Your

Guide to Pelvic Floor Therapy

A COMPREHENSIVE GUIDE TO ANSWER AS MANY QUESTIONS AS WE CAN TO HELP YOU FIND THE RIGHT PROVIDER & RELIEF

What is pelvic floor therapy?

Pelvic floor therapy is a specialized type of rehabilitation that focuses on identifying a dysfunction in the levator ani muscles that may be contributing to incontinence, pelvic pain, prolapse, constipation, pregnancy/postpartum issues and sexual dysfunction.

Who can be a pelvic floor therapist?

Physical therapists and occupational therapists can be pelvic floor therapists - you may also hear “pelvic floor rehab or pelvic floor specialist.” Physical and occupational therapists must receive training in pelvic floor therapy and internal examinations post graduate school, as these techniques and specific diagnostic testing for levator ani dysfunction is not taught in PT/OT school. It is important to note that internal exams are optional to the patient, but it is crucial that your therapist has been trained to do them in order to accurately determine levator ani dysfunction.

What are pelvic floor disorders/dysfunctions?

The levator ani muslces are a group of 3 muscles called puborectalis, pubococcygeus and iliococcygeus. They attach from the pubic bone to the tailbone (coccyx) and surround the urethra, vagina and rectum in women; the urethra and rectum in men. Women have extra muscular structures around the urethra and vagina for support. Both men and women also have external muscles that play a role in urethral/anal closure, sexual function and support called the bulbospongiosus, ischiocavernosus, transverse perineal and external anal sphincter. All of these muscles are voluntary, meaning we can contract and relax them. Part of these muscles, however, are automatic meaning they respond to changes in pressure (from bladder and bowel) and movement. Urinary, bowel and sexual function is automatic - meaning we shouldn't have to strain or force these functions. Usually when pelvic floor dysfunction is present - we see difficulty with the bladder, bowels, sex/intimacy/insertion or other presentations of pain.

The Bladder & The Pelvic Floor:

The relationship between the bladder and the pelvic floor is simple - the pelvic floor helps to keep the urethra closed with the urethral sphincter as the bladder fills. When the bladder contracts to empty, the pelvic floor must open/relax to empty completely. This process happens roughly every 3-4 hours. This is a normal, automatic process that should occur without straining to pee or going just in case. The pelvic floor and urethral sphincters also function based on pressure - they must be resilient enough to withstand pressure of a full bladder, a cough, a sneeze, a jump - without allowing leakage to escape. Depending on symptoms, we can retrain the pelvic floor to contract when needed (based on what activity causes leakage) or relax when needed (to completely empty the bladder or stop the immediate urge to pee). Leakage does not always mean weakness - it must be investigated to determine if it is due to excess pressure/stress to the sphincter and muscles or urgency - all caused by probable levator ani dysfunction or an issue with pressure from the ground up (when we jump) or from top down (when we sneeze!)

The Bowels & The Pelvic Floor:

The relationship between the bowels and the pelvic floor is a little more complicated. There are more automatic functions here and most commonly the pelvic floor dysfunction is coordination. When we have an urge to poop, the internal anal sphincter relaxes in response to the pressure of stool entering the rectum. The external anal sphincter and levator ani must stay contracted here to prevent leakage. When it is time to go on the toilet, the external anal sphincter and levator ani must relax for the stool to exit. There should be no straining and it should not take longer than five minutes. Identifying your stool type and frequency gives us many clues into bowel dysfunction. Other factors play a role including diet, fiber intake and your nervous system. The fight/flight system (when we are in distress) is the opposite of our rest/digest system. The most common pelvic floor dysfunctions we see with bowels is that the muscles are contracting when they should be relaxing when trying to pass a bowel movement. This leads to straining and pain with passing. Anal fissures and hemorrhoids are also the result of excessive straining and tension in the external sphincter and levator ani.

