SEX IS SUPPOSED TO BE ENJOYABLE, SO WHY DOES IT HURT?

Dr Emma Readman

Case study

- Ms EE is a 55 year old G3P3
- PHx
  - Coeliac disease
  - 2 laparoscopies for mild endometriosis
  - Hypertension
  - 3 vaginal deliveries
  - Back pain
  - Some knee pain

HPC

- MIRENA in 21 ys, not bled in years, last changed Feb
- No Hot flushes, last time hot flushes 2 ys ago
- Pain on and off for years, better after surgery not resolved
- 2 distinct pains one under the ribs and one LIF
- Can be crippling, can make her curl up
- Can be burning can be squeezing pain can be stabbing
- Better heat packs, can have some change with movement
- Bowels always intermittant, some bloating
- Bladder urgency, gets up 3 times at night, pain worse when full bladder, dragging pain when using the bladder
- Always pain with intercourse. Worsening, not able to handle it any more.

Examination

- R SI joint extremely sore
- L Iliacus muscle causes pain
- Also l sided rectus abdominus pain
- L sided vulval light touch causes the l lower abdominal burning pain
- L levator ani causes l sided pain
- High tone all pelvic floor muscles

Assessment and management

- Perimenopausal
- Atrophy with MIRENA and menopause
- Muscle and nerve based pain
- Treatment
  - Endep 5% in versabase to vulva BD
  - Physio
  - Take out MIRENA, oestrogen vaginally
  - Maybe valium pessaries

Myofascial pain

- The mean prevalence of myofascial pain syndrome among adults 30-60 years old is reported to be 65%, and in the elderly older than 65 years old it reaches 85%.
  - Drewes AM, Jennum P. Epidemiology of myofascial pain, low back pain, morning stiffness and sleep- related complaints in the general population. J Musculoskelet Pain 1995;3:121
  - Podichetty VK, Mazanec DJ, Biscup RS. Chronic non-malignant musculoskeletal pain in older adults: clinical issues and opioid intervention. Postgrad Med J 2003;79:627-33.
- In a study of 177 patients with chronic pelvic pain, with 74% having abdominal wall trigger points, 71% of the patients had focal pain areas in the vaginal wall involving the levator ani, obturator internus, and piriformis muscles.
  - Slocumb JC. Neurologic factors in chronic pelvic pain: trigger points and the abdominal pelvic pain syndrome. Am J Obstet Gynecol 1984;149:536-43.

Why?

Potential contributing factors

- Altered biomechanics (gait, posture, core, respiration, prolapse)
- Muscular response to stress
- Maladaptive guarding to pain (especially abdominals and intra-/extra- pelvic muscles)
- Poor sports training techniques/overtraining
- History of over activation (eg, elite sports, intense childhood regimes such as ballet/gym)
- Constant abdominal activation to appear slimmer
- Injury or dysfunction (current or previous): spinal, hip, pelvic, lower limbs, obstetric
- Surgical: repeated sensitizing events,
- persistent post operation muscle guarding
- Attempting core exercises when over activity is already present

Also

- Dermatoses and candida (superficial dyspareunia) look at vulva do swabs
- Atrophy vaginal oestrogen
- Obstetric trauma /local injury
- Other pathology
  - Endometriosis (US and examine, maybe laparoscopy)
  - PID (swabs,maybe laparoscopy)
- **Psychological issues/abuse**

Muscle problems- What are we looking for in history?

- Triggers for musculoskeletal pain
  - Back pain/hip pain/leg pain
  - Movement disorders
  - Emotional pain anxiety, depression
- Assessment for pain type
  - unilateral and is most often described as aching, throbbing, heaviness, or as pelvic pressure. “I feel like my organs are falling out”
  - Musculoskeletal pain can be worsened by prolonged sitting or standing, anxiety, bowel movements, physical activity, or sexual intercourse.
  - Pain that starts in the afternoon and becomes progressively worse throughout the day is characteristic of musculoskeletal dysfunction such as levator ani syndrome.

