Treatment of pelvic pain before, during and after pregnancy: A PT perspective
Introduction: Penny Swanson PT
Case 1. Pelvic pain before pregnancy

Patient with dyspareunia due to lichens sclerosis
History of symptoms:

- Vulvar itching
- Uncomfortable wearing tight pants
- IUD placement – painful
- Married as virgin unable to have sex
- Tried dilators x 6 months
- Saw MD, trial vaginal estrogen
- New symptom lower abdominal pain
- Tests: US, CT, saw Gastroenterologist
- Referred to OB: Dx lichens sclerosis
- Tx: testosterone/estrogen vulvar cream, clobetasol with improved skin quality
- Referral to pelvic PT placed
Pelvic floor assessment
Pelvic floor assessment findings:

- Significant tension reaction to touch even externally
- How I address: consent, stop if causes pain, establish their control, trust, lidocaine
- Pt had complete loss of her labia minora
- Scar and fusing of the clitoral hood over the body
- High tone pelvic floor
- Short tight pelvic floor
- Urge incontinence and frequency issues that are new
Initial evaluation & treatment:

- Complete intake and examination
- Suggest avoiding all trials of intercourse and dilator use for now ask to bring dilators to appt
- Invite partner to attend PT session “team sport” if patient would like
- Ask MD for order of topical lidocaine for use in treatment to reduce pain
- Pain science information
and breathe
Patient received lidocaine Rx and brought to appt

Partner came. Physiology of arousal education

Positioning options that reduce fear/woman in control of speed/depth.

Suggest hold trials until ready but planning ahead/expectations

Instruct in pelvic stretches with diaphragmatic breathing “pelvic breath”
- Pt brought in dilator set and lidocaine
- Session done in the clinic
- Home instruction in dilator use posturing, timing, frequency
- No pain using lidocaine!
Treatment 3
Biofeedback Assessment
Bladder education: Anxiety/stress and bladder urgency relationship

Urge control techniques to help with UI

Gave Bladder diary to fill out
Review progress with dilators at home.

Review stretches, diaphragmatic breathing in the clinic.
Treatment 4

- Bowel education – constipation, abdominal pain common sequela with high tone PF

- Review bladder diary urgency work effective so far

- Manual therapy internally, scar glide work to clitoral region, dilator progression and stretching with lidocaine
Treatment 5

- Continuation of manual work in the clinic without lidocaine to check progress

- Use dilator in clinic practice movements, postures, HEP

- Review arousal education, position choices, lubricant use

- Okay trial of intercourse when SHE feels ready
Treatment 6

Pt reports successful penetrative intercourse including orgasm using lidocaine!

Manual therapy in clinic

Discussed options for weaning dilator frequency over time/goals

Return to clinic in 2-4 weeks for follow up questions/issues
Follow up after 2 weeks.

Continued success with penetrative sex, still intermittent pain issues but able to enjoy sex still.

Incontinence issues resolved

Abdominal pain resolved

Review continue work manually and with dilators.

Setbacks, self treatment considerations

Answer questions and DC from PT with HEP
Clinical Pearls...

• Pelvic floor pain is poorly localized
• Chronic tension in PF can lead to short tight PF muscles
• Bowel and bladder issues can be sequelae of short tight or high tone PF
• PF muscles connected to ANS so sensitive to stress/anxiety/pain
• Tests & Procedures to diagnose pelvic pain can feel traumatic to patients

Message:
Send patients early vs as a last resort!!
Stand up and breathe!
Case 2. Pelvic girdle pain during pregnancy
History

- G2P1 @ 32 weeks with 4-week history of pelvic girdle pain (PGP)
- History of PGP following birth of her first child that lasted for 3 months
- Mild stress incontinence since birth of her first child.
- Pt concerned that it is starting during pregnancy this time.
Research:

- PGP most common between 14-30 weeks of gestation.
- Persistent pain postpartum occurs in 7-25% with 1/5 of these more serious problems that persist for 1-2 yrs

Female prevalence rate of incontinence after first pregnancy 37.4%


Pelvic floor muscle weakness is a risk factor for PGP

Pain symptoms aggravated by:

- Transfers in and out of car, rising from sitting, in and out of bed
- Her sleep is interrupted as turning in bed at night is painful
- Donning on her pants in standing
- Getting up and down from the floor with childcare activities, lifting her son
- Yoga
Posture assessment

Relaxed poor posture

Cue for best posture
Stork Stance assessment: Pelvic ring instability and neuromuscular control

Left stork: pelvic drop and pain reproduction

Right stork: level pelvis no pain reproduction
Tests

- Left hip flexion reproduces patient’s PGP

- Laslet cluster test- good reliability for SIJ but care in pregnant population (SIJ tests: distraction, thigh thrust, Gaenslen, compression, and sacral thrust)

- Lumbar AROM testing negative but hyper-mobility noted
Functional assessment

Lunge

Squat
Functional testing: Doming of linea alba noted with transfer and diastasis testing
66% have diastasis in 3rd trimester

Pelvic floor muscle weakness, a risk factor for PGP, is associated with weakness of abdominal wall diastasis

Visit 1
“It’s more about what you don’t do rather than what I do to you.”