Sexual Function & The Pelvic Floor:

The relationship between sexual function and the pelvic floor relates to pain, arousal and orgasm - in women and men. Superficial muscles called the bulbospongiosus and ischiocavernosus play a role in blood filling to the penis and clitoris. Tension in these areas can affect sensation, erection and orgasm.

In women specifically, the vagina and levator ani relax with penetration. Pain with insertion, deeper pain, pain in certain positions and pain following intercourse can all be a result of muscular dysfunction. This also applies to pain with insertion in regards to tampons, vaginal ultrasounds and/or pap smears (see vaginismus in next page).

Orgasm in men and women occur differently. From what has been studied, there are different rhythms of pelvic floor muscle contract/relaxations. This means that the pelvic floor has a direct role on orgasm function - from strength, coordination and pain. It must be able to fully contract and relax, and have the coordination to do so. Any difficulties and pain with orgasm can be related directly to the pelvic floor muscles.

Pelvic Pain Conditions & The Pelvic Floor:

There are many pelvic pain conditions and we will touch on a few that we see commonly and are treatable by a trained pelvic floor therapist.

- Interstitial Cystitis
  - Also known as painful bladder syndrome, the AUA guidelines named pelvic floor therapy the only grade A evidence-based treatment approach for the management of symptoms. Manual therapy techniques for tension, trigger points and nervous system regulation is recommended. Kegels should never be prescribed.
- Vaginismus
  - Defined as an involuntary contraction of the levator ani that prevents insertion of ANY kind into the vagina such as a finger, tampons, ultrasounds, pap smears, etc. Internal exams should never be forced on women with vaginismus and treatment is focused on a gradual dilator program, mindfulness, breathing, nonpainful stretching and nervous system regulation approaches.

- Vulvodynia
  - Vulvar pain includes pain anywhere at the vaginal opening, labia or clitoris. Pain may feel like burning or itching without a known cause. Levator ani tension or nerve pain may be the cause.
- Pudendal Neuralgia
  - The pudendal nerve comes from the sacrum and innervates the urethra and urethral sphincter, clitoris, labia, penis, testicles, perineum and anal sphincter. It has motor and sensory innervation, meaning an issue with this nerve could cause weakness of the urethral and anal sphincters (leakage!) and pain in many of the genital regions. It is tricky to treat and a hallmark sign is pain with sitting because of where it runs from the sacrum under the sit bones.
- Endometriosis
  - Endometriosis is complex because it causes pelvic pain that is often cyclical with period onset, bladder pain, painful intercourse and constipation. We can help manage all of those symptoms, as well as painful periods due to the tension that chronic pain causes in the levator ani and surrounding muscles.

“Other Pains” & The Pelvic Floor:

Pain in the pelvis can be complex because the pelvis is our center with many muscle and ligament attachments to the spine, abdomen, hips and lower extremity. What happens from the top down impacts our pelvis (abdominals to pelvis) and from the bottom up impacts our pelvis (think about slamming our foot down and the reaction force up through the hip/pelvis/spine).

We can also have pains in the pubic area, genital area, tailbone, sacrum/SI joint and lower back that is directly related to the levator ani. Many times physicians, chiros and even other PTs who are not trained in the levator ani anatomy and physiology completely miss that there is an entire musculature system connected from the pubic bone to the tailbone. Tailbone pain is a direct correlation to the pelvic floor. Lower back, SI joint and the hip pain are directly connected to the pelvis. What we have to do is put together any other pieces that may accompany that pain such as bladder symptoms, bowel symptoms, sexual symptoms or pain brought on by sitting. Pain in the lower back or hip that has been unresolved through traditional PT should be suspected of pelvic floor dysfunction.