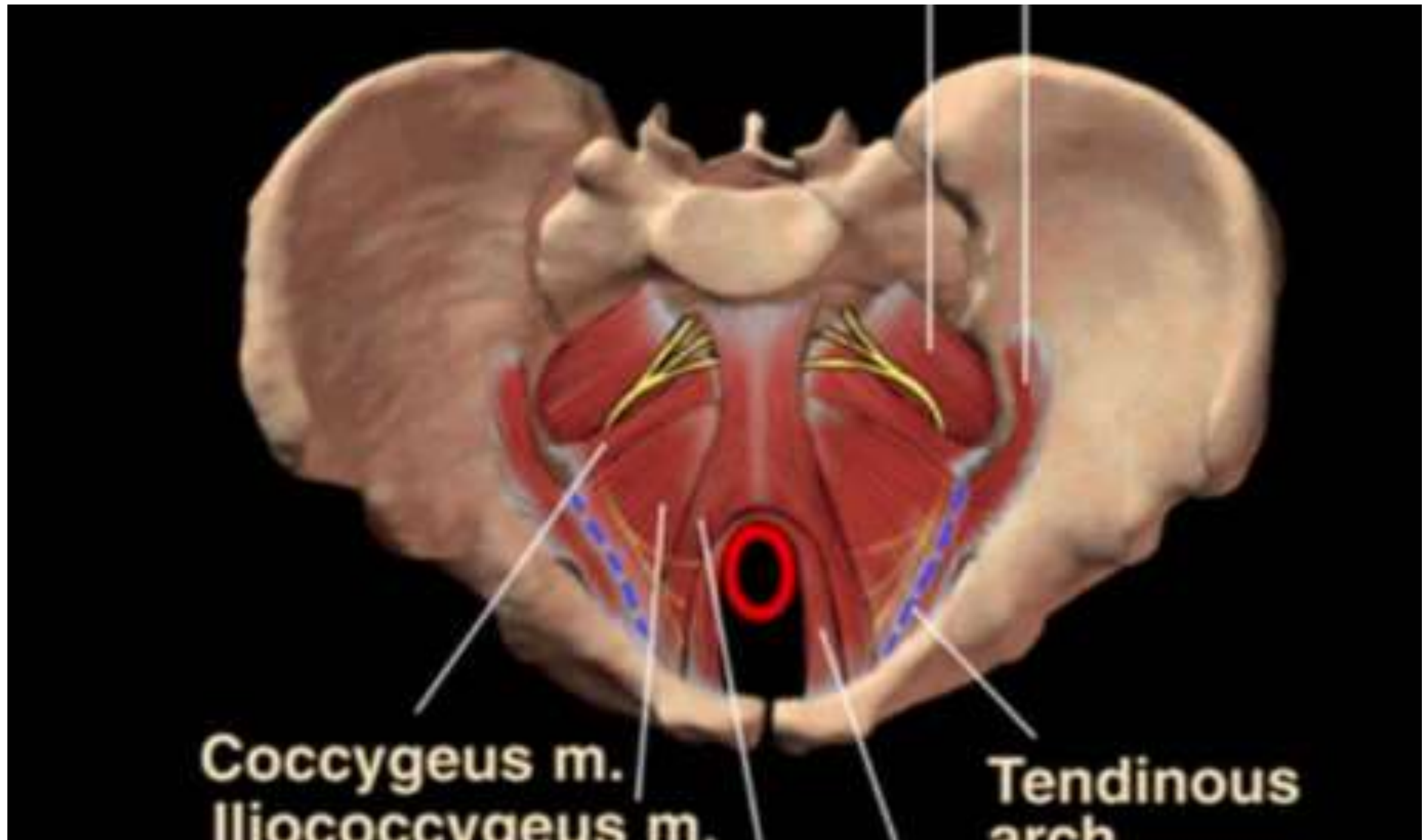
What to look for on history 2

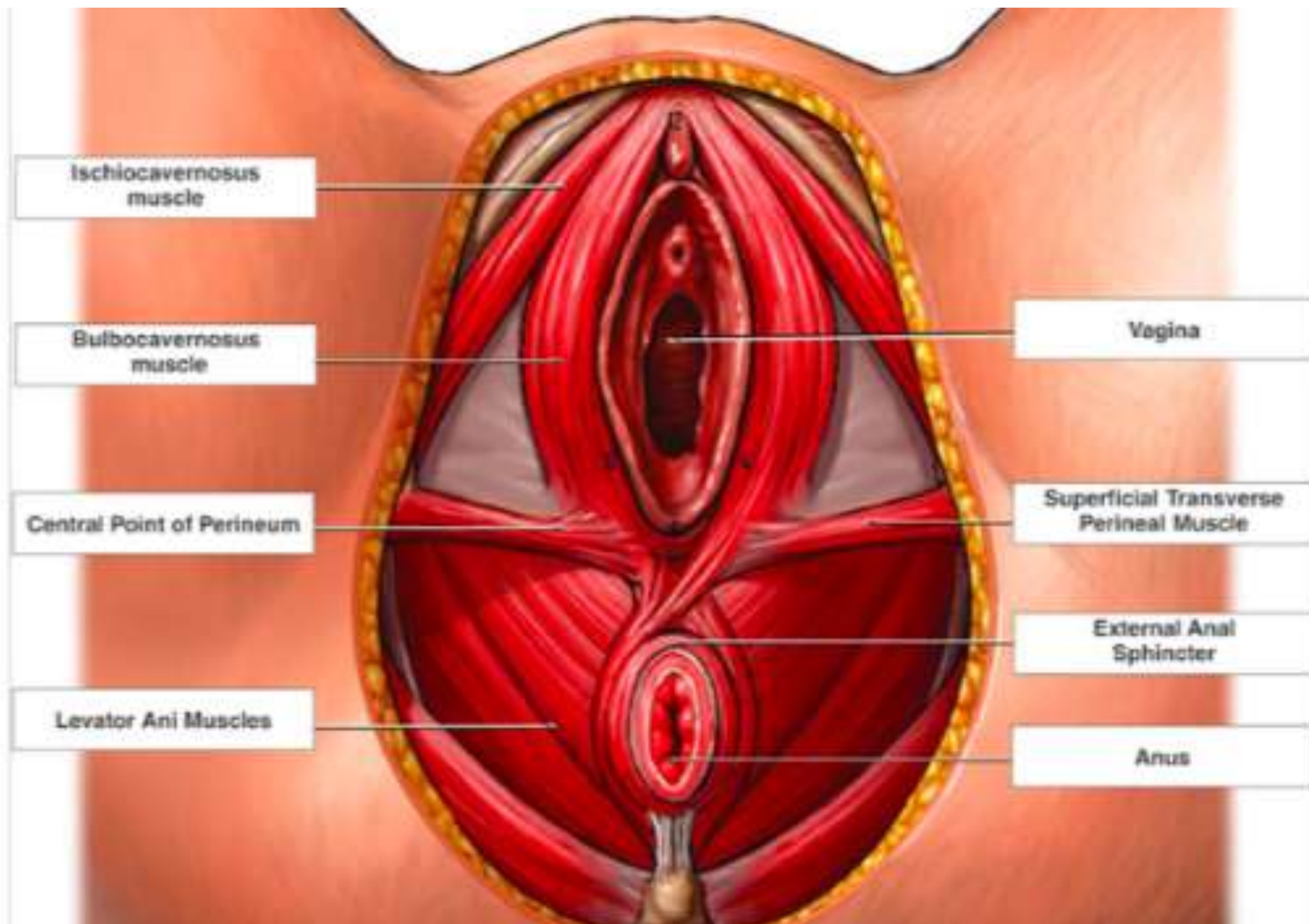
- Symptoms of other pelvic floor functional impairment
- Pelvic floor muscle spasm is defined by a constellation of symptoms that include
  - dyspareunia,
  - low back pain,
  - bowel symptoms of constipation, diarrhea, excessive flatus, painful defecation, or a sensation of incomplete evacuation,
  - and urinary symptoms of frequency, urgency, or nocturia.
- Pain on running/coughing/pain worse during the day/exertion/orgasm

