

## • Upregulation of 3 systems

### • Neuromuscular system

- Overactivity of PFM antecedent or secondary to vestibulodynia

### • Immunologic system

- Introital mast cells, inflammatory molecules, nerve growth factors
  - May be upregulated by: infections, mechanical trauma, chemical or physical abuse

### • Pain system

- Upregulated by proliferation of local nerve fibers and endings which contribute to the following
  - Hyperalgesia (an increase in the magnitude of pain)
  - Allodynia (pain from a non-painful stimulus, like light touch)

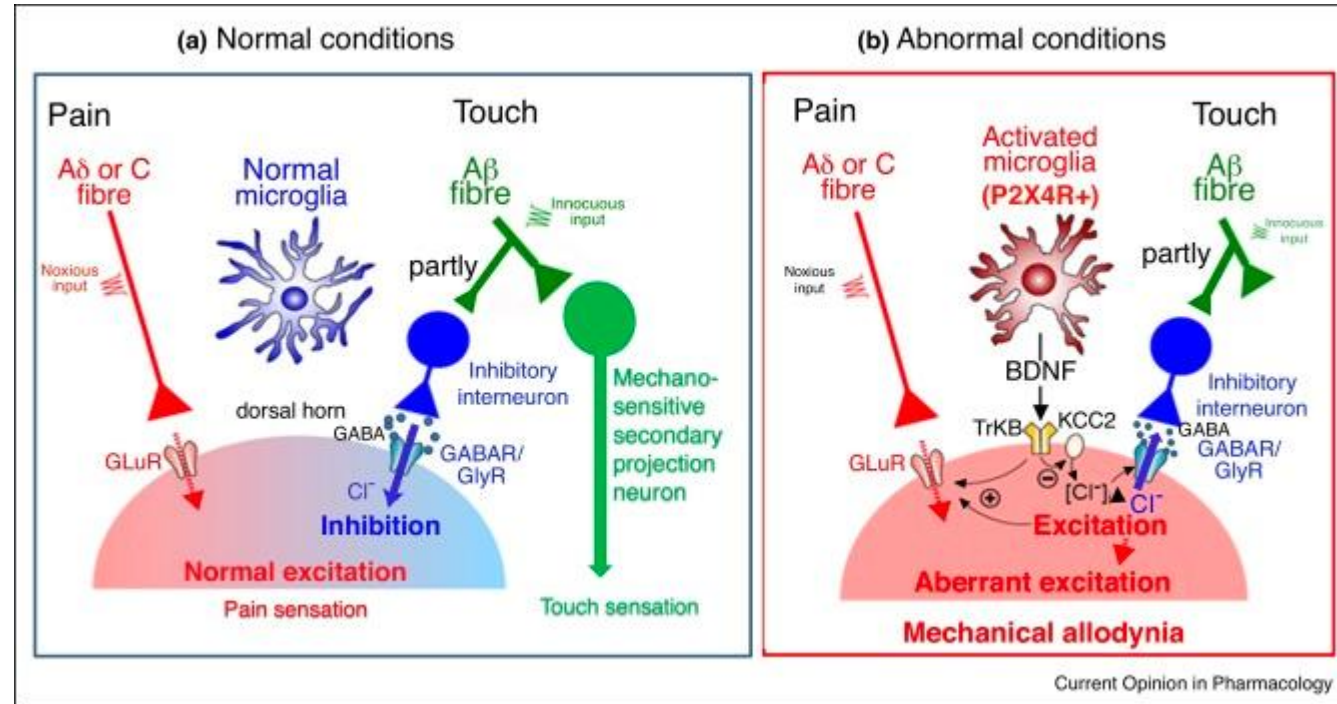


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# Increased PFM Tone Causes <sup>1</sup>

- Joint malalignment of SI, lumbar spine, coccyx, pubic symphysis
- Habitual postural dysfunctions
- Childbirth trauma/episiotomy/tears
- Surgical trauma, adhesions
- Pelvic inflammation/infection/disease
- Hemorrhoids/fissures/fistulas
- Bowel and bladder disorders
- Sexual abuse

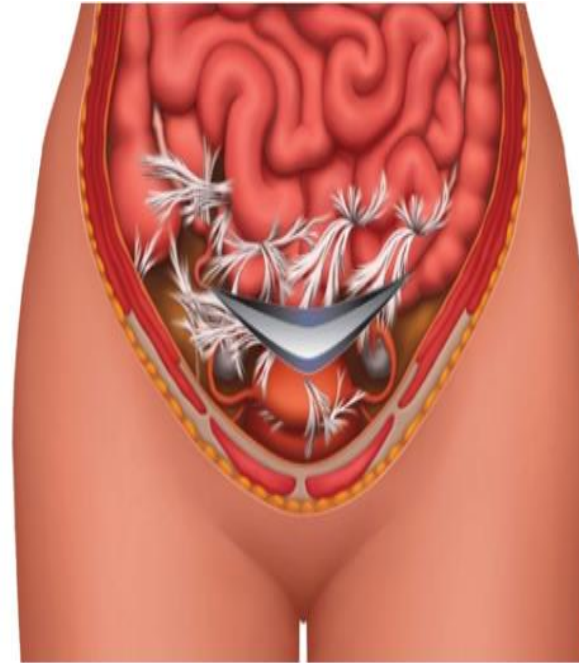


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- 20% of
- 5-10%
- Childh  
functi
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just se
- Imp



**81% of women**



**43% of men**

sexual

self; not

e!

# Trauma Informed Care Approach <sup>85</sup>

- Be aware of the possibility of past sexual abuse, even if the patient reports a negative history
- Pelvic examination may cause extreme anxiety; re-trigger trauma
- Give patients **VOICE** and **CHOICE**
- **CONSENT** at every stage
- Good communication and patient education will often help to allay anxiety
- Maintain eye contact and engage them in conversation during examination
  - Look for signs of disassociation
- ***Imperative that the therapist learn to read the patient's body language and responses!!!***

