



## Caring for the PF after a Traumatic Birth

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# Caring for the PF after a Traumatic Birth

1. Immediate Post natal Care
2. Long term sequelae in Post Natal women wrt pelvic & perineal pain conditions

# Caring for the PF after a Traumatic Birth

## Immediate PN care

- Analgesia
- Ice fingers
  - Wrapped in wet cloth or inside clean pad
  - 10 – 15 mins
  - 2<sup>nd</sup> hrly
  - Don't sit on ice
  - Never burning
  - For pain & swelling








# Caring for the PF after a Traumatic Birth

- Positioning
  - Side lying
  - Sit on 2 rolled towels w one towel strip under each thigh
- Perineal hygiene
  - Wash w warm water x 4 – 6/ day
  - No soap

# Caring for the PF after a Traumatic Birth Bowels

- Type 4 = soft & formed
- 25 – 30 g fibre/ day
- 2.5 – 3 litres fluid / day
- Fibre supplements-
  - Metamucil, Psyllium
  - Normafibe, Benefiber
- Aperients- Normacol
- Glass hot water 1<sup>st</sup> in am
- Exercise

## The Bristol Stool Form Scale

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces ENTIRELY LIQUID

# Caring for the PF after a Traumatic Birth Bowels

- Feet on a 15 cm stool
- Knees higher than hips
- Bulge abdomen OUT
- Support stitches w toilet paper on hand or pad

Reproduced by the kind permission of Ray Addison,  
Nurse Consultant in Bladder & bowler dysfunction.  
Wendy ness colorectal nurse specialist

## Correct position



Knees higher than hips  
Lean forwards and put elbows on your knees  
Bulge out your abdomen  
Straighten your spine

# Caring for the PF after a Traumatic Birth

## Pelvic floor mm exercise

- Prevent pelvic organ prolapse
- Stop leakage of urine or flatus when you cough, lift, bend, sneeze etc
- Increase bowel control
- Help you hold on when you want to go to the toilet
- Improve sexual response
- Increase circulation
- Promote healing

# Caring for the PF after a Traumatic Birth

## Pelvic floor mm exercise

- Imagine stopping flow or holding wind
- Squeeze & lift in anus & vagina
- Hold for 3 – 5 sec , do 5 reps = 1 set ; do x 3 /day
- Progress- inc sec hold, inc reps
- Functional bracing - ie grip up **BEFORE** cough, sneeze, lift, bend & to help hold on when wanting to go to toilet (bladder & bowel)

# Caring for the PF after a Traumatic Birth

## Perineal & Pelvic pain

# Pelvic & Perineal Pain

## Obstetric background

### Preferring Elective CS

- ◆ 17 % (33) O & G<sup>^</sup>
- ◆ 7 – 24% O & G \*
- ◆ 4.4 % midwives \*
- ◆ 45.5 % *urogynae* #

<sup>^</sup>*Al-Mufti R 97* ; \**MacDonald C et al 02*; \**Wright et al JB 01*;  
\**McGurgan et al 01*; #*Wu JM et al 05*

# Pelvic & Perineal Pain

## Reasons for Preferring CS

- ❖ 80 – 93 % perineal injury
- ❖ 83 % anal injury
- ❖ 81 % urinary incontinence
- ❖ 58 % sexual dysfunction
- ◆ 24 – 39 % foetal injury
- ◆ 17 – 39 % convenience
- ◆ 27 % fear
- ◆ 7 % pain

*MacDonald C et al 02; Wright et al JB 01; McGurgan et al 01; Wu JM et al 05*

# Pelvic & Perineal Pain

- ◆ Dissatisfaction w sexual Fn 12/12 aft birth assoc w not BEING sexually active at 12/40 (x 11 higher chance) & assoc w older mat age at delivery
- ◆ Satisfaction not assoc w CS
- ◆ Women X 5 less likely to be sexually active aft 3<sup>rd</sup> / 4<sup>th</sup> degree tear *Van Brummen et al 2006*
- ◆ Assoc btw AVD : perineal pain & dyspareunia *Hicks et al 2004*

