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GLOBAL INTERSTITIAL CYSTITIS, BLADDER PAIN SOCIETY Newsletter

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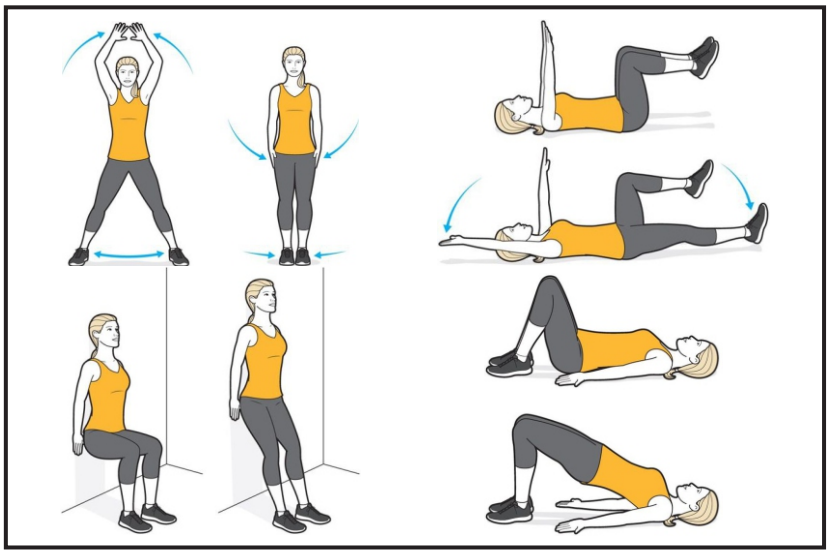
Overactive Pelvic Floor & Physiotherapy in Patients with IC/BPS



Pelvic floor dysfunction has been known to be associated with Interstitial Cystitis Bladder Pain Syndrome. Almost a quarter to a third of patients diagnosed with IC/BPS have a spastic pelvic floor at the time of diagnosis. A spastic pelvic floor or an over active pelvic floor may be associated as a causative etiological agent in a majority of these patients. How ever it may be a secondary phenomenon.

Ethology of Overactive pelvic floor

Pelvic floor can become spastic because of many reasons.

1. Musculoskeletal ethology.
The pelvic floor is supplied by lower lumbar and sacral nerves. Injury or degenerative changes in the lower spine , like prolapsed intervertebral disc, osteopenia or osteoporosis can lead to spasm of lower lumbar and pelvic floor muscles. Many of these patients present as low back ache and perineal pain. There may be no clinically discernible neurological deficit in the affected dermatome. Spasticity is the main and sometimes only clinically evaluable sign.

2. Pelvic inflammation.
Inflammation can involve any of the pelvic organs and side pain. Pain is also felt in the lower back as part of the inflammation. Usually a protective spasm of the pelvic floor and lower back muscles results from this condition. Prolonged inflammation invariably results in the pelvic floor spasm which may continue to persist even after complete remission of original pelvic pathology and its associated inflammation.

3. Postural.
Unhealthy postural habits which may may appear simple variations may in long term actually lead to a spastic lower spine and pelvic floor.

4. Anxiety and Stress.
Physical manifestations of Anxiety and stress may initiate or perpetuate the spasm of pelvic floor. A person who already has an overactive pelvic

floor and has difficulty in passing urine may go into an episode of retention of urine because of a reverberating thought of an impending retention due to past experience.

5. Iatrogenic.

Many of the IC/BPS patients , who present with frequency are mistakenly diagnosed as some form of overactive bladder. These are them referred for pelvic floor therapy , and they end up getting a pelvic floor tightening therapy. This only aggravated the already miserable condition of pelvic pain.

Pathophysiology of overactive pelvic floor and IC/BPS

Normal micturition cycle depends upon the complete relaxation of the pelvic floor during the voiding phase. Inability of the pelvic floor poses resistance to the flow of urine initiated by the contraction of detrusor muscle. This generates a kind of turbulence at the most sensitive part of bladder , the "Trigone" or the Bladder neck. This generates signal of distress and pain through the sympathetic nerves which richly supply this area. Pain causes further spasm of pelvic floor leading to the accentuation of pain itself.

Clinical Approach to a patient with suspected overactive Pelvic floor

History of hesitancy and poor stream associated with the pain and other clinical features of iC /BPS are indicators of overactive pelvic floor. History of recurrent retentions is almost pathognomic if hypotonocity of Bladder has been ruled out.

Clinical examination clinched the diagnosis. Presence of tight pelvic floor is easily discernible on clinical examination.

Urodynamics with EMG is only required if the diagnosis of overactive pelvic floor is not certain on clinical grounds. A thorough examination of spine, best done by an orthopaedic surgeon may be done to exclude a primary pathology in lower spine. Evaluation by a physiatrist or a specially trained physiotherapist is must.

Treatment

Education of patient and family are the most important ingredients of treatment. Evaluation by psychologist and focussed psychotherapy sessions may be considered.

Release of Myo fascial bands by either external massage or internal application of pressure at the right areas is most effective therapy for this condition. Pelvic floor relaxation exercises can be taught and a supervised sessions by specialised physiotherapists along with biofeedback mechanisms are the preferred approach. Periodical re-evaluation by physiotherapist of patients who are on self exercise therapy are a must. Swimming is certainly expected to help these patients.

Oral Skeletal muscle relaxants like Baclofen, cyclobenzaprine and Clonazepam do help in alleviating the symptoms while physiotherapy is taking effect.

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USICON 2020

GIBS-USI Joint Session 2020

GIBS has successfully concluded the joint session with the Urology Society of India, the "Global update on Interstitial Cystitis, Bladder Pain Syndrome" in the first ever GIBS-USI session during the Annual Conference of USI, **"USICON 2020"** on 23rd January 2020 in Kochi. Read More

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