# PT Evaluation

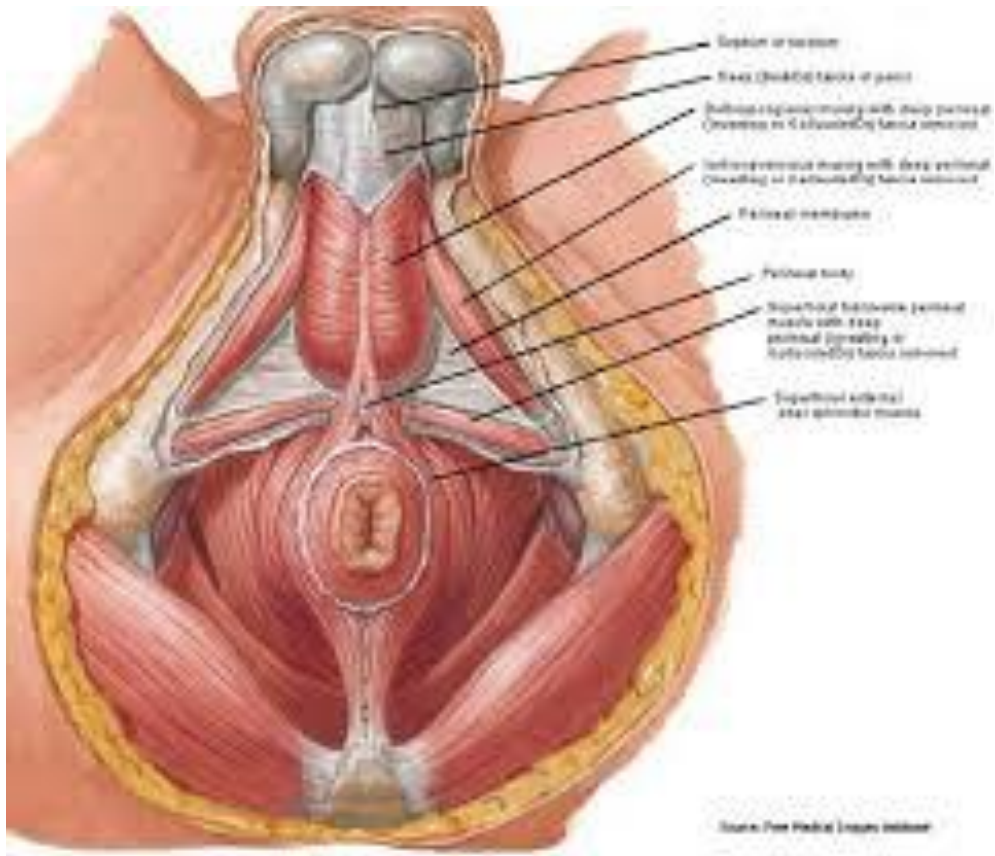
# Physical Therapy Examination and Evaluation

- Review of record and medical screening
- Patients subjective story
- Review of four systems
  - Musculoskeletal
  - Bladder
  - Bowel
  - Reproductive/Sexual
- Exam
  - Neuro and sensory exam
  - Musculoskeletal exam
  - Posture examination
  - External pelvic floor examination
  - Internal pelvic floor examination
  - Muscle strength



[https://www.alpinephysicaltherapy.com/wp-content/uploads/2020/10/Annual-PT-Exam\\_Featured-Image-1-1080x675.jpg](https://www.alpinephysicaltherapy.com/wp-content/uploads/2020/10/Annual-PT-Exam_Featured-Image-1-1080x675.jpg)

# External Pelvic Floor Examination- Male & Female

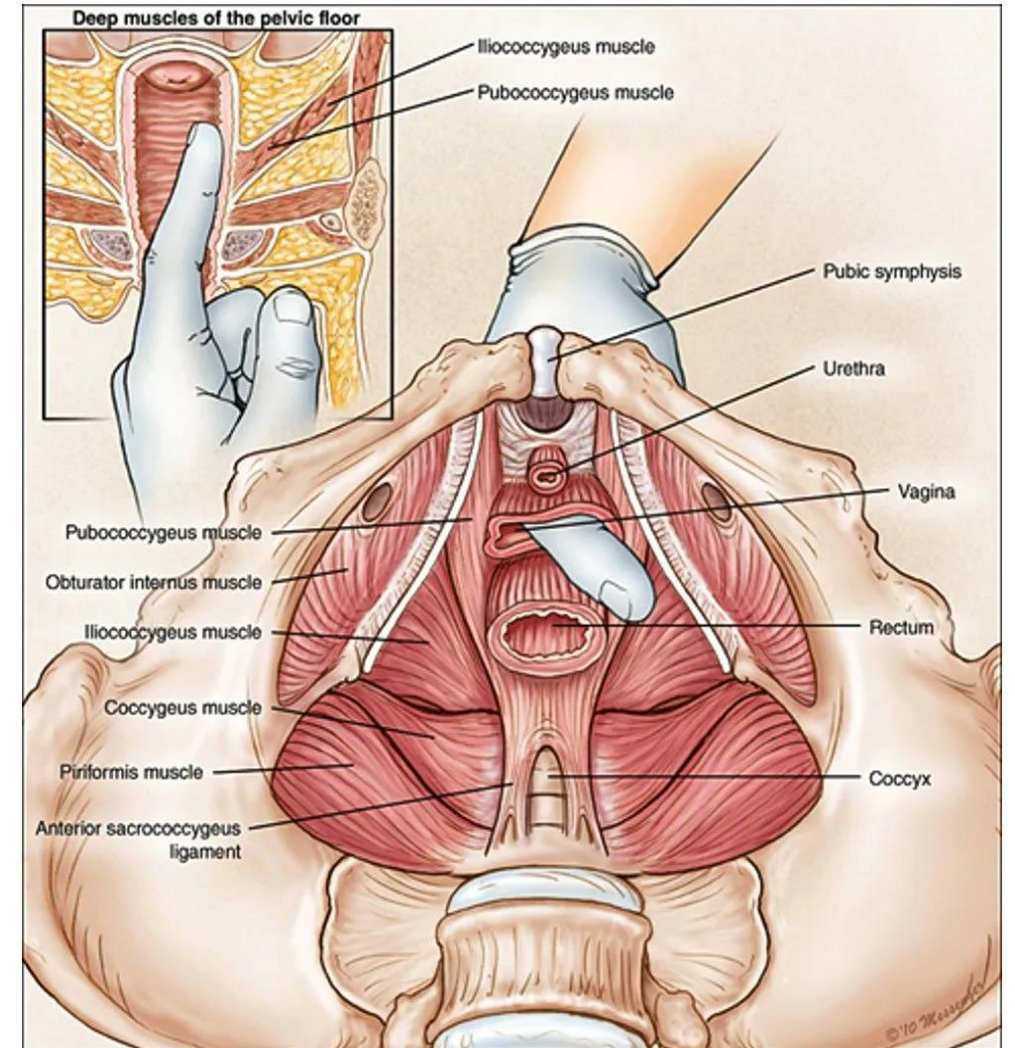
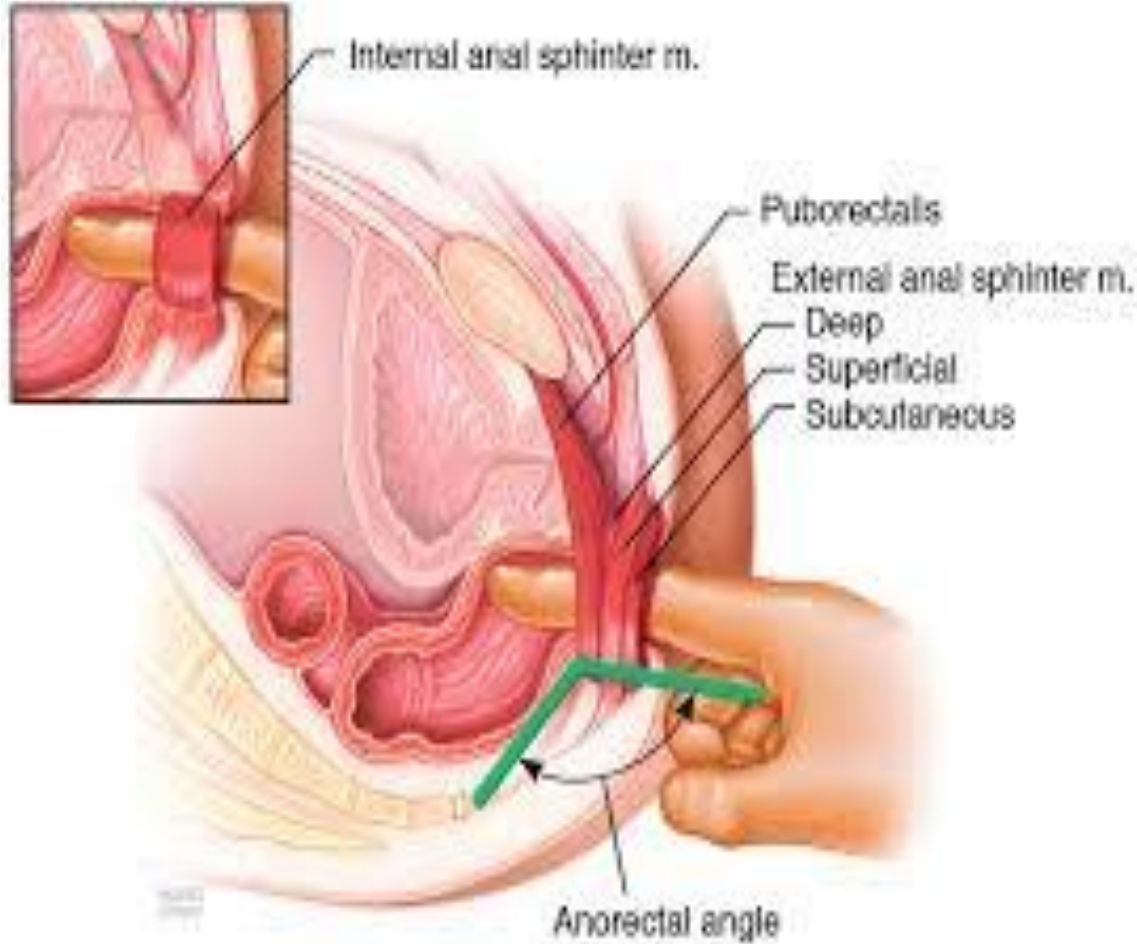


