Occupational Therapy and Pelvic Floor Rehabilitation

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Personal Background

- Brenau Graduate
- Practicing OT for five years
- Specializing in pelvic floor for three years
Learning Objectives

- Identify male and female pelvic floor and pelvic girdle structures
- List common pelvic floor dysfunction and populations treated in pelvic floor rehabilitation
- Understand the evaluation and treatment of pelvic floor dysfunction in pelvic rehabilitation
- Discuss the role occupational therapists in pelvic health using the AOTA Centennial Vision and Vision 2025, OT Practice Framework and Georgia State OT Licensing Act
Pelvic floor & pelvic girdle

- Pelvic floor muscles are located within the bony pelvis
- Bowel, bladder and sexual function
- Stability
- Mobility
- Protection of organs
- Dynamic
Pelvic Floor Muscles

Illustration #2 Female Pelvic Floor Anatomy

clitoris
urethra
ischiocavernosus
vagina
bulbocavernosus
vestibule
transversus perineum
perineal body
levator ani:
  pubococcygeus
  iliococcygeus
anal sphincter
anus
gluteus maximus
coccyx bone
Pelvic Floor Muscles

Illustration #4  Male Pelvic Floor Anatomy

- ischiocavernosus
- bulbocavernosus
- perineal body
- levator ani:
  - pubococcygeus
  - iliococcygeus
- transversus perineum
- anus
- anal sphincter
- gluteus maximus
- coccyx bone

© Amy Stein, Heal Pelvic Pain
Pelvic Floor Muscles

- Pre-rectal fibres (of puborectalis)
- Urethral hiatus
- Rectal hiatus
- Vaginal canal
- Puborectalis
- Pubococcygeus
- Iliococcygeus
- Coccygeus
Pelvic Girdle

- Sacroiliac joint
- Iliac crest
- Ilium
- Sacrum
- Coccyx
- Hip joint
- Ischium
- Pubis
- Pubic symphysis
- Femur
Canister Model

- Glottis
- Multifidi
- Diaphragm
- Pelvic Floor
- Abdominals
- Multifidus
- Transversus abdominis
- Muscles of pelvic floor
- Diaphragm
# Pelvic Floor Dysfunction

- Urinary incontinence
  - Urge
  - Stress
- Fecal incontinence
- Dyspareunia
- Levator ani spasm
- Vaginismus
- Coccydynia
- Neurogenic bladder

- Perineal tear or episiotomy
- Prolapse (vagina, urethra, bladder, rectal or small intestines)
- Other diagnoses/conditions related to pelvic floor dysfunction:
  - Diastasis recti
  - Low back pain
  - Hip pain
  - Depression/Anxiety
  - Hormonal imbalances/vitamin deficiencies
Treatment Population

- Male and female throughout their lifespan

- Surgical interventions/Medical procedures PFR can be warranted before and/or after. Examples include:
  - Prostatectomy
  - Childbirth (Vaginal or C-Section)
  - Vaginal mesh placement/removal
  - Radiation
  - Anal fissure/fistula repair
  - Botox injections
Evaluation of Pelvic Floor Dysfunction

- Document consent, offer 3rd party presence & describe role of OT
- Occupational profile (medical hx, meds, surgeries, onset, abuse, pad use/voiding frequency/number of accidents)
- Discuss how pelvic floor dysfunction is limiting occupational performance with ADLs/IADLs
  - Compare to PLOF/CLOF & AE/DME needs
- Marinoff Scale, NIH-Chronic Prostatitis Symptom Index, Pelvic Floor Impact Questionnaire-short form 7, Female Sexual Function Index, Cleveland Clinic Scale
- Hormonal component
Evaluation of Pelvic Floor Dysfunction

- Behavioral assessment-toileting habits & routines, dietary influences
- External skin integrity, Q-tip test, atrophy, hemorrhoids, anal wink, ROM: contract/relax/bulge, internal MMT using Modified Oxford Scale, gross LE strength testing
- Pelvic alignment, leg length discrepancy
- Abdominal wall assessment
  - Scarring, diastasis recti, rib angle
Intervention

- Bowel and bladder diary
- Voiding tips/adaptive equipment/activity analysis
  - Timed toileting routine, toileting tongs, coccyx cushion, body mechanics (i.e. squatty potty), splinting techniques, colon massage, pessary use for pelvic organ support
- Education on positioning & body mechanics to optimize independence with ADLs/IADLs (work, sexual intercourse, toileting, lifting, etc.)
- Dietary influences
- Education on effects of medication and bowel and bladder function
- Education on personal hygiene, lubrication and skin integrity
Intervention: Strengthening Approach