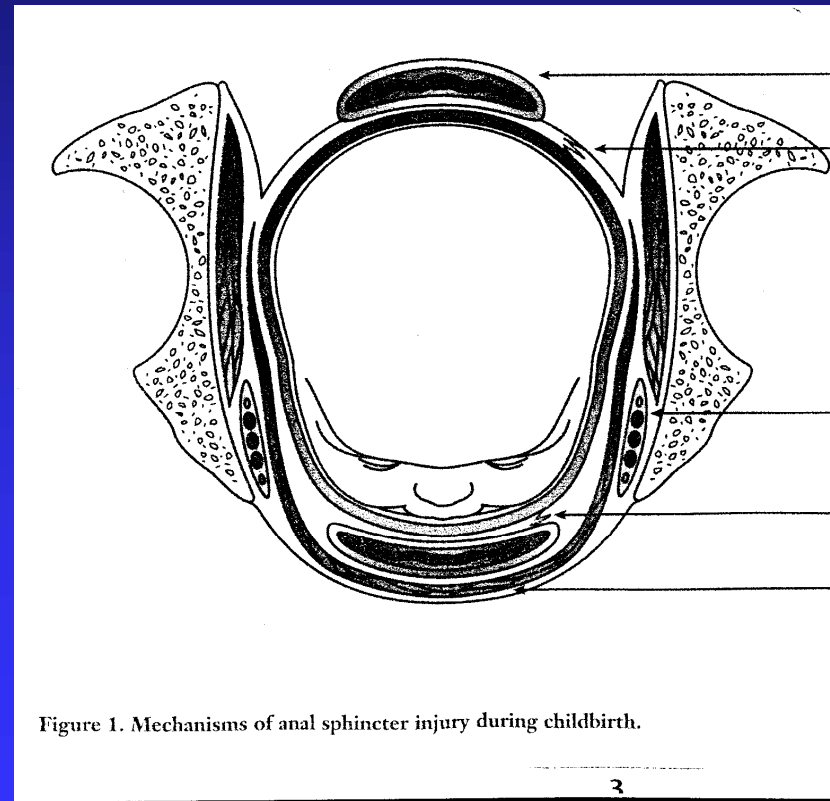
# Pelvic & Perineal Pain

## Obstetric Contributing factors

- Pelvic or perineal pathology e.g.
  - *Endometriosis* (usually dec pain in preg & BF); if adhesions – worsening of pain in preg
  - *Scar fibrosis -episiotomy, perineal tear scar*
  - *Taut fourchette*
- Trauma – physical e.g.
  - *# (coccyx in delivery) – coccydynia*
  - *Child birth, haemorrhoidectomy*; anal fissure due to constipation
- Hormonal changes – atrophic vaginitis due to low oestrogen in pregnancy & BF; years without E2
- E2 = pink, moist, elastic, well vascularised

# Pelvic & Perineal Pain

Obstetric neuropathy =  
compression of contents  
of pudendal canal against  
pelvic side wall -> traction injury  
during foetal descent ->  
? Pudendal Neuralgia =  
pain in distribution of  
pudendal nerve, ie anus,  
perineum, vagina, labia, clitoris  
and beyond



# Pelvic & Perineal Pain

## Pudendal Neuralgia

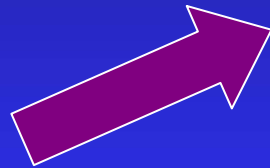
- Pain = burning, painful cold sensation, electric shock
- Pain assoc w : p & n; stinging; numbness; itching
- Other: sexual arousal syndrome – unpleasant, inappropriate; pain worse in sitting, better on toilet seat; worse during course of day, improved or nil pain at night

# Pelvic & Perineal Pain



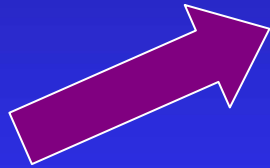
PFM dysfunction  
i.e., over contraction

# Background - PFM contraction



# Background - PFM relaxation

Background - Failure of Relaxation PFM =  
PFM over activity



# Background

## PFM over activity : Sequelae for PFM

- Short, tight, tense, bulky, myalgia PFM
- Overloaded PFM
- Myofascial trigger points (MFTP) -> local pain in PFM and / or ref pain to LS, abdomen, perineum, pelvis, rectum, labia
- Urethral, vag or anal pain & symptoms via PFM compression
- Increased bulk of PFM -> decreased vag capacity AP & lat
- Decreased (n) ROM, decreased CHRS ability  
-> decreased vag fn