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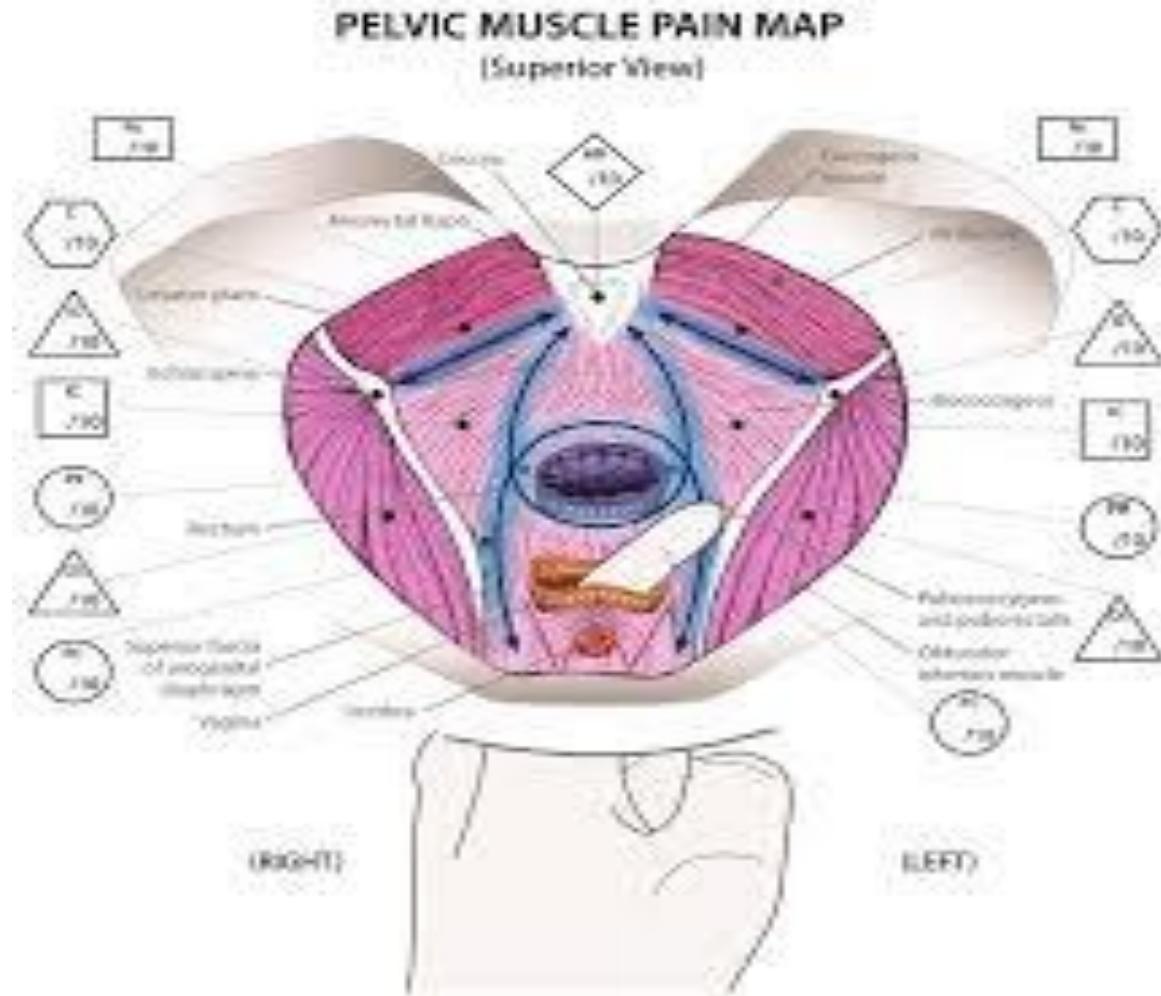
# Internal Pelvic Floor Examination- Male and



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<https://femalephysioco.com/wp-content/uploads/Internal-Pelvic-Floor-Assessment-Explained.jpg>

# Pain Mapping/Internal Exam



Jantos, M., 2020. Pain mapping: A mechanisms-oriented protocol for the assessment of chronic pelvic pain and urogenital pain syndromes. *Pelvip erineology*, 39(1), p.3.