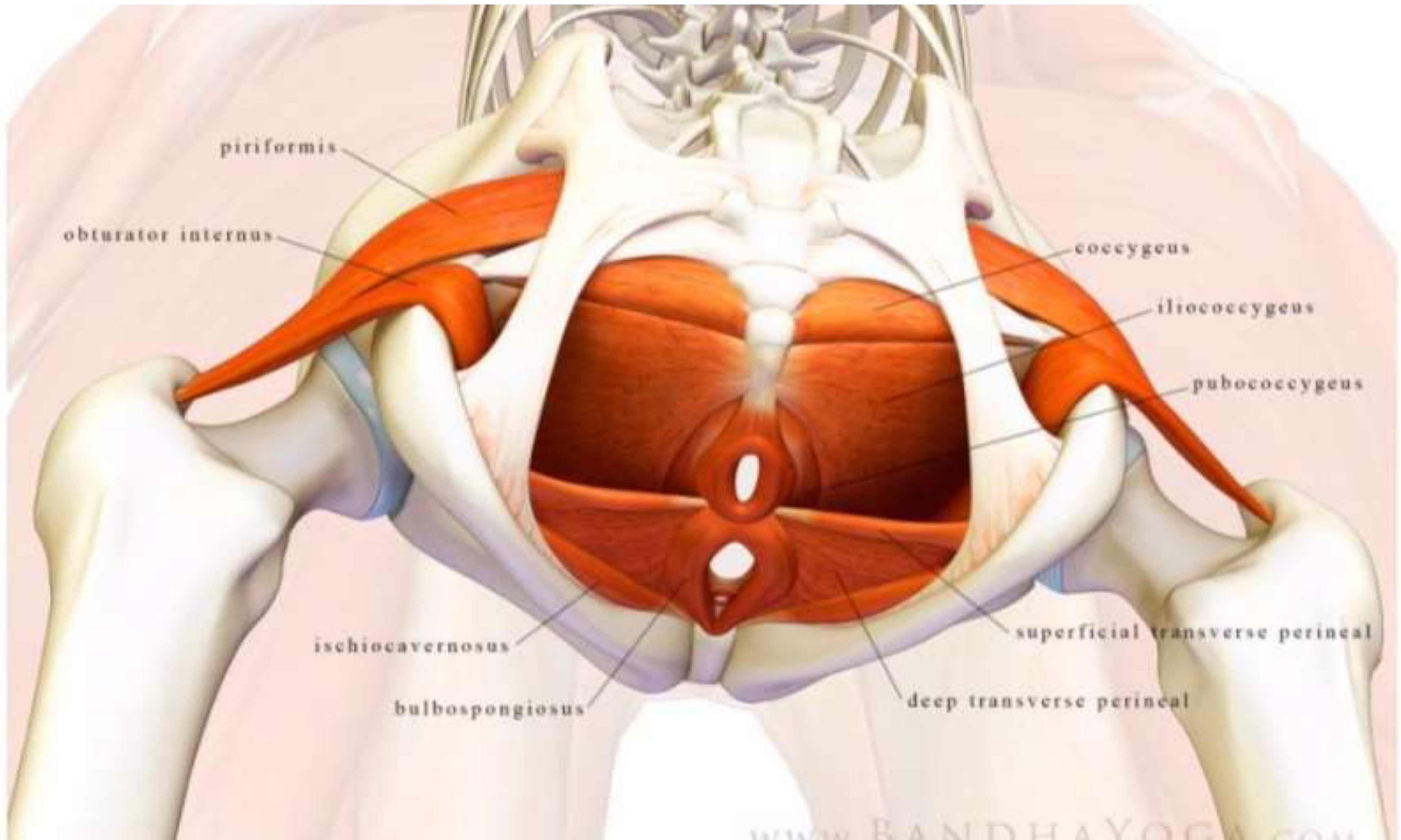
Is there a nerve based problem/ central sensitisation?

- Pudendal nerve pain
  - I can’t sit down
- Other nerve based pains
  - Burning, prickling pain
  - Sharp stinging pain
  - Hyperaesthesia “ I hate clothing or anything touching it”
  - Anaesthesia “ I can’t feel anything”
- Central sensitisation
  - Pain all over the body
  - Travelling pain
  - Scribble on a diagram all over the body

What do we need to examine for?




Ischiocavernosus muscle
Bulbocavernosus muscle
Central Point of Perineum
Levator Ani Muscles
Vagina
Superficial Transverse Perineal Muscle
External Anal Sphincter
Anus


