



GLOBAL INTERSTITIAL CYSTITIS
BLADDER PAIN SOCIETY

Volume 7 Issue 6 || June 2025

GIBS NEWSLETTER

Evaluation of the Pelvic Floor in women with BPS/IC: An Underutilized Tool!

Latest Updates

DECADE Celebration!! 10th Annual Congress on IC/BPS - GIBS 2025

Date: 23rd & 24th August 2025
Venue: Kokilaben Dhirubhai Ambani
Hospital, Mumbai

Theme: Decode, Demystify, Drive
IC/BPS

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Bladder Pain Syndrome/Interstitial Cystitis (BPS/IC) is a debilitating condition with an estimated global prevalence of 300–500 per 100,000 women¹. Clinical presentation is variable, but commonly includes urinary urgency, frequency, and pelvic pain or pressure perceived to originate from the bladder, in the absence of infection or identifiable pathology². Despite the array of treatment options ranging from lifestyle and dietary modifications to medications, intravesical therapies, cystoscopic hydrodistension, physical therapy, and neuromodulation—outcomes are frequently suboptimal.

One contributing factor to suboptimal outcomes is the predominant focus on bladder-specific interventions, often overlooking coexisting pelvic floor dysfunction. Studies report pelvic floor hypertonicity or myofascial pain in 50–90% of women with BPS/IC³. Pelvic floor dysfunction may either mimic BPS/IC symptoms or develop secondary to persistent bladder pain via viscerosomatic convergence. In both cases, central sensitization may ensue, amplifying pain signals and contributing to widespread pelvic discomfort, mood changes, sleep disturbances, voiding dysfunction, and constipation⁴.

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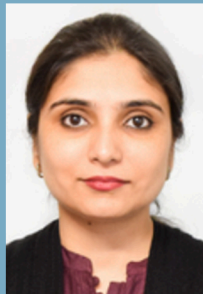
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Proper evaluation of the pelvic floor is essential in managing BPS/IC, yet many healthcare providers lack formal training in this domain. This article outlines an evidence-based five-step approach to pelvic floor assessment:

Step 1: Posture, Gait, and Mobility Assessment

Patients with chronic pain often exhibit lumbar lordosis, thoracic kyphosis, or an antalgic gait. Evaluating posture and gait provides insights into musculoskeletal compensations contributing to pelvic floor dysfunction⁵.

Step 2: Abdominal and Hip Evaluation

Palpation of the abdomen assesses for visceral tenderness and fascial restrictions. Passive range of motion in the hips and assessment of associated muscles such as the psoas and iliacus reveal common tension patterns contributing to pelvic discomfort.

Step 3: Visual Examination of the Perineum and Vulva

Visual inspection includes assessment of labial and perineal tissues for scarring, atrophy, or pigmentation changes. Pelvic floor muscle (PFM) function is assessed by instructing the patient to contract and relax the muscles. Perineal body position relative to the ischial tuberosities helps distinguish between hypertonic and hypotonic PFMs.

If the perineal body is below the level of the ischial tuberosity it is suggestive of hypotonic pelvic floor, whereas a position above the ischial tuberosity is suggestive of hypertonic pelvic floor.

Step 4: Using a cotton swab, sensitivity is assessed at standard clock-face positions (e.g., 3, 6, and 9 o'clock) on the vulva. Pain intensity is rated on a scale of 0–10. This test not only aids diagnosis but also serves as a longitudinal tool to monitor treatment response⁶.



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Step 5: A single-digit intravaginal examination

should be conducted with the patient's informed consent and after appropriate counselling, respecting their pain threshold. This assessment provides valuable information regarding the tone, tenderness, and functional integrity of both the superficial and deep pelvic floor muscles (PFMs), including the bulbospongiosus, ischiocavernosus, superficial transverse perineal muscles, levator ani, obturator internus, and coccygeus.

To facilitate orientation during palpation, an imaginary clock face is superimposed over the vulva: the clitoris represents 12 o'clock, the anus 6 o'clock, and the left and right ischial tuberosities 3 o'clock and 9 o'clock, respectively (Figure 1)⁵. The ischiocavernosus muscle is best palpated at 1–2 o'clock or 10–11 o'clock positions, over the labia majora. The bulbocavernosus is examined around the introitus, while the superficial transverse perineal muscles are assessed from 3 o'clock to the perineal body at midline. Tenderness on gentle palpation suggests superficial myofascial dysfunction.

Before evaluating deeper muscles, the perineal surface is visually inspected. Normal PFM tone produces a mildly concave appearance between the ischial tuberosities, with the perineal body slightly elevated. A single digit is inserted at the level of the perineal body and advanced above the hymenal ring. The size and location of the vaginal opening, as well as the ease of insertion, help assess resting tone. Normal tone allows easy, pain-free insertion with the opening situated just above the introitus. In contrast, hypertonicity presents as a smaller, higher opening, while hypotonic muscles may cause the perineum to appear convex or drooping.

