Demystifying Pelvic Health Physiotherapy

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Aims of today's session

- What is Pelvic Health Physiotherapy?
- What do we treat?
- Pregnancy related conditions
- Pelvic Floor Muscle Dysfunction
- How to refer

Pelvic Health Physiotherapy

We are a team of specialist physiotherapists who provide assessment, treatment and management of pelvic health related problems including:

- Pregnancy-related musculoskeletal conditions of the back and pelvis
- Bladder and bowel dysfunction in men and women
- Pelvic Organ Prolapse
- Pelvic pain in men and women
- Postnatal continence/prolapse and Diastasis recti

Pelvic Health Physiotherapy

We work closely with:

- Consultants
- GPs
- Specialist continence nurses
- Specialist urology and colorectal nurses
- Midwives
- Msk physiotherapy
- ICATS

Also refer patients to pessary clinic and for urodynamic studies

Low Back Pain and Pelvic Girdle Pain (PGP) in Pregnancy



Prevalence and Impact

- Pregnancy-related pelvic girdle pain (PGP; alone, or in combination with LBP) affects 56-72% of individuals. It is a significant cause of disability and reduced quality of life.
- 1 in 10 may persist postnatally, and lead to persistent pain long-term.
- Significant cause of sick leave in pregnancy, and can have significant impact on maternal mental health and experience of pregnancy.

PGP/LBP and depression/anxiety

- Strongly positive correlation between low back and pelvic girdle pain in pregnancy (LBPP) and depression/anxiety (Virgara et al, 2018)

- A woman with LBPP was 13 times more likely to have increased risk of depression/anxiety (Bjelland et al, 2013)

- The presence of emotional distress during pregnancy is independently associated with the persistence of pelvic girdle pain after delivery.

Factors that can contribute to back pain in pregnancy:

- Fear, anxiety and lack of knowledge
- Flexibility
- Strength
- Daily work/activity
- Pregnancy changes
- Repetitive postures
- Previous back pain/injury

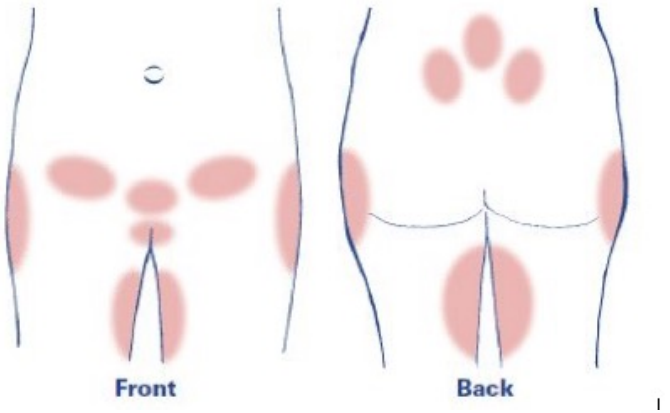


Symptoms of PGP

Pain in all or some of the areas shaded in the diagram.

May also have:

- difficulty walking
- pain when standing on one leg (e.g. climbin stairs, dressing, or getting in or out of the bath)
- clicking or grinding in the pelvic area
- pain during activities of daily life such as stairs, dressing, in/out of car or bed, walking



Commonly held beliefs



- “My hormones are making my joints soft and unstable”
- This will only get worse as my pregnancy goes on
- If my pelvis is sore I can’t have a normal delivery
- “something is wrong and broken in my body”
- “there’s no point in seeking help because …(nothing can be done, it will just go away afterwards)”
- “It’s because my baby is too big, lying a certain way”

Why is it important to look at the myths?

- We need to change the narrative… PGP is poorly understood by health professionals, and women are often given incorrect, fear-inducing, and unhelpful information.
- PGP was traditionally viewed as a hormonal or biomechanical issue, but recent research demonstrates that causes are multifactorial and we need to look at the whole person.
- Current research suggests that fear/anxiety, poor sleep, home environment, stress, job dissatisfaction and previous birth trauma may be drivers for sensitivity of the pelvis during pregnancy.

Myths (Dumoulin, 2022)

HORMONES:

- Previously thought (and taught) that relaxin caused PGP.
- There is NO correlation between relaxin levels and PGP (Hansen et al, 1996; Albert et al, 1997; Björklund et al, 2000; Marnach et al, 2003; Bjelland et al, 2014).

STABILITY:

"My pelvis is unstable"

- Can lead to guarding, increased sensitivity and fear of movement.
- People with PGP should be reassured that it is safe and beneficial to move in ways that are comfortable to them.

Myths (Dumoulin, 2022)

LACK OF SAFETY:

- Changes in **POSTURE** in pregnancy do not correlate with pain intensity in PGP.
- Breast-feeding DOES NOT prolong or worsen PGP – do not need to stop to improve symptoms.
- Vaginal births have a lower risk of severity and persistence of PGP. Many women are afraid they will not be able to give birth because of pain levels.

TRUTH – PGP can be managed

LIFESTYLE AND EDUCATION: PGP influenced by stress response system, emotional wellbeing and sleep.

Pain can be improved through individualised pain education, lifestyle counselling and daily movement strategies to empower people with PGP.