piriformis
obturator internus
coccygeus
iliococcygeus
pubococcygeus
superficial transverse perineal
ischiocavernosus
bulbospongiosus
deep transverse perineal
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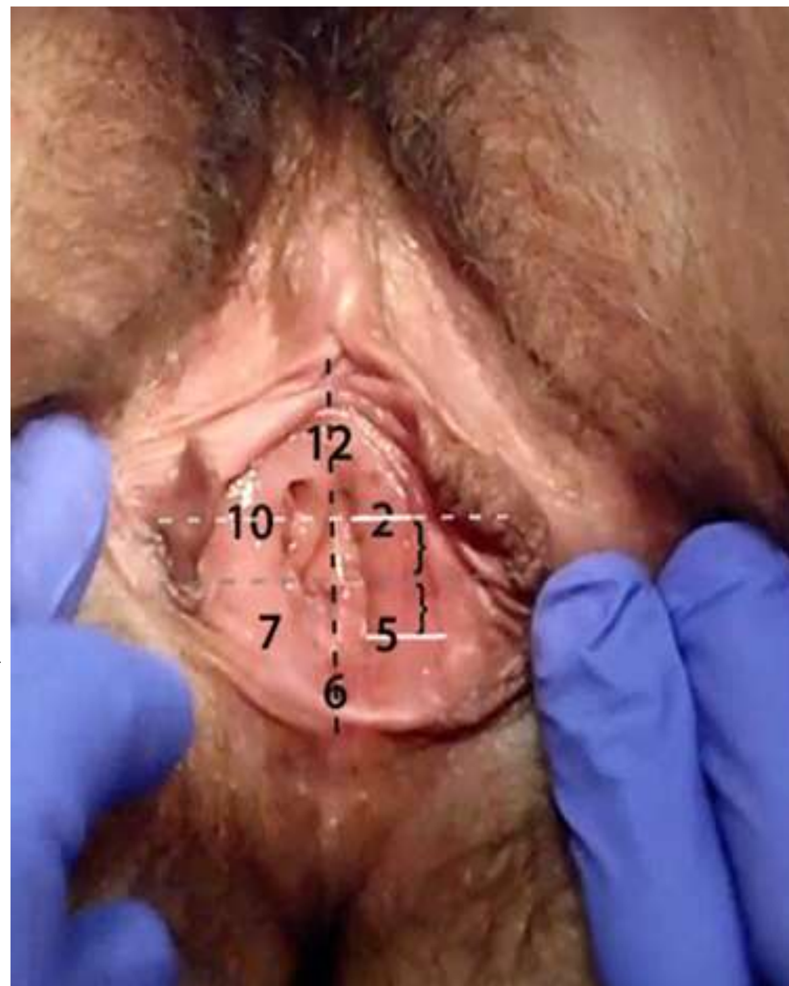
External Assessment

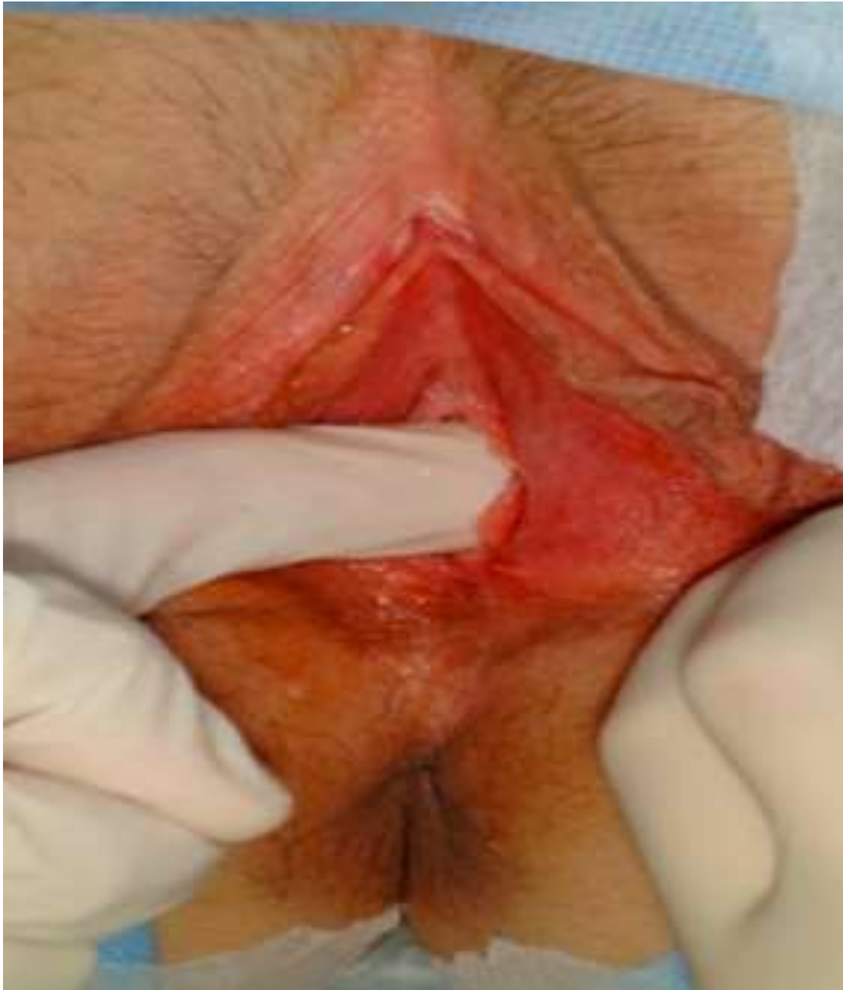
- Vaginal introitus – watch movement on request to contract / relax PFM
- Test vulvar sensitivity
  - Burning vestibular pain
  - Cotton tip test painful
- Ice cube on the leg and then vulva if not cold/hyper-cold then nerve