- Complete the evaluation
- Education about condition and activity and body mechanic guidelines.
- Trial of Support bracing options
Sacro iliac compression belt
Level D research evidence.
Pregnancy lumbar/abdominal support belt
Second Visit:
Body mechanic education with ADL’s, transfers, childcare activities.

Without compliance progress WILL be limited.
Activity guidelines

Teach safe ways of exercising, walking.
Assess and discuss use of SIJ belt
Stretches with symmetry to avoid strain on pubic bone or SIJ
Avoidance of asymmetrical poses in yoga and instruct in safe ways to exercise and stretch.
Initiate core activation: Transversus abdominus + pelvic floor
Third Visit

- Assess changes, challenges in ADL’s, work life, childcare, exercise

- Core strength progression-exercise instruction

- Functional and postural core activation practice

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Pelvic floor screening questions

Visual exam or biofeedback to test for ability to activate/release pelvic floor muscles
Visit 4
Bowel and bladder education

Core & dynamic strength work
Manual therapy
Visit 5
Pelvic floor exercise prescription current and after delivery
Delivery position education for PGP
6th visit:

- Pain significantly improved. Demonstrates correct mechanics in office visit 100% of the time
- Independent with core strength & stretch program
- Wearing SI belt with heavier activity
- Pelvic floor program ongoing, still mild SUI issues
- Reinforce compliance throughout pregnancy
- DC with home program
Summary for pelvic girdle pain in pregnancy:

Early education with onset of symptoms may help prevent more severe case from occurring.

Keeping patients active with safe types of exercise important in prevention of worsening PGP.

PGP and pelvic floor weakness are linked, DRA and PF support dysfunction is linked in the research- a system approach to these patients are needed.
Stand, Stretch & Breathe....
Case 3
The Postpartum patient
PT treatments in the 4th trimester
2018 ACOG committee opinion paper: Optimizing Post partum care: The 4th trimester

- Recognized ongoing care needed after birth beyond initial post birth visit with comprehensive visit no later than 12 weeks post delivery.

- Assess the physical, mental, social support and access to therapies, including physical therapy for pelvic health or musculoskeletal conditions.

- At our PT clinic at SMC/Issaquah in June we implemented a 4th trimester screening with all new moms by our referring providers 4-6 weeks post delivery.
Example of Post-partum patient history:

• Pt is G1P1 at 8 week post vaginal delivery of 8# baby with second degree tear/stitches with complaints of intermittent pelvic heaviness at end of the day, if walks carrying the baby. Looked with a mirror and saw something “disturbing”. She is fearful of resuming intercourse due to perineal soreness with BM and with 6 week visit with her OB. Mixed stress/urge incontinence symptoms that are improving but still present. Ran for a bus and had pelvic pain and incontinence.
Body mechanic education with childcare & breastfeeding
Pelvic floor assessment:

Scar healing

Pain

Bowel and bladder function

PF neuro-muscular control
Evaluation of Diastasis recti
Curl up test norms:

• There is minimal distortion of linea alba at rest & with sit up test
  = no wrinkle, sag or dome

• Less than 20% change in the inter recti distance during a curl up test regardless of abdominal strategy used

• Transversus abdominus contraction draws fascia laterally helps provide force closure for SIJ
Tension on LA more important than narrowing the gap

• Narrowing of rectus during curl-up test in DRA causes distortion of linea alba (LA). TrA activation creates a widening of Diastasis but less distortion LA improving force transfer between the sides of the abdomen.

• Tension of connective tissue stimulates collagen deposition and TrA is only muscle that does this by widening the gap in some people

• Synergy or balance of rectus, internal and external obliques and TrA is assessed in PT

Individualized progression of core stabilization program

• No exercise recipe book
• Previous activity level
• Each person assessed for posture, alignment, joint integrity, timing and task specific issues
• Pelvic floor healing, prolapse, diastasis considerations
• Best treatment is individualized and difference between PT vs post partum app on your phone
Thank you
Tests | Description (Positive Findings)
---|---
**Distraction** | Pt supine. Examiner applies posterolateral directed pressure to bilateral ASIS. (Reproduction of pain)
**Compression** | Pt sidelying. Examiner compresses pelvis with pressure applied over the iliac crest directed at the opposite iliac crest. (Reproduction of symptoms)
**Thigh Thrust** | Pt supine. Examiner places hip in 90 deg flexion and adduction. Examiner then applies posteriorly directed force through the femur at varying angles of abduction/adduction. (Reproduction of buttock pain)
**Sacral Thrust** | Pt prone. Examiner delivers an anteriorly directed thrust over the sacrum. (Reproduction of pain)
**Gaenslen's** | Pt supine with both legs extended. The test leg is passively brought into full knee flexion, while the opposite hip remains in extension. Overpressure is then applied to the flexed extremity. (Reproduction of pain)