# Physical Therapy Treatment of PFM Dysfunction



# Underlying Goals of Physical Therapy

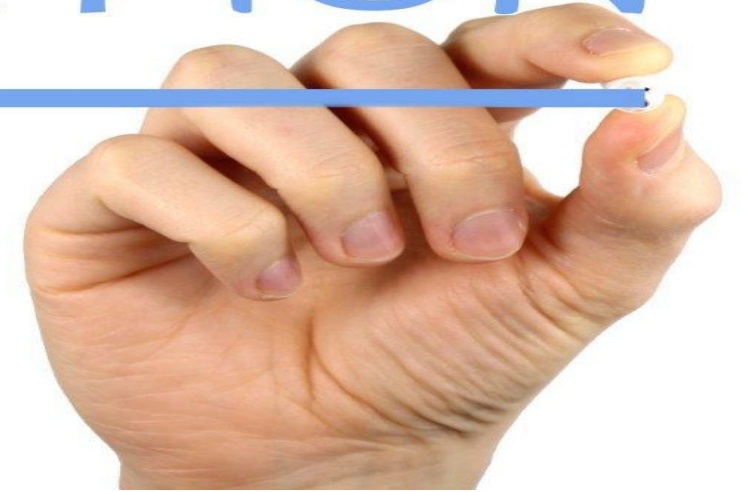
- Identify any behavioral, physical or biomechanical dysfunction contributing to the condition
- Correct the underlying habits
- Re-establish coordination



Photo available at: <http://www.4us2be.com/health-fitness/detox-your-body/>



# Patient EDUCATION



- Understanding PFM function
  - Bladder/Bowel
  - Sexual Function
  - Supportive function
- Understanding the specific presenting pathology
- Understanding what voluntary controls can be modified
  - Role of PT
- Proper body mechanics and habits
  - Toileting techniques and behaviors
  - Pelvic pain
- Pain Education!



# Patient Education <sup>1</sup>

- Normal values for urination/defecation
- Proper positioning during voiding
- Mechanics of urination/defecation
- Risk factors for incontinence
- Behavioral Retraining
  - Use of Bladder and Bowel Diary
  - Postural education
- Risk factors for pain
  - Avoidance of pain provoking activities



# Physical Therapy Treatment <sup>1</sup>

## Manual Therapy

- Myofascial Release, Soft Tissue Mobilization
  - Surgical scars & adhesions
- Trigger Point Release, Massage, Positional Release, Contract/Relax, Reflex Inhibition
  - Tension myalgias, overactivity, referred pain
- Direct Joint Mobilization & Muscle Energy Techniques
  - Pelvic obliquity, sacral torsions, coccygodynia, etc.
- Visceral Mobilization
- Nerve Flossing
  - Nerve flossing involves performing a controlled glide that moves a nerve back and forth relieving tension

# Physical Therapy Treatment <sup>1</sup>

## Stretching

- Hip adductors, hamstrings, obturator, piriformis, abdominals, iliopsoas
  - Connections to PFM facilitate stretch indirectly to the PFM for overactivity

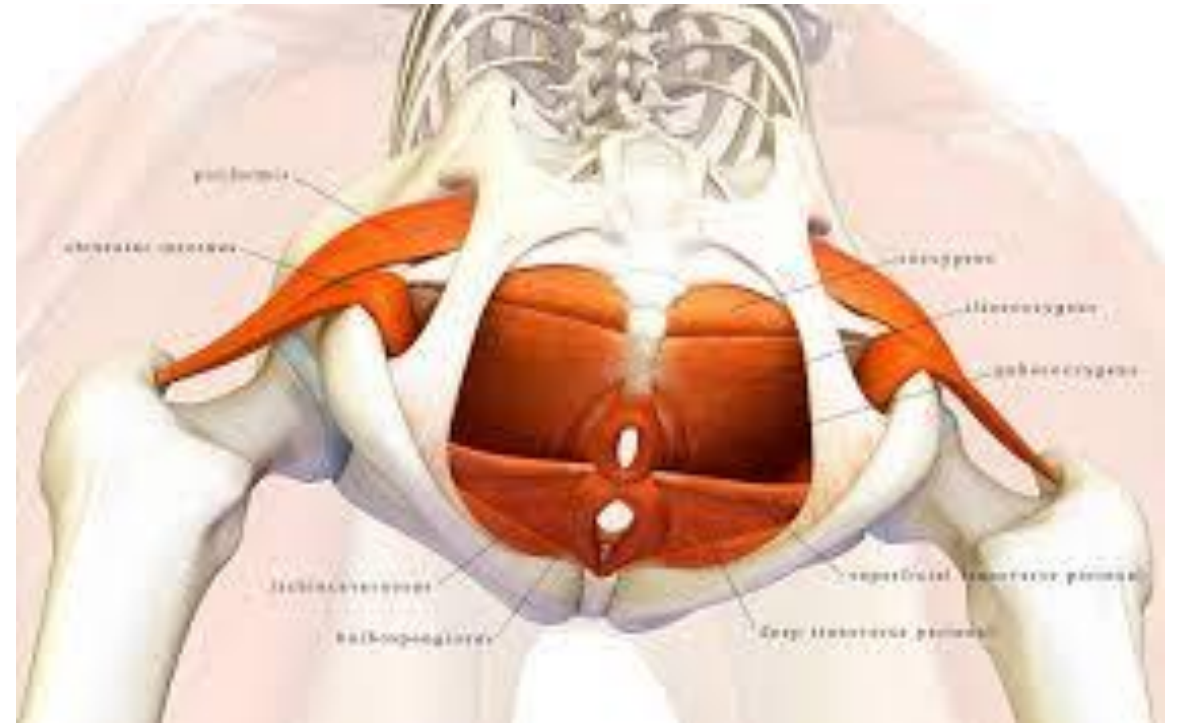


Photo: <https://thefemaleathletedpt.com/why-you-should-be-training-your-glutes-for-your-pelvic-floor/>

# Physical Therapy Treatment <sup>1</sup>

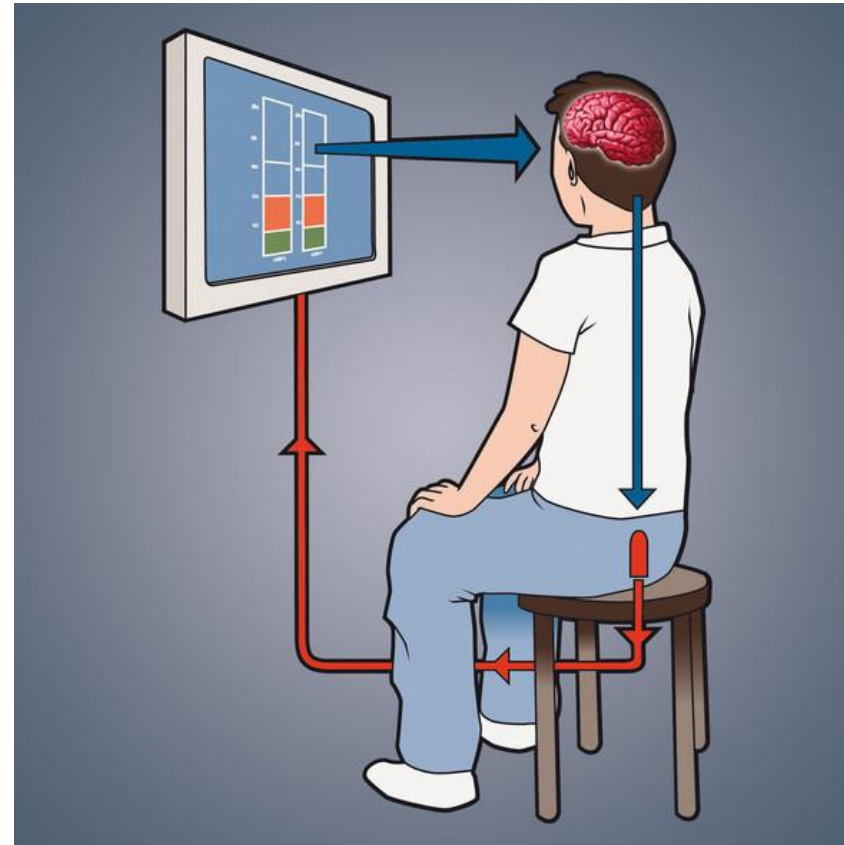
## Modalities

- Thermal & non-thermal ultrasound
  - Wound Healing
  - Scar prevention/management
  - Edema prevention/management
  - Warming tissues as needed prior to other treatments
- Electrical Stimulation
  - \*\*Urinary Urgency for Reflex inhibition
  - FES
  - TENS for pain
- Superficial heat/ice