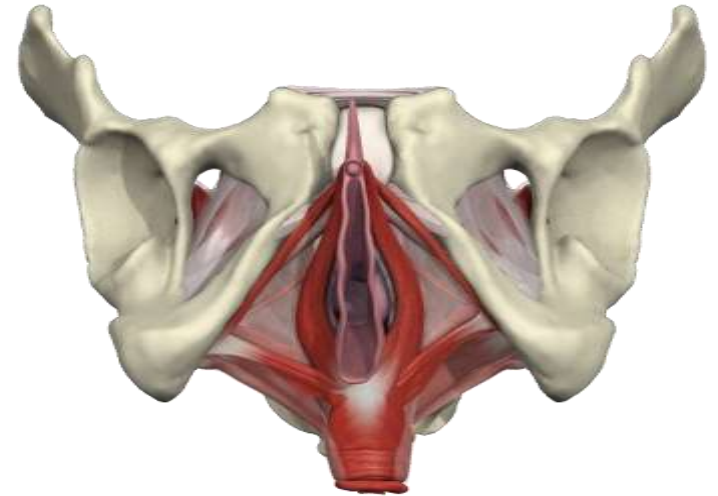


How to assess for mm

- 2 kgs of pressure
- That is when nail bed begins to blanch
- Ask every time does this cause the pain?
- Ask the patient to fully contract then relax the pelvic muscles with a finger in