PHYSICAL ACTIVITY:

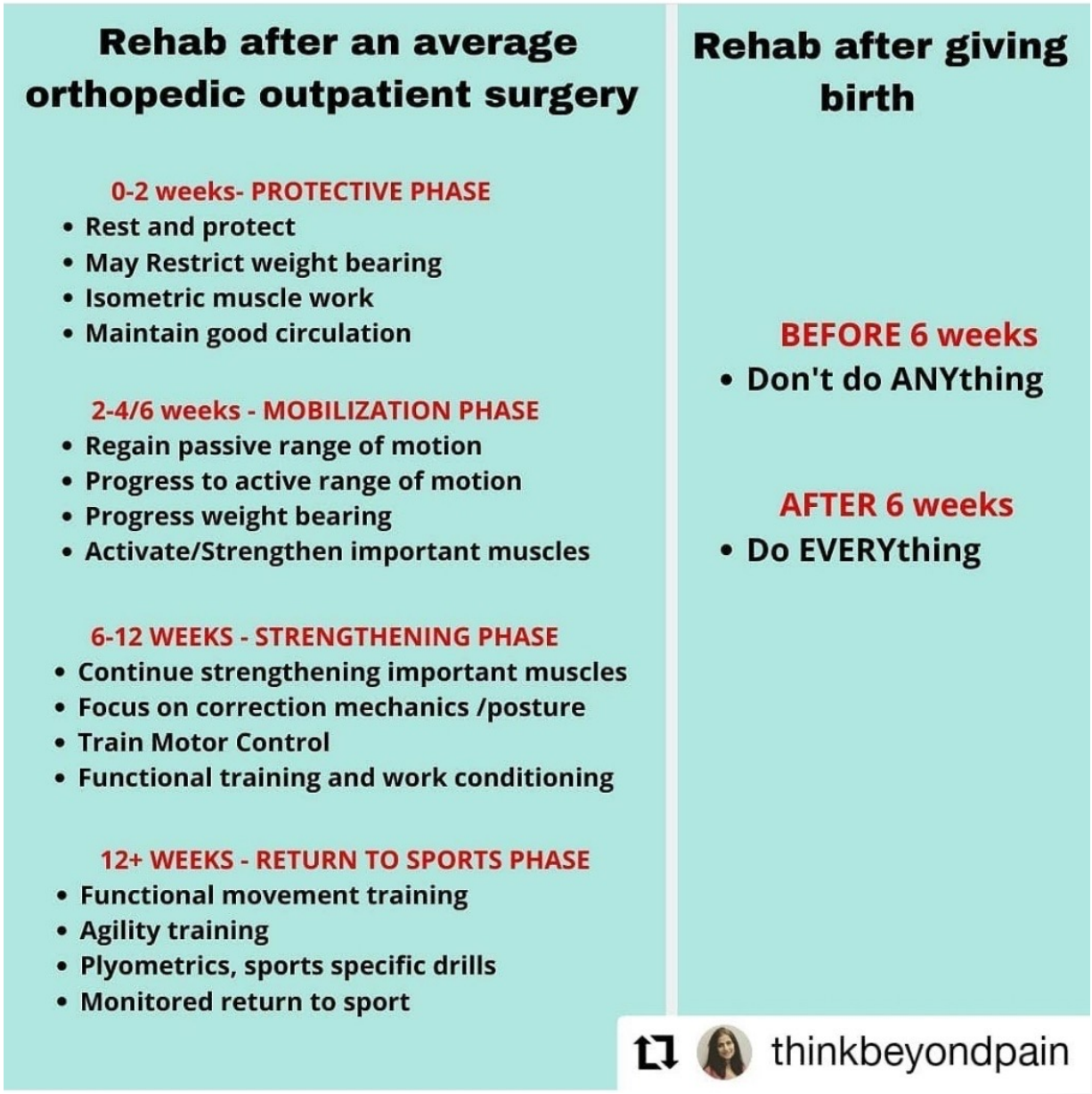
Exercise has been shown to help reduce PGP in pregnancy and to prevent it if started beforehand.

Manual therapy and belts may be used to promote sensory motor changes through novel proprioceptive input that promotes confidence and safety in movement.

Physio input for LBP/PGP in pregnancy

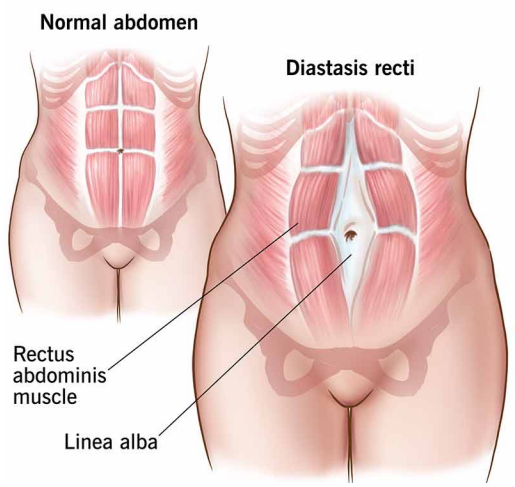
- Provide evidence based information about causes and prognosis of LBP/PGP
- Dispel the myths (hormones/catastrophizing/baby size and position)
- Promote safe, confident movement, using clinical reasoning and based on assessment findings.
- Look at the big picture – activity/sleep/work/family situation/previous experience of pregnancy.

The postnatal patient



Postnatal referrals

- Ongoing LBP/PGP/Coccyx pain
- Postnatal pelvic floor dysfunction
- Diastasis Rectus Abdominis



- Incidence 35-100%
- Impact – may be linked with back pain and incontinence
- Subjective report of doming, gapping, occurrence in previous pregnancy.
- Advice – may not spontaneously resolve (6-week window then will plateau unless intervention)
- Individualised rehab really important for those not resolving after 6 weeks.

Referring for Pregnancy-related pain

- Refer directly from GP through normal outpatient msk physiotherapy pathways.
- Pregnancy-related pain may be seen by Pelvic Health teams or Musculoskeletal teams, depending on Trust.
- Timescale – early intervention preferable for maximum benefit but never too late. Can refer at any stage in pregnancy, and will be prioritised as urgent.
- Timely advice and education

  = better prognosis for recovery