# Physical Therapy Treatment <sup>1, 143, 146</sup>

## Modalities: Biofeedback

- Biofeedback:
  - A conditioning treatment where typically unknown information about a physiological process is converted into simple visual or auditory cues <sup>91</sup>
- Based on operant conditioning techniques





# Physical Therapy Treatment <sup>1, 143, 146</sup>

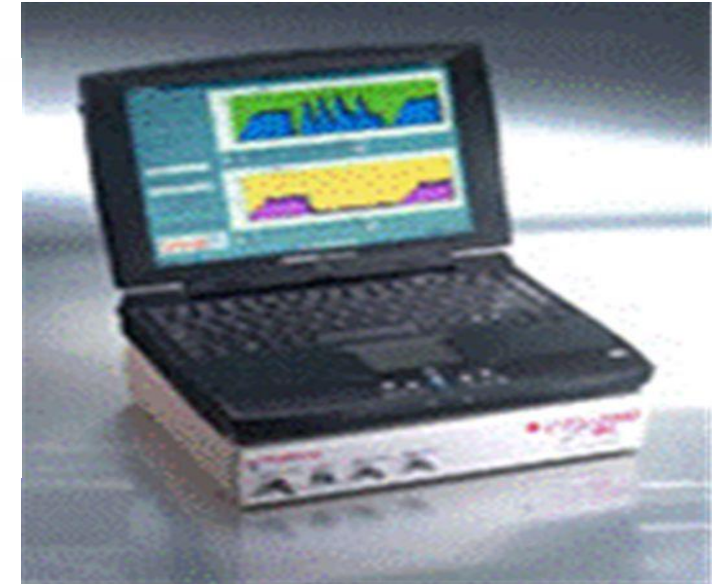
- Biofeedback/Neuromuscular Re-education
  - Diagnostic as well as treatment tool
  - Up-training/strength training
  - Down-training/coordination or relaxation
  - Provide insight and motivation
- **Goal:** Attempting to get the voluntary control of responses at a conscious level, so they can be altered to be more effective



# Biofeedback/Neuromuscular Re-education <sup>6,7,90, 144</sup>

146, 151

- Purpose: Retraining the PFM to correct dyssynergia, improve coordination and strength/support
- Types:
  - Manual cues
  - Mirror
  - Surface electromyography (sEMG)
  - Pressure EMG
  - Balloon catheter
  - Rehabilitative Ultrasonic Imaging



\*No single technique appears more effective than others, based on therapist's training and experience

# PT and Pain Science Education <sup>10</sup>

- Pain is a **protector** in the setting of *real* or *perceived* threat
- Pain does **NOT** equal the health of our tissues

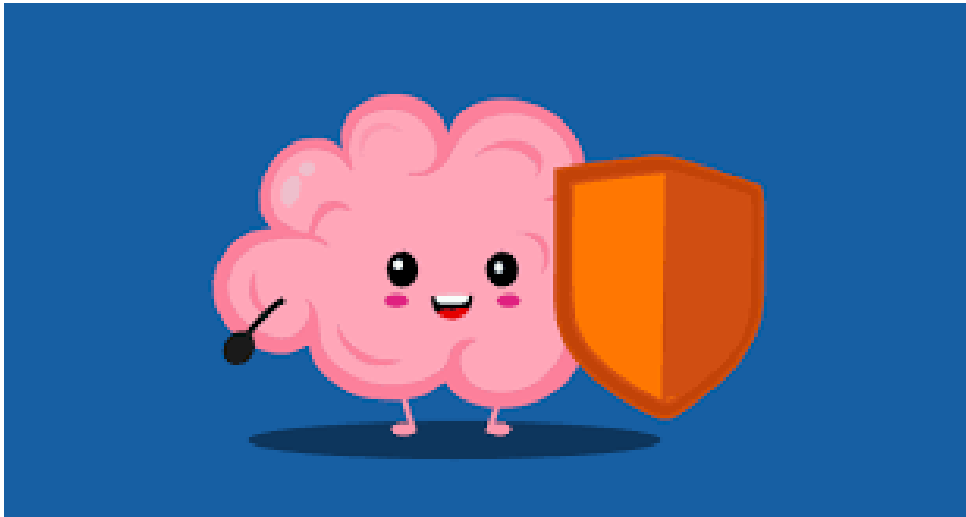


Photo:<https://encrypted-tbn0.gstatic.com/images?q=tbn:ANd9GcR1jLWdhKfG6htcixk64uLuREZ2iSfQywt0xQ&s>

- Moving away from “Fixer” (PT) and “Fixee” (patient)
  - PT are guides to empower patients
  - Active treatment plans versus passive treatments of tissues
- Collaborative relationship
  - Giving patient’s voice and choice in their care
- Consider language:
  - “Persistent pain” vs “chronic”
  - Tissues are “healed” but tight (versus trigger points)

# 4 Themes for Pain Science Education <sup>10</sup>

1 A sensitized nervous system leads to an **OVERPROTECTIVE** pain system

2 Pain does **NOT** mean tissue damage

3 How I think about, see and feel my pain can make it worse

4 I **CAN** change my pain slowly

# PT and Pain Science Education <sup>10</sup>

## Education and Action!

- Essential to combine Pain Science Education with practical strategy advice
  - Empowering
  - Respectful