Pregnancy/Postpartum & The Pelvic Floor:
It is no secret that pelvic floor dysfunction occurs in moms, but why? In pregnancy, the pelvic floor muscle is strained over time to due the weight of baby and uterus - it has to withstand a lot of increased weight in a short period of time! In a vaginal birth, the pelvic floor muscles stretch up to three times its length. Sometimes tearing happens and prolapse is common post vaginal birth. In a cesarean birth, the pelvic floor is not stretched but it is still strained from pregnancy and now the abdominal muscles have an incision. In all pregnancies, the abdominals stretch and a diastasis recti occurs. The abdominals and the pelvic floor muscles MUST work together - if one is weak, usually the other is tight to compensate. Both must be strong and work together (if abs are contracting, pelvic floor is contracting). Preparing the pelvic floor muscles for birth to reduce trauma and prepare for postpartum recovery is the best we can do to eliminate and reduce risk for pelvic floor dysfunction long term. Regaining abdominal and pelvic floor strength and coordination while teaching proper lifting mechanics for motherhood can help reduce leakage and prolapse overtime.

Pelvic Organ Prolapse & The Pelvic Floor:

Prolapse can occur of the bladder, rectum and uterus into the vaginal canal. The bladder is the most common. Pelvic organ prolapse alone is not a cause for concern. The symptoms are the most bothersome and are not necessarily correlated with the severity of the prolapse. Bothersome symptoms that are treatable with pelvic floor therapy include vaginal heaviness and lower back pain. Painful sex and leakage may also be symptoms.

Pelvic floor therapy for prolapse can be complex. Success for pelvic floor therapy for prolapse includes genetics (yes, prolapse can be genetic due to ligament laxity!) and tissue/fascial integrity. If a prolapse is severe (grade 3-4), it may be hard for the levator ani to contract for support and a pessary may be necessary. A thorough assessment of prolapse is warranted in pelvic floor therapy noting the presence of the prolapse in different positions (lying down versus standing) and for any pelvic floor tension. Tension in the levator ani may be the contributing factor to heaviness, lower back pain and painful sex. Identifying tension and reinforcing strength, support and mobility through the abdominals, hips and spine is crucial.

Pediatrics & The Pelvic Floor:

Children are not immune to pelvic floor dysfunction and actually experience symptoms much more commonly than we may realize. Potty training before a child is physically and mentally ready may lead to poor bladder and bowel habits that carryover into adulthood. Constipation is a common problem for children due to behavioral issues - if a child has a painful bowel movement, they tend to withhold stool due to the pain. Withholding stool leads to larger stool that is then more difficult to empty leading to straining/pain - a snowball effect. Bedwetting is also usually due an underlying cause of constipation. Bedwetting beyond the age of 5-6 needs to be evaluated by a pelvic floor pediatric therapist. Urinary leakage in kids from age 5 to 17 is also not normal and treatable through pelvic floor therapy. Children do not receive internal examinations. Sometimes external observation of coordination may be recommended, but always an option to the child and parent. Function of pelvic stability, abdominal strength, muscle tension, pressure management and breathing strategies are assessed and treated through play and functional movement.

Who is pelvic floor therapy for?

Every human being has a pelvic floor - a levator ani that helps to control bladder/bowel/sexual function as well as provide stability/support to the pelvis. This means that anyone who has problems with their bladder, bowel, sexual function, pelvic pain or stability of the pelvis will benefit from pelvic floor therapy.

How do I know if pelvic floor therapy would help me?

Please fill out our pelvic floor dysfunction screening at the end of this guide! This is also a quiz on our website at www.breakfreept.info. You can also give us a call to chat about your specific issue or come by our office for a free consultation.

Benefits of pelvic floor therapy:

Pelvic floor physical or occupational therapy is a low risk, affordable and effective treatment option for pelvic floor dysfunction. It may benefit anyone who experiences:

- Urinary leaking
- Strong urges to pee
- Weak urine stream

- Always looking for a bathroom/peeing just in case
- Vaginal heaviness or pressure
- Painful sex or insertion of tampons, exams
- Constipation
- Bedwetting
- Anal fissures/hemorrhoids
- Lower back and SI joint pain
- Hip pain
- Tailbone pain
- Fecal leakage
- Erectile Dysfunction
- Orgasm Dysfunction
- Jaw clenching/TMJ pain
- Piriformis syndrome/sciatica
- Diastasis recti

Is pelvic floor therapy just kegel exercises?