# Background

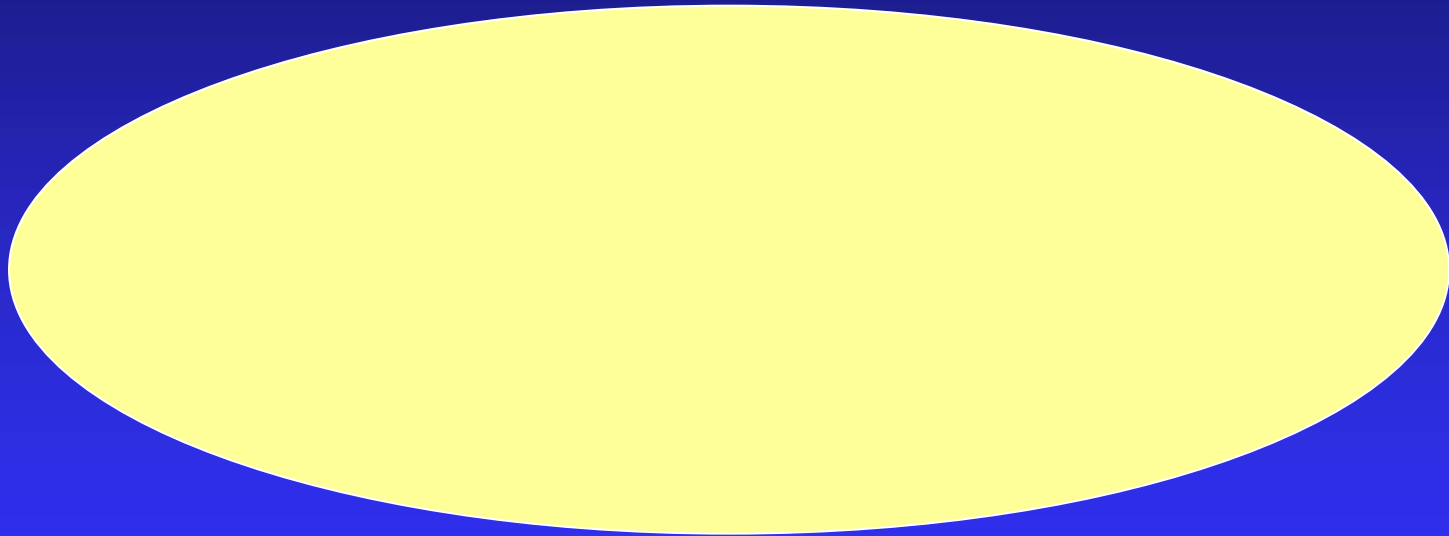
## PFM over activity : Sequelae

- Obstructed defaecation - puborectalis syndrome; dec evacuation
- Obstructed voiding - interrupted stream, straining, residuals, retention, overflow , UTIs, freq, urgency
- Decreased vaginal function –
  - Intercourse – dyspareunia, vaginismus, apareunia
  - Tampons, Pap smears
  - VEs, vaginal US, dilators
- Pudendal Nerve – neuralgia/ entrapment of PN via compression in Alcock's canal
- Associated psychological issues

# Background

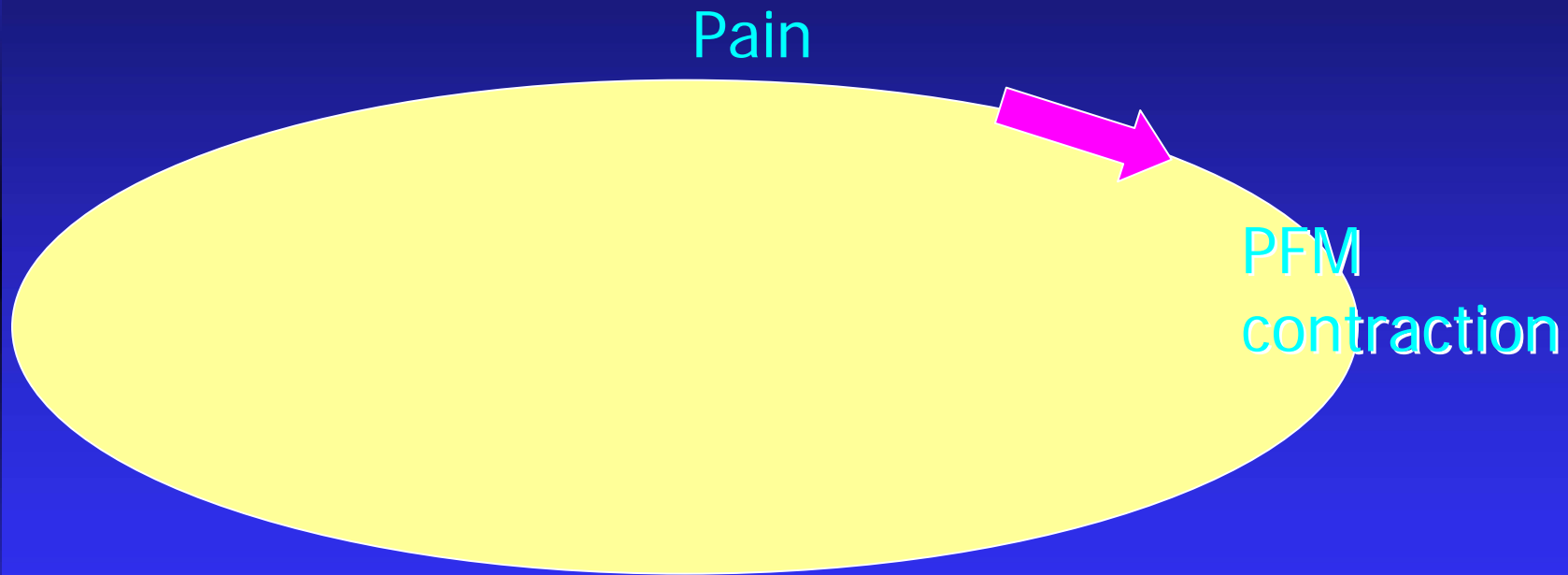
Pain & Pelvic Floor Muscle (PFM) over  
activity