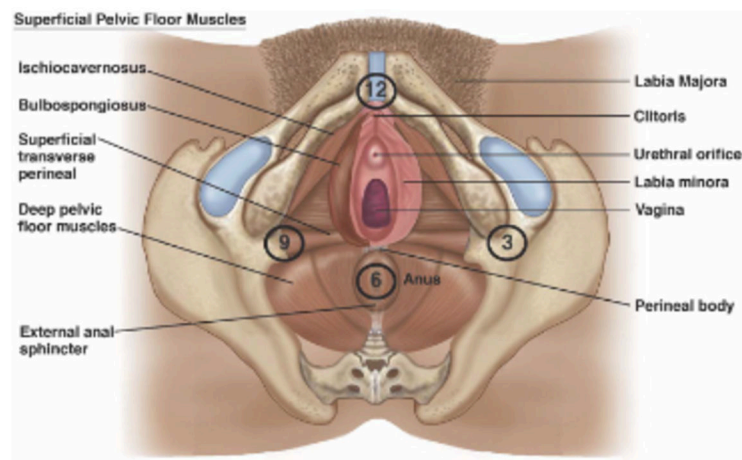


Figure 1: Palpation of superficial pelvic floor muscles

Deep muscle assessment begins with palpation of the levator ani, typically at 5 or 7 o'clock, by inserting the examining finger 2–4 cm past the superficial layer (Figure 2)⁵. At 6 o'clock, the anal sphincter and rectum are palpated, while the coccygeus is accessed laterally from the coccyx toward the ischial spine. The obturator internus is palpated by sweeping the digit laterally to 9–10 o'clock (right side) and 2–3 o'clock (left side). Further anterior and superior movement to 11 or 1 o'clock localizes the puborectalis and periurethral tissues.

Assessment should include evaluation of muscle symmetry, endurance, and coordination. Symmetry is assessed by comparing muscle tone and responsiveness on both sides. Endurance is evaluated by asking the patient to maintain a contraction for 5–10 seconds. Coordination is determined by observing the rhythm and ease of repeated contraction–relaxation cycles.

The Modified Oxford Scale (0–5) is used to grade PFM contractility, with 0 representing no contraction and 5 indicating strong, normal contraction.

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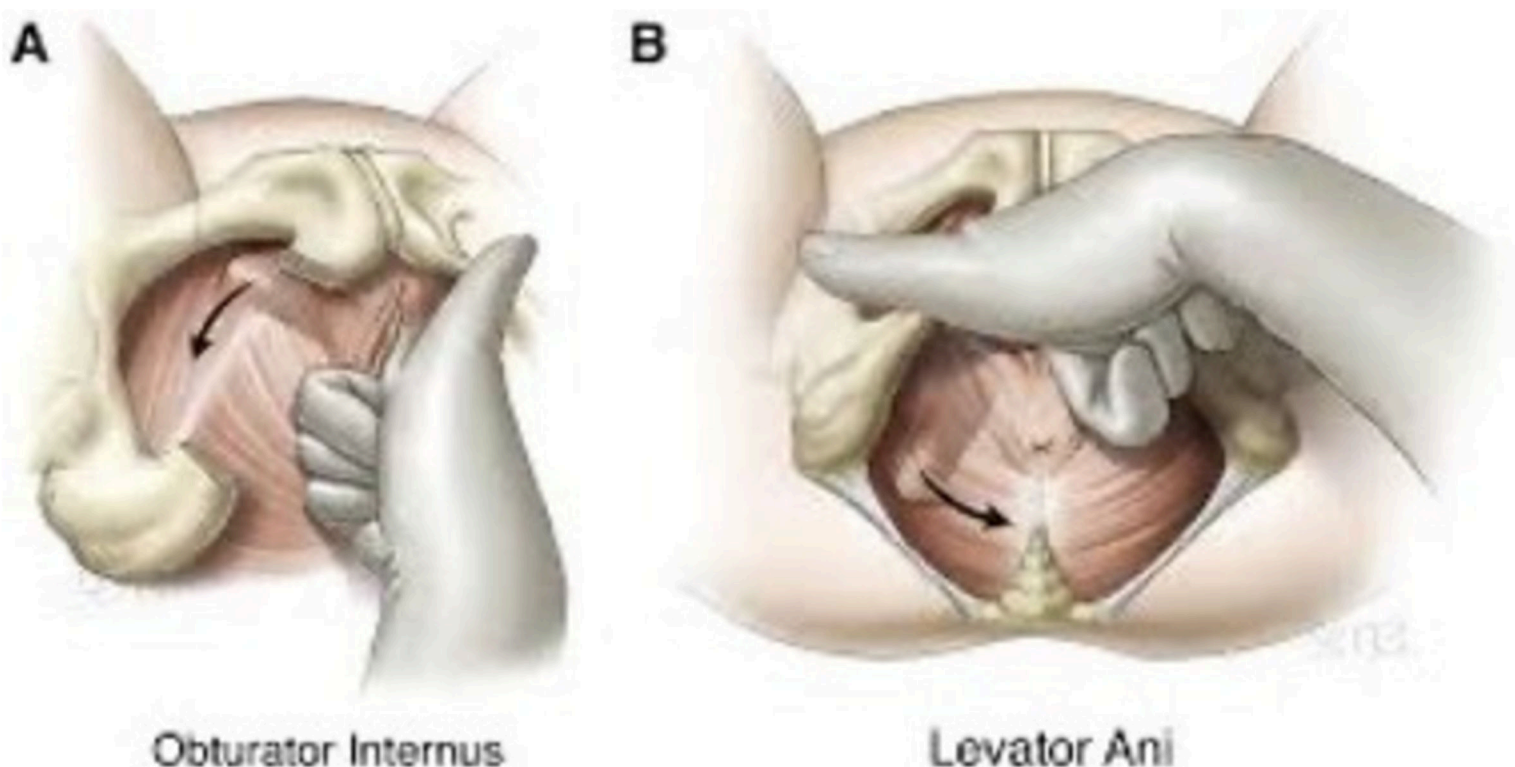


