GLOBAL INTERSTITIAL CYSTITIS, BLADDER PAIN SOCIETY

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NEWSLETTER

PELVIC FLOOR DYSFUNCTION IN IC/BPS – LOOK BEYOND BLADDER

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IC/BPS is a Complex Syndrome which has 2 main components that includes urinary symptoms and Pain both of which mostly coexist or seen in isolation too . It is a confusable entity that has led to many Healthcare personnel not being able to diagnose and hence treat the patients.

Women are more prone to this disease and it usually does coexist with a number of gynaecological diseases such as Endometriosis , chronic pelvic pain , Pelvic floor dysfunction , Vulvodynia and sexual dysfunction . The bladder may be impacted by the more generalised neuromuscular upregulation of the pelvis and the pelvic organs . Hence looking beyond bladder with focus on the Pelvic Floor to rule out pain focus is the first step in making a meaningful impact on their symptoms.

In this article I will concentrate on the need to evaluate the pelvic floor in all patients of IC /BPS . As it is a disease of exclusion , awareness and thinking out of the Box is very important .

Most of these women usually have already undergone multiple bladder centric treatments and are relieved of their urinary symptoms but may have persistent pain. It could be due to inadequate assessment of the pelvis and hence these patients need an extra understanding to evaluate their pelvic floor .The key to handle such patients is to give them assurance and make them aware that they will need multimodal treatment along with a multidisciplinary team involving the Physiotherapist , Pain management team .

Patients need to be fully evaluated with careful history and physical examination which is crucial for identifying the location of Trigger points , as these patients have pain in many body parts . Each individual can present with different symptoms for eg some may have predominant urinary symptoms while others may present with chronic pain , and the rest with both . Each patient needs a tailor made treatment profile depending on their symptoms .

Pelvic floor dysfunction is commonly seen in the women population and usually it could be due to a relaxed pelvic muscles (Hypotonic) as seen in genital prolapse and the other half could have tense Pelvic muscles (Hypertonic) or spasms as seen in IC/BPS patients .

Pelvic floor dysfunction affects the anterior, apical or posterior vaginal compartment. There are two types of dysfunction: hypotonic or LPFD and HPFD (seeTable 1). Many patients with BPS/IC can have concomitant HPFD, with muscle tenderness and spasms, and voiding dysfunction, both are the manifestations of pelvic floor hypertonicity.2 It has been estimated that the prevalence of HPFD in patients with BPS/IC ranges from 50% to 87%.3 Pelvic floor dysfunction exacerbates BPS/IC symptoms, and it could be a response to events such asvulvar or vaginal pain. There may be a viscero-muscular reflex resulting in the pelvic floor muscles being in a hypertonic contracted state.

Table 1 Types of pelvic floor dysfunctions [1]

- Hypotonic disorders Hypertonic disorders
- Stress urinary incontinence Overactive bladder, BPS/IC
- Pelvic organ prolapseOveractive bowel
- Fecal incontinence Vulvodynia,
- CPP Sexual dysfunction

Pathophysiology

In normal voiding, one must be able to relax the pelvic floor, sending a signal to the brain for the bladder to contract. Whereas in Pelvic floor muscle spasm there is pseudo-dysynergiawhich can cause obstructed voiding, leading to urinary urgency, frequency, hesitancy and pelvic pain. A tense and tight pelvic floor can result in referred pain to the vulva, rectum and perineum and is one of the most common causes of dyspareunia.

An inflammatory disorder of the pelvic viscera as in IC/BPS , a trauma or exceptional behaviour might elicit noxious stimuli to the sacral cord that sets up a pelvic floor muscle dysfunction with sacral nerve hypersensitivity and a sacral cord wind-up .2 The guarding reflex is a viscero-muscular reflex activated with resultant increase in the tone of the pelvic floor during routine daytime activity. In BPS/IC patients, there is an afferent autonomic bombardment that can enhance and maintain a guarding reflex that manifests itself as a hypertone of the pelvic floor.This hypertonic state results in decreased muscle function, increased myofascial pain, and myofascial trigger points. The pelvic floor muscles then become a source of pain even if the bladder is treated (13).Most often the pelvic muscles are tight with trigger points in these muscles and they experience pain . The inflammation affects the fascia and muscles of the pelvis , inner thighs , lower abdomen . The inflammation can combine to irritate the nerves that run through the pelvis which can causepain to manifest allover the pelvis and its surrounding areas . This pain and discomfort gives a false feeling of urge to go to the bathroom even when the bladder is empty , giving a sense of urgency.

On physical examination patients with HPFD are unable to produce more contractile strength and therefore cannot produce an effective squeeze. A single finger can be introduced in the vagina to assess pelvic floor awareness, and the ability to squeeze and relax the levatorani. Often patients with HPFD will have a "V" configuration of the introitus and, as a finger is advanced, it will drop off the shelf caused by the contracted levator muscles. Active "trigger points" are often identified by an exquisitely tender area palpable at the level of the pelvic side wall within a taut band that reproduces the patient's pain, as well as the referral pattern of her pain.

Symptoms

- Urinary issues , such as urgency with Pain
- Constipation or bowel straining.
- Lower backache
- Pain and pressure in the pelvic region, genitals, or rectum
- Sexual discomfort for women
- Muscle spasms in the pelvis

Treatment

Several studies have shown that pelvic floor physical therapy (PFPT) with intravaginal myofascial release is an effective treatment for pelvic pain, urgency-frequency syndrome in IC/BPS patients with PFD 4. PFPT works to stretch and elongate the pelvic floor muscles to provide prolonged pain improvement5. Pelvic Floor relaxation techniques can be taught to patients , to practice at home along with meditation and stress management . All these multi modal therapy can go along way in relieving the patients of IC/BPS , giving them a quality of life boost .

The Future

We must improve our understanding on the comprehensive evaluation and management of pelvic pain. Also we healthcare workers need to learn about PFD which can be the main trigger factor for pain spasms , along with female sexual dysfunction and the relationship these may have with bladder symptoms. Therefore the patient must be evaluated entirely , identifying pain triggers and also assess psychosocial factors too .

Time to engage our colleagues to create a multidisciplinary team to evaluate pelvic pain patients , know our limitations and refer patients as and when our standard therapies are not working, in the best interest of our patients . Women with IC/BPS symptoms have suffered for years because the medical field has failed them. It is time now to look beyond the bladder.

Dr. Vidya Bandukwala

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GIBS On The Go LIVE WEBINAR

GIBS has successfully conducted WEBINAR on IC/BPS with

26th November 2020

Madras Medical Mission Hospital (MMM)

Topic: **Diagnostic Conundrum in IC/BPS**

Participants: **354 plus**

SWATI SPENTOSE

session at the 29th Malaysian Urological Conference MUC 2020 on

27th November 2020

Topic: "Evolution and Journey in IC/BPS: The State of Art in 2020"

Speaker:

Dr. Sanjay Pandey
[An eminent Urologist from India]

Participants: 2000 plus

Moderator/Chairperson:

Dr. David M. Kaufman
[Board certified Urologist from USA]

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