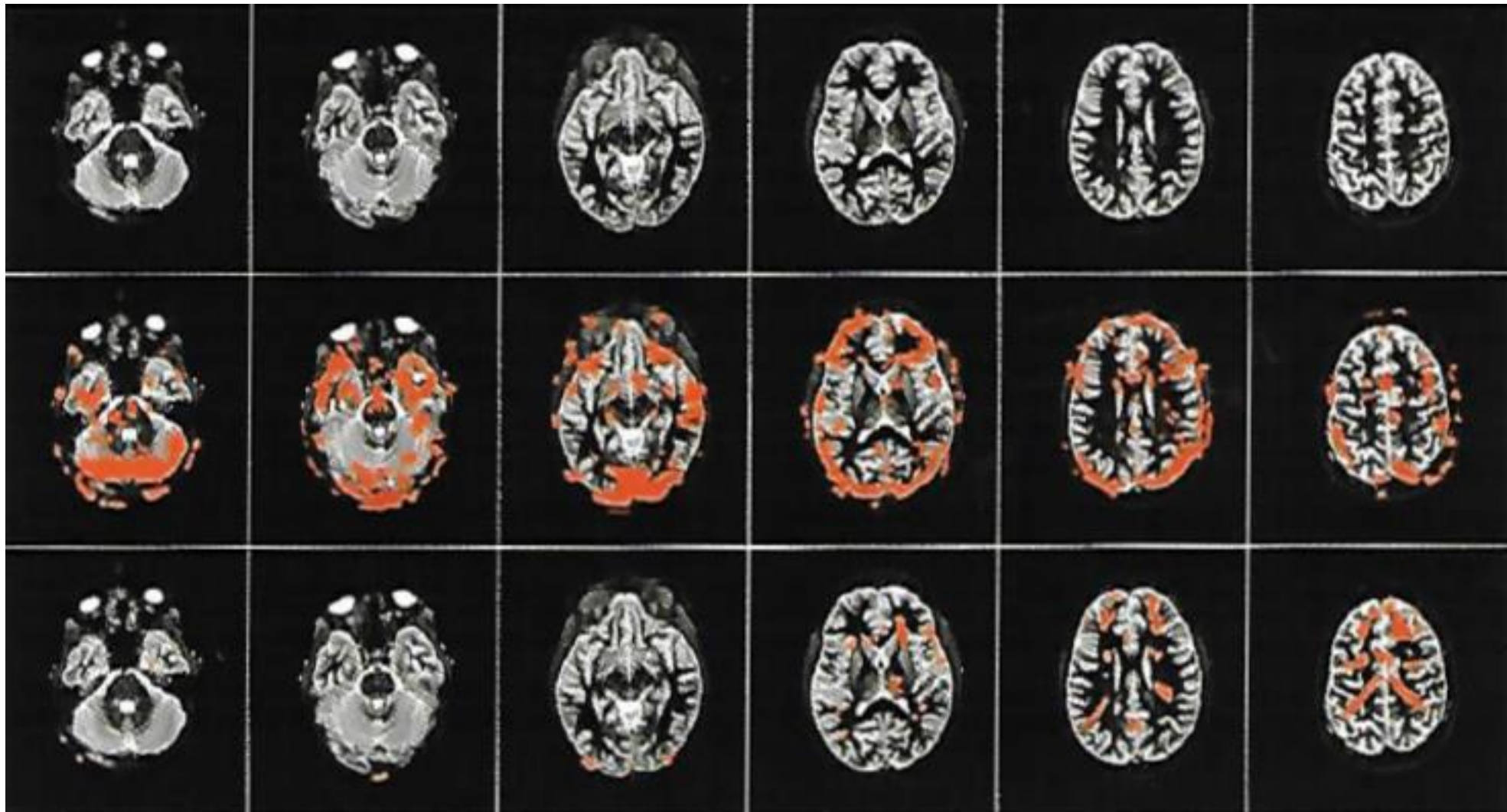
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# Physical Therapy Treatment: Central Nervous System Regulation <sup>12</sup>

- **Breath Work**
  - Triangle breath: inhale, exhale, hold
  - Heart centered breath: equal time inhale and exhale
  - Diaphragmatic breathing
    - Can be more challenging to correctly perform if PFM tension leading to diaphragm tightness
- **Vagus Nerve quieting strategies**
  - Humming
  - Chanting
- **Visualization of the goal- sports psychology**
- **Mindfulness**
- **Behavioral health referral to address trauma and other specific emotional coping strategies**





Adapted from: *Why Pelvic Pain Hurts*: 2014 Louw, Hilton, Vandyken

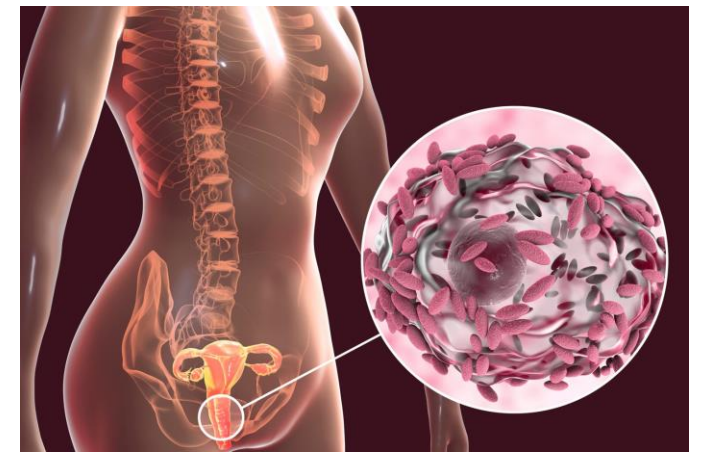
- The first row in this picture is an MRI of someone who has had chronic pain for 3 years.
- The second row is the same person, and they have just completed a movement that gives them pain.
- The third row is the same person, doing the same activity, after learning about pain science for 30 minutes.

# Multidisciplinary & Multimodal Approach is KEY!



# Pelvic Pain Case Studies

# Case Study 1: History

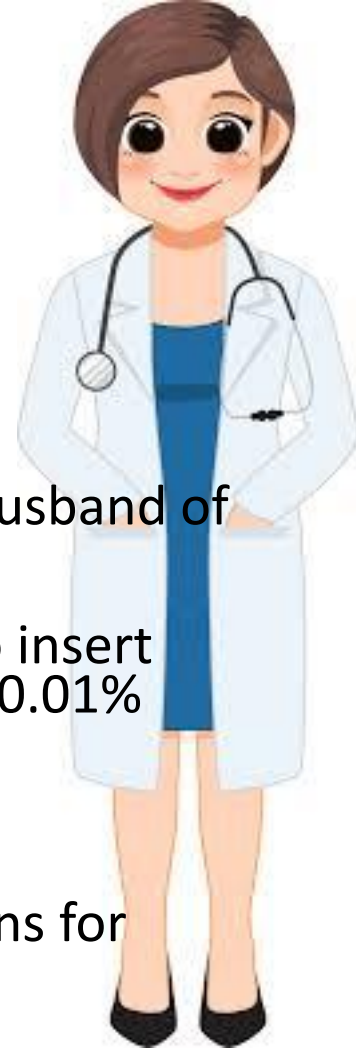


- 44 y/o G2P2 female who presents with % secondary dyspareunia (tampon use and intercourse) over the last five years along with copious vaginal discharge d/t diagnosis of desquamative inflammatory vaginitis (DIV)
- She denies any bladder or bowel symptoms or low back pain, regular menses, history of two cesarean sections of 7# babies; no other pertinent medical history
- Previous treatment includes trials of various medications including:
  - Bactrim, clotrimazole, and 50 mg hydrocortisone suppositories, under the care of her specialized vulvar pain gynecologist and dermatologist
  - None of these medications improved her symptoms



# Case Study 1: Functional Presentation

- Pain intensity is 8/10 with initial penetration with lingering 4/10 pain at introitus for hours after penetration
  - Abstaining from penetration due to the pain
- Previously able to have pleasurable, pain free penetration with same partner (her husband of 15 years)
  - Partner aware of symptoms and supportive
- Wears daily tampons to manage discharge to avoid clothing changes despite pain to insert
- She has since been prescribed a topical compound of 100mg hydrocortisone/gram, 0.01% estradiol, 2% clotrimazole for which she is to use 1g QD
  - Admits that due to her busy schedule she uses the medication about 1-2 times per week
- Clinical oncologist and researcher; Mother of two teenagers
  - Pilates 5x/week and avid tennis player
- **Patient Goals:** To resume pain free sexual activity and no longer need to use tampons for daily discharge