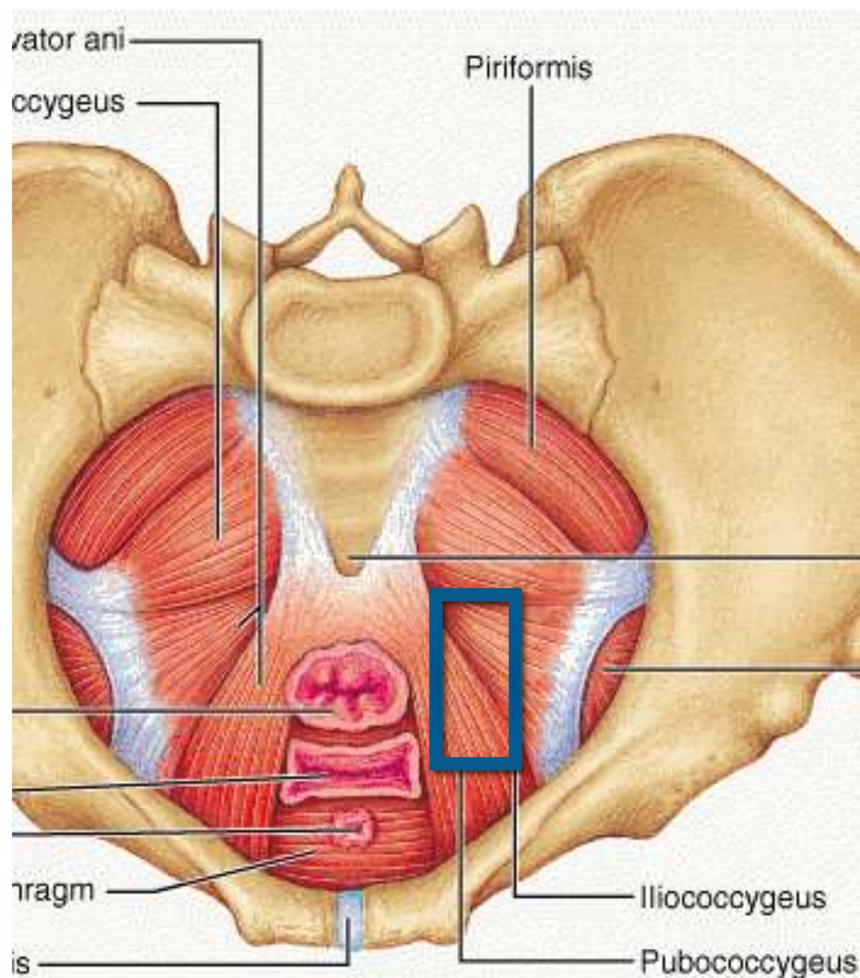
Assessing superficial PFM





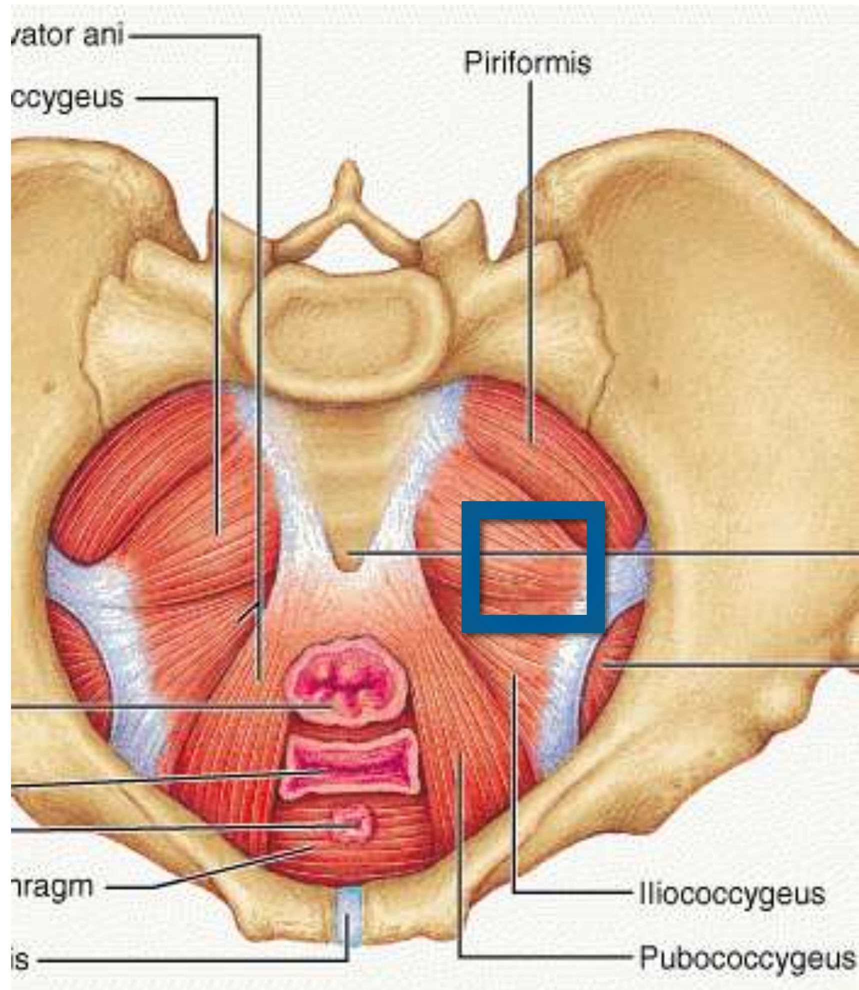
- Examine the hymenal remnant very gently, then directly beneath the hymenal remnant is the bulbospongiosis (bulbocavernosus)
- Tender ++ at
  2 and 10 o'clock

Levator ani assessment



- Then move internally and examine levator ani
- 4/5 o'clock and 7/8 o'clock which is where most commonly there are muscle trigger points. 2+ joints in.
- Spasm of a portion of the levator ani is often detected as a palpable band resembling a guitar string within the muscle or a focal trigger point.
- Contract and fully relax
- Assessing for; Increased tension, Under /overactive, Tenderness /TPs