- Underactive pelvic floor muscles
  - Lack of voluntary or involuntary contraction

- Non-functioning pelvic floor muscles
  - No palpable muscle contraction

- Diaphragmatic breathing

- Biofeedback

- Kegels: Fast twitch vs. slow twitch (100/day)
  - Penile pump & vaginal weights
  - Electrical stimulation

- TA & multifidus activation

- Global muscle support of the pelvis
Intervention: Relaxation Approach

- Overactive pelvic floor muscles
- Diaphragmatic breathing
- Biofeedback
- Paradoxical Relaxation & guided imagery
- Graded exposure/desensitization
  - Pelvic Health Podcast: Drs. Sandy Hilton & Dronnie Lennox Thompson
- Pelvic stability
- Internal/external pelvic floor muscle release
  - Contract/relax
  - Dilators
  - Soft tissue mobilization
  - The power of AROM/AAROM (i.e. hips)
AOTA Centennial Vision/Vision 2025 and Pelvic Floor Rehabilitation

- Expanding occupational therapy services to all genders throughout their lifespan through pelvic rehabilitation
- Meeting society’s occupational needs by addressing bowel, bladder and sexual dysfunction
- Collaborative approach in client treatment to improve therapeutic outcomes
Promoting client “health, well-being and participation in life through engagement in occupation” (American Occupational Therapy Association, 2014, p. S2)

Address decreased voluntary control of bowel and/or bladder body functions

Performance patterns, habits, routines, roles & rituals, can impact health and well-being (body functions and structures)

- i.e. Void at the same time every day out of habit/routine = smaller bladder capacity vs. nurse unable to void at desired time due to professional roles and job performance requirements = urinary retention/UUI
OT Practice Framework and Pelvic Floor Rehabilitation

Utilizing activity analysis skills to address difficulty with ADLs/IADLs/occupations while considering the interaction between one’s client factors, performance skills & performance patterns to promote optimal occupational performance

- Vaginal speculum use & pelvic exams
- Tampon insertion/pad use
- Sexual activity (co-occupation with significant other)
- Decreased sitting tolerance
- Lifting abilities
Sleep participation: Performing nighttime care of toileting needs and hydration
- Elevation of feet/limiting fluid intake before bed to decrease nocturia

Toileting and toilet hygiene: Cleaning body, caring for menstrual and continence needs
- Tampon insertion & pad use
- Timed toileting routine
- Voiding tips
Promote occupational performance in leisure and social participation through decreased urinary or bowel accidents and/or decreased pelvic pain

Health management and maintenance: Nutrition and physical fitness to promote developing, managing and maintaining routines for health and wellness promotion

- Bladder and bowel diets
- Exercise to facility blood flow for musculoskeletal function
Evaluation & treatment of clients whose independence and occupational performance with ADLs/IADLs is limited by "developmental deficiencies, the aging process, learning disabilities, poverty & cultural differences, physical injury or disease, psychological and social disabilities or anticipated dysfunction" (Georgia State Occupational Therapy Licensing Act, 1976, p. 993, 379, 97, 1302, 1706).
Evaluation techniques

- Sensory motor abilities, development of self-care activities & capacity for independence, physical capacity for prevocational & work tasks, play & leisure performance

Treatment

- Activity analysis, ADLs, IADLs & patient education, adaptive equipment, sensory motor activities, manual therapy, therapeutic exercise, modalities, work capacities, cognitive retraining
Takeaways

- Use of AOTA’s Vision Statement, OT Practice Framework and Georgia State Regulations as a guide to carry out evaluation and treatment of pelvic floor dysfunction
  - Goal is to achieve client’s desired therapeutic outcomes for improved QOL, occupational performance and independence level

- Multidisciplinary approach – Referral to other professionals

- Holistic approach to treatment
  - It’s not just in the pelvis!

- Barriers to treatment
  - Societal norms about bowel, bladder and sexual function
  - Lack of awareness of pelvic floor dysfunction and functional limitations
Call to Action

Certification

- Herman and Wallace-Pelvic Rehabilitation Practitioner Certification (PRPC) and/or ABPTS-American Board of Physical Therapy Specialties: Women’s Health Clinical Specialist (WCS)
  - https://hermanwallace.com/pelvic-rehabilitation-practitioner-certification/comparison-chart

Pelvicrehab.com
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