No. If you do go to a pelvic floor therapist and you are only given kegels, especially without an offer of an internal muscle evaluation, you are not with a pelvic floor specialist. Kegels are the name for a voluntary levator ani contraction - meaning you can squeeze the muscle. We do test for your voluntary strength and coordination and you may need kegels if you are very weak as a foundation.

However, we find that any weakness is usually due to coordination and is improved in conjunction with addressing muscle imbalances within the abdominals and hips.

How much will pelvic floor therapy cost?

Prices vary based upon location and expertise of the therapist. Many pelvic floor therapists are out of network with insurance based on their state and location. This is because of the private nature of requiring 1:1 and insurance not reimbursing PT/OT a sustainable amount for services. Also, many diagnosis codes for pelvic floor specific diagnoses are not deemed medically necessary which can make insurance coverage tricky. It is important not to base your decision on a pelvic floor therapist only on price. Choose based upon your comfortability and expertise of the therapist on your specifc condition and symptoms.

Where do I find a pelvic floor therapist?

There are many searches available to find a reputable therapist! I recommend pelvicrehab.com because it is free to join. There is a search as well through the APTA, American Physical Therapy Association and Pelvic Guru, however this list is not exhaustive because

therapists have to pay to be on those lists. Other great things to ask offices if you are calling around:

- Where was the pelvic floor therapist trained?
- Can they treat specifically (insert: prolapse, vaginismus, men, etc.)
- Do you have a private room I'll be seen in?
- Do you offer internal muscle exams?
- Can you give me price transparency? (How much will I be paying every visit and that I will not get a surprise bill?)
- What is your treatment philosophy?

What makes "Break Free" different?

Read our "About Us" guide! We believe that the pelvic floor involves the entire body. It is rarely a dysfunction on its own and we have to consider how we are moving functionally and how our nervous system is responding to treat fully. We are passionate in our work and would love to help you or guide you in the right direction. I believe what makes us different is our passion for pelvic health and genuine healthcare. The evidence for pelvic health physical therapy is backed in the research - it is just time for us to recognize how common it is and make it a standard in care overall.

Cozean Pelvic Dysfunction Screening Protocol

Instructions: Check all that apply

- [ ] I sometimes have pelvic pain (in genitals, perineum, pubic or bladder area,or pain with urination) that exceeds a '3' on a 1-10 pain scale, with 10 being the worst pain imaginable

- [ ] I can remember falling onto my tailbone, lower back, or buttocks (even in childhood)

- [ ] I sometimes experience one or more of the following urinary symptoms:
  - Accidental loss of urine
  - Feeling unable to completely empty my bladder
  - Having to void within a few minutes of a previous void
  - Pain or burning with urination
  - Difficulty starting or frequent stopping/starting of urine stream

- [ ] I often or occasionally have to get up to urinate two or more times at night

- [ ] I sometimes have a feeling of increased pelvic pressure or the sensation of my pelvic organs slipping down or falling out

- [ ] I have a history of pain in my low back, hip, groin, or tailbone or have had sciatica

- [ ] I sometimes experience one or more of the following bowel symptoms:
  - Loss of bowel control
  - Feeling unable to completely empty my bowels
  - Straining or pain with a bowel movement
  - Difficulty initiating a bowel movement

- [ ] I sometimes experience pain or discomfort with sexual activity or intercourse

- [ ] Sexual activity increases one or more of my other symptoms

- [ ] Prolonged sitting increases my symptoms

If you checked 3 or more, pelvic floor dysfunction is likely. You may benefit from an assessment from a pelvic floor therapist.