# Case Study 1: Examination

- Pelvic and Vaginal Exam:
  - Erythema and allodynia from 3-9 o'clock of vestibule
  - Copious non-malodorous white discharge at introitus
  - Ability to voluntarily contract and relax PFM; inability to lengthen PFM for defecation/penetration
  - PFM exam: 3+/5 MMT; 5 second holds, 6 reps; 6 fast twitch contractions
  - Palpable trigger points present: B pubococcygeus (6/10) and iliococcygeus (5/10) with reproduction of dyspareunia
  - Mobile Pfannenstiel scar without restriction or pain
- Lumbopelvic Exam: all unremarkable including: Full ROM, Negative pelvic girdle testing; B LE's: 5/5 MMT; negative hip screen; ambulates independently with normalized gait pattern



# Case Study 1: Treatment

- Detailed education regarding DIV changes and dyspareunia/LPV diagnosis with resultant sensitivity of nervous system and musculoskeletal impairments
- Emphasized importance of medication compliance as prescribed if goal is to stop use of tampons; tampons role in contributing to her ongoing pain
- Barriers to compliance



# Case Study 1: Treatment

- Non-instrumented neuromuscular re-education/biofeedback (mirror and digital feedback)
  - Restore coordinated PFM activity for lengthening needed for pain reduction and pain free penetration
- Manual techniques for PFM trigger points and tight tissues
  - Reduce pain, improve muscle length/flexibility
- Pelvic/hip stretches
  - Reduce tension globally
- Home exercise program



## Surgical Techniques

### Assessment of the Pelvic Floor Muscles in Women with Sexual Pain

Julie Sarton, DPT, WCS  
Department of Obstetrics and Gynecology, University of California, Irvine, CA, USA

The diagram illustrates the pelvic floor muscles in three layers. The superficial layer includes the bulbospongiosus, ischio-cavernosus, and superficial transverse perineal muscles. The intermediate layer, also known as the urogenital diaphragm, consists of the deep transverse perineal, sphincter urethrae, and compressor urethrae muscles. The deep layer includes the deep transverse perineal, deep ischio-cavernosus, and deep ischio-urethral muscles. A hand is shown palpating the perineal area, with a finger inserted into the vagina to assess muscle tone and length.

**FIGURE 1**  
During the pelvic examination of women with sexual pain, the pelvic floor muscles (PFMs), one of the largest structures in the pelvis, should be palpated systematically. Using single-digit palpation, the clinician should assess for changes of the PFMs including hypercontractility, trigger point formation, and muscle shortening. Overall, the PFMs can be divided into three discrete layers. The superficial and intermediate muscles are depicted in step one. The superficial layer consists of the bulbospongiosus, ischio-cavernosus, and superficial transverse perineal muscles. The intermediate layer, also known as the urogenital diaphragm muscles, consists of the deep transverse perineal, the sphincter urethrae, and the compressor urethrae muscles.

3526 J Sex Med 2010;7:3526-3529

# Case Study 1: Treatment

- Once muscle spasms reduced and PFM coordination for lengthening improved, progressive dilator training
  - For desensitization of vestibule; stretch of PFM; and neuromuscular coordination to use PFM lengthening during insertion all to attain goal of pain free penetration
  - Added to HEP

Visits: 1x/ week 30 minute appointments of one on one care with primary PT for 8 weeks, then 3 visits spaced every 2-3 weeks for a total of 11 visits over 16 weeks





# Case Study 1: Outcome

Resolution of pain with any penetration  
to have pain free sexual activity and penetration of tampon  
consistently x 6 weeks by last PT session  
Minimal need for tampons for DIV discharge with consistent  
compliance with compounded medication

- Discharge PT to independent HEP to maintain progress

# Case 2: History Male 28 Perineal Pain

- 28 year old male with primary diagnosis- pelvic floor pain 10 years duration with numbness tightness in the perineum and hamstrings sudden pain post episode of masturbation.
- Erectile dysfunction for past several years, able to orgasm, libido intact, no prior PT
- No dysuria, urinary frequency, urgency, hesitancy, hematuria or incontinence per urology
- MHX Type 1 Diabetes mellitus age 12- A1c 6.4-switching to a pump
- Varicocelelectomy in college no complications
- Second year law student and works in a financial institution. To be married in June 2024
- Meds Insulin aspart U-100 (Novolog) 100 unit/mL (3mL)  
Insulin glargine (Lantus) 100 unit/mL injection  
tadalafil(Cialis)5 mg  
Tretinoin (Retin-A) 0.05% cream

# Case 2: Functional Presentation

## Subjectively

- Pain on 0-10 scale: average 8, worst 10, best 6
- Subjectively felt lack of penile sensitivity and tightness in his perineum
- Exacerbating factors: Stress  
Alleviating Factors: Rest, relaxation, perineal pressure points, stretching
- Safety- No allergies, no anxieties or depression, no falls
- PT Goals  
Eliminate pelvic pain  
Decrease hamstring tightness  
Improve normal sensation