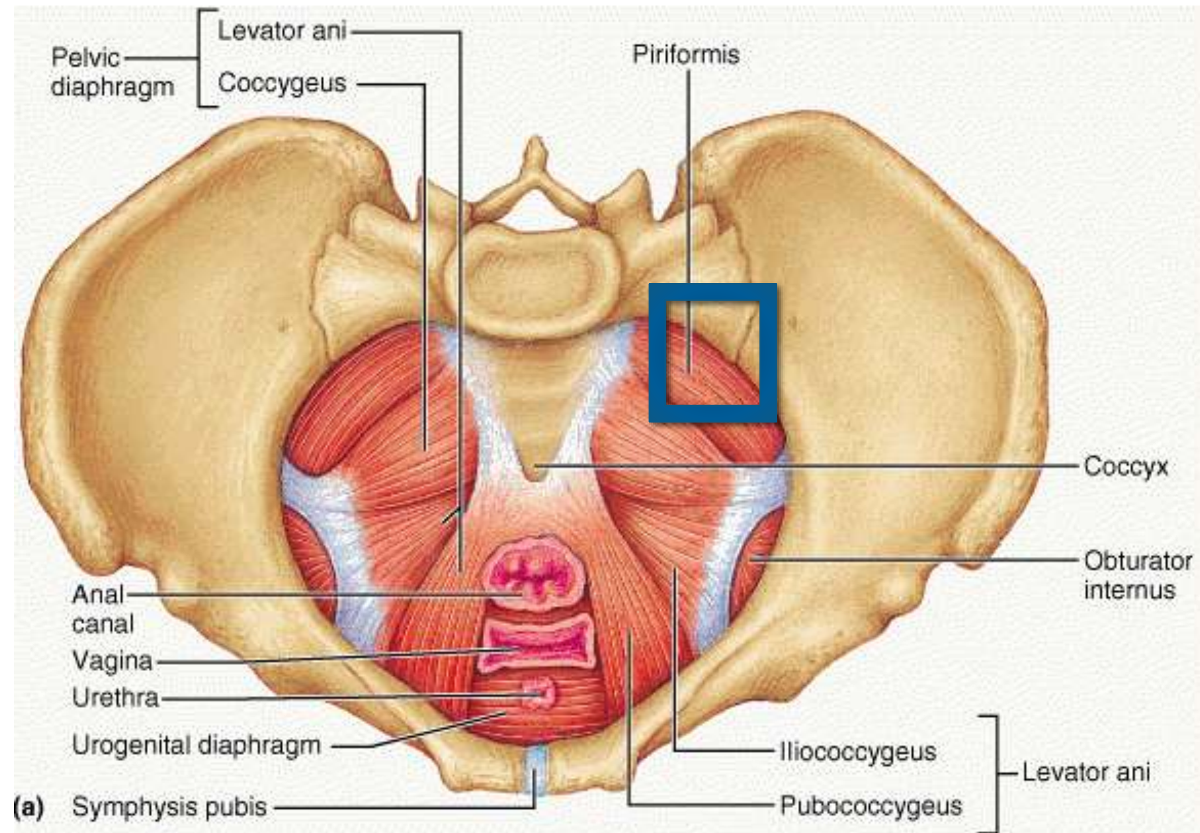
Obdurator Internus



- Sharp low abdominal pain / deep pain with sex
- 3 joints in at 2 and10 o’clock
- Palpate, lying with knees bent - resisted knee abduction - pain

Piriformis

- To examine
  for piriformis press posterolaterally and superiorly to
  the ischial spine



Who for physio?

- Patients who are likely to benefit from pelvic floor physical therapy
  - pain that is reproducible on palpation or contraction of pelvic floor, abdominal wall, or back muscles,
  - patients with significant deconditioning as a result of pain avoidance behaviors
  - Better if the patient can get there
- Really difficult if not convinced
- Not going to work if sexual abuse and not able to be examined
- Give them a **chronic disease plan**

Who to refer to?

- **Referral to a physical therapist with expertise in pelvic floor therapy for pelvic pain, as outcomes have been shown to be better with therapists with specialized expertise**

What can happen if not

- Many pelvic floor physical therapists also treat incontinence.
- **Kegel exercises can be counterproductive in a pelvic pain population**, because it elicits repetitive contraction of a chronically hyper contractile muscles.
    - Till, Sara R. Wahl, Heather N. As-Sanie, Sawsan The role of nonpharmacologic therapies in management of chronic pelvic pain: what to do when surgery fails. Current Opinion in Obstetrics and Gynecology. Volume 29(4), August 2017, p 231-239

Patient advice

- Set reasonable expectations.
- Physio commonly causes a temporary increase in muscle discomfort, similar to what one would experience with a new exercise regimen.
- This should decrease, but many patients believe that therapy is harmful or ineffective if they do not anticipate this.
- Physical therapy often involves internal (vaginal) manipulation so that this does not come as a surprise.
- They will be given home exercises and stretches, and adherence to the home therapy regimen increases the probability of long term improvement in pain

Pelvic Pain foundation of Australia

Knee to Chest Start lying on your back with both legs straight and relax. Bend one knee to your chest. Hold an easy stretch for 30 seconds and breathe deeply into your belly. Repeat the stretch with the other leg.

Knee to Opposite Shoulder Start lying flat. Bring your left knee to your chest and diagonally to the opposite shoulder. Hold an easy stretch for 30 seconds. Breathe Mindfully. Repeat the stretch with the right leg.

Take Home Message

- Dyspareunia is a muscular problem

  Until proven otherwise!

- **Physiotherapy** is the key
- There is a Tsunami of pain out there!