Figure 2: Palpation of Obturator Internus and Levator ani

Findings should include resting tone, contractile strength, and the muscle's ability to return to baseline after contraction. Notably, hypertonic muscles often demonstrate weak voluntary contraction and incomplete relaxation.

Following tone and strength assessment, circumferential palpation is performed to identify:

- **Tender points**, which elicit localized pain
- **Trigger points**, which are taut bands of muscle that refer pain to remote areas like the vulva, sacrum, or perineum

These findings should be documented and may warrant referral for pelvic floor physical therapy or myofascial release techniques.

Finally, a digital rectal examination may be performed to assess the tone of the anal sphincters, function of the coccygeus muscle, and tension in the surrounding pelvic ligaments.

Conclusion:

Comprehensive pelvic floor evaluation is indispensable in the management of BPS/IC. Failure to recognize pelvic floor dysfunction may perpetuate chronic pain and hinder recovery. Clinicians should be equipped with the skills and knowledge to integrate pelvic floor assessment into standard practice for improved patient outcomes.

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DRUG SNIPPET FOR TREATMENT OF ICBPS



Hydroxyzine

Mechanism of Action

H1-receptor antagonist with low to moderate antihistaminic properties; inhibits respiratory, vascular, and GI smooth-muscle constriction.

Moderate to high anticholinergic and antiemetic properties.

Pharmacokinetics

Absorption

Onset: 15-30 min (PO)
Duration: Sedation, 4-6 hr;
antipruritic, 1-12 hr.
Peak serum time: 1-2 hr

Metabolism

Metabolized by liver

Elimination

Half-life: 20 hr (adults); 29 hr (elderly); 37 hr (hepatic dysfunction)

Excretion: Urine

Dosing

25-75 mg /day (useful in patients with allergies)

Side Effects

Anticholinergic: Dry mouth

Central nervous system: Drowsiness (usually transitory and may disappear in a few days of continued therapy or upon reduction of the dose), involuntary motor activity (tremor, convulsions) usually with doses considerably higher than those recommended.

Clinically significant respiratory depression has not been reported at recommended doses

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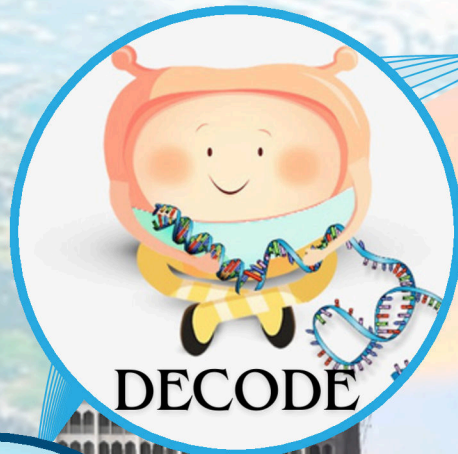
AUGUST 23rd & 24th, 2025

HIGHLIGHTS

- ✓ Advances in IC/BPS
- ✓ Workshops
- ✓ Orations from Subject Expert around the Globe!

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Hospital, Mumbai, India

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