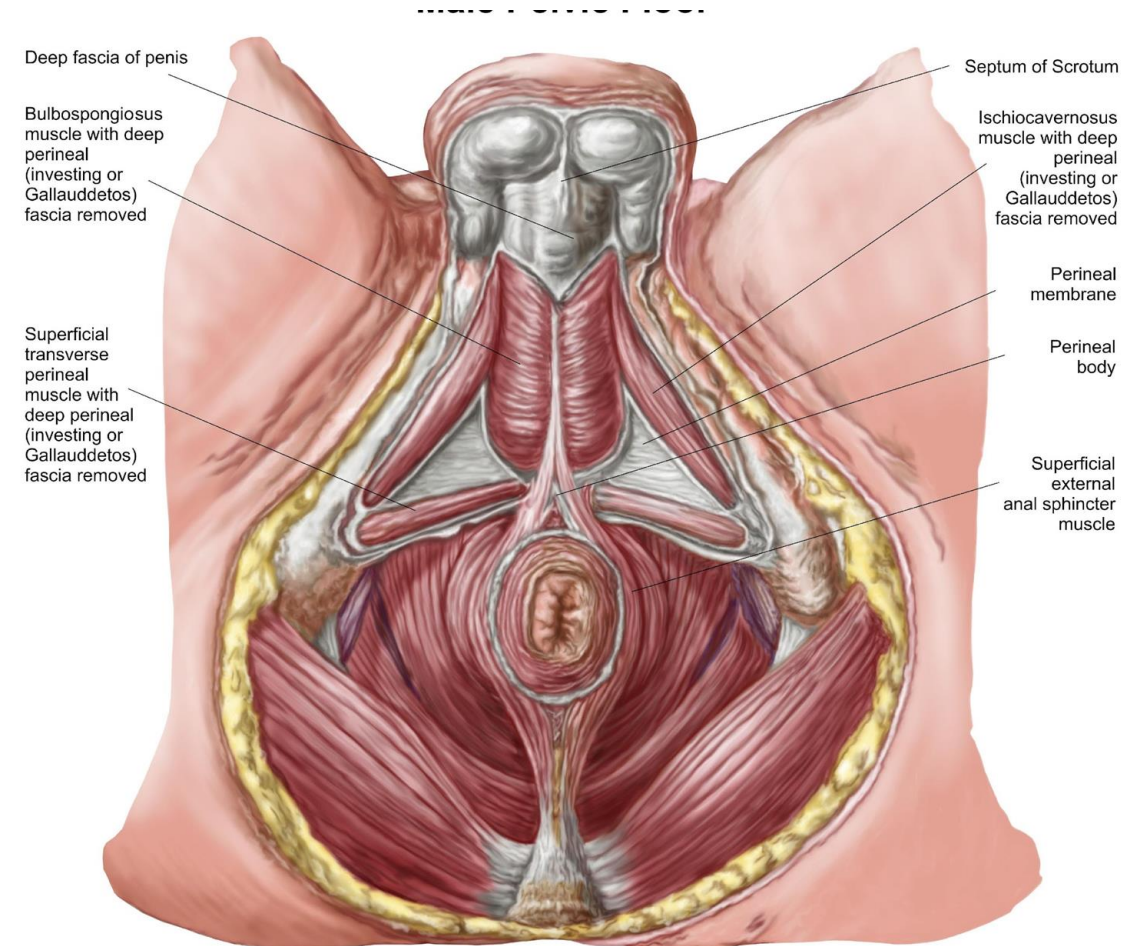


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# Case 2: Examination

Objective- internal rectal pelvic floor examination

- Sensation: intact externally, normal anal wink
- Muscle exam  
Gross pelvic floor contraction 2/5  
Endurance 5 seconds with fasciculations noted with sphincteric contraction, discoordination with contraction and relaxation- for relaxation phase he contracts
- Palpation-  
pain with external palpation  
increased pain to internal palpation
- Lumbar exam- negative hip, lumbar, pelvic girdle testing, gait normal
- Pudendal nerve irritation



<https://images.ctfassets.net/btlq0oep24gl/28C42INJhjE8leGvU49Bt6/e6d666fdd2003bfb1f0c3ad6f0ef7e23/pelvic-floor-of-human-male-royalty-free-illustration-1588886579.jpeg>

## Case 2: PT Treatment <sup>77</sup>

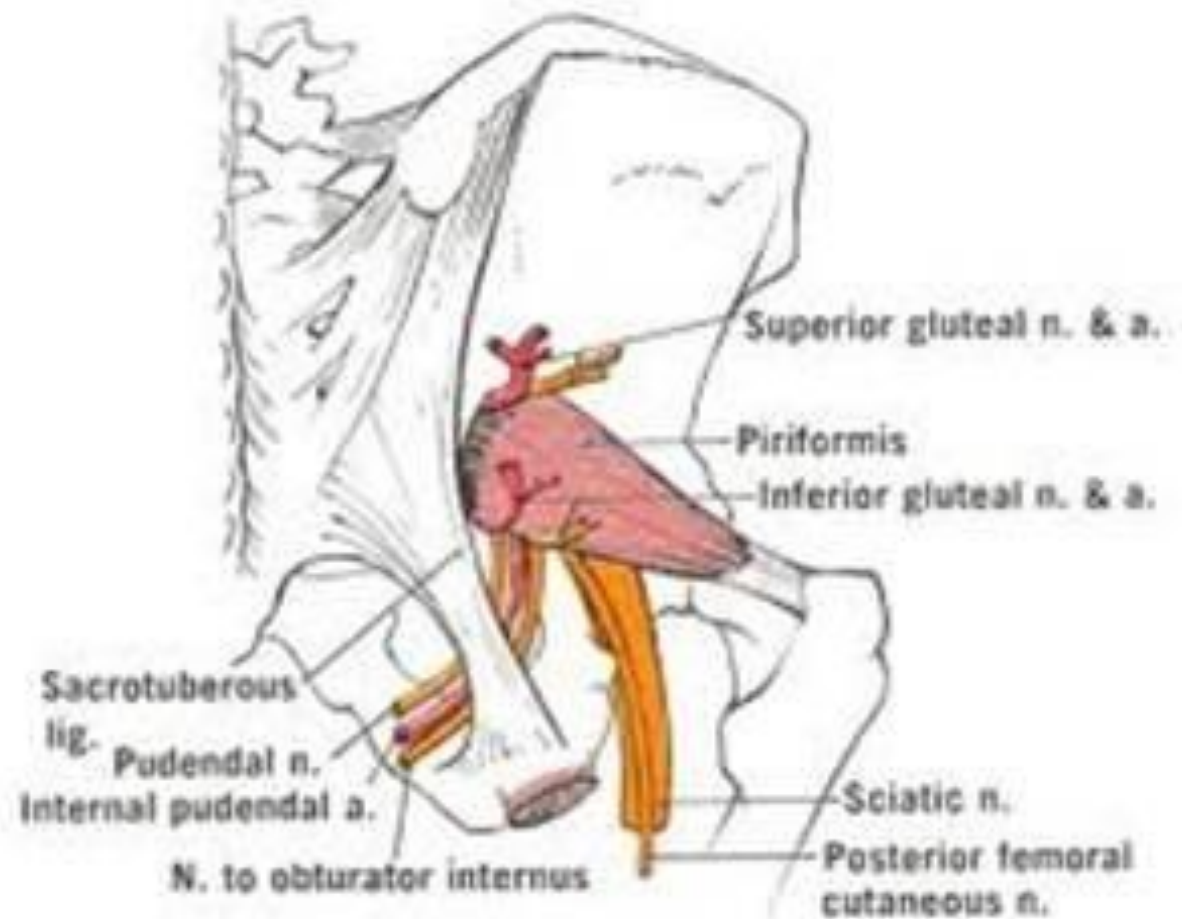
Patient was seen for 13 sessions from June 2023-  
July 2024

### 1. Treatments included:

Behavioral training of bowel and bladder  
Internal pelvic floor myofascial trigger point  
release techniques  
Therapeutic core strengthening exercises  
Lower extremity stretching series  
Nerve flossing  
Positional releases

### 2. Home program:

Graduated exercise program  
Pelvic floor exercises  
Stress reduction





# Case 2: Outcomes and End Results

- Strength 5/5  
Endurance 10 second holds 10 repetitions
- Palpation: no pain on external or internal pelvic floor
- No pain with pelvic floor contractions
- Sensation/Neuro intact- no pelvic floor or perineal tightness, normal penile sensitivity



# Referring to Pelvic Physical Therapy



- Referral after formal medical workup to rule out musculoskeletal causes of symptoms
- Prescription/referral for PT
- Patient calls to schedule appointment
- It IS covered by insurance because it is PT!
  
- To Find A Pelvic Floor Physical Therapist in Your Area:
  - <https://pelvicglobal.com>
  - <https://pelvicrehab.com/>
  - <https://www.antapelvichealth.org/ptlocator>



Questions?

A close-up photograph of a person's hands holding a white strip of paper. The hands are positioned in a way that the paper is held horizontally across the palm. The person is wearing a light blue or grey long-sleeved shirt. The background is a soft, out-of-focus grey. The text on the paper is in a bold, black, serif font.

**THANK YOU**

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