Pain



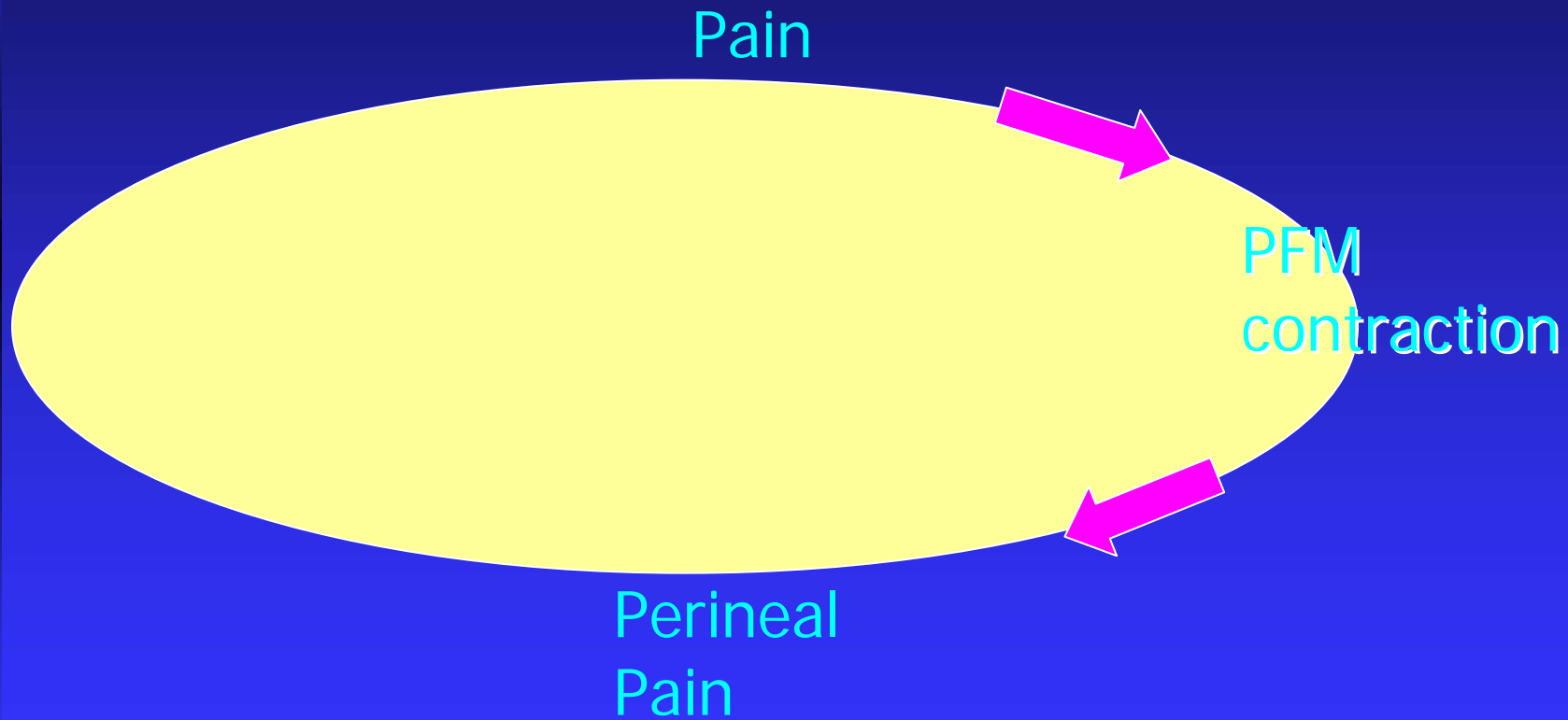
# Background

Pain & Pelvic Floor Muscle (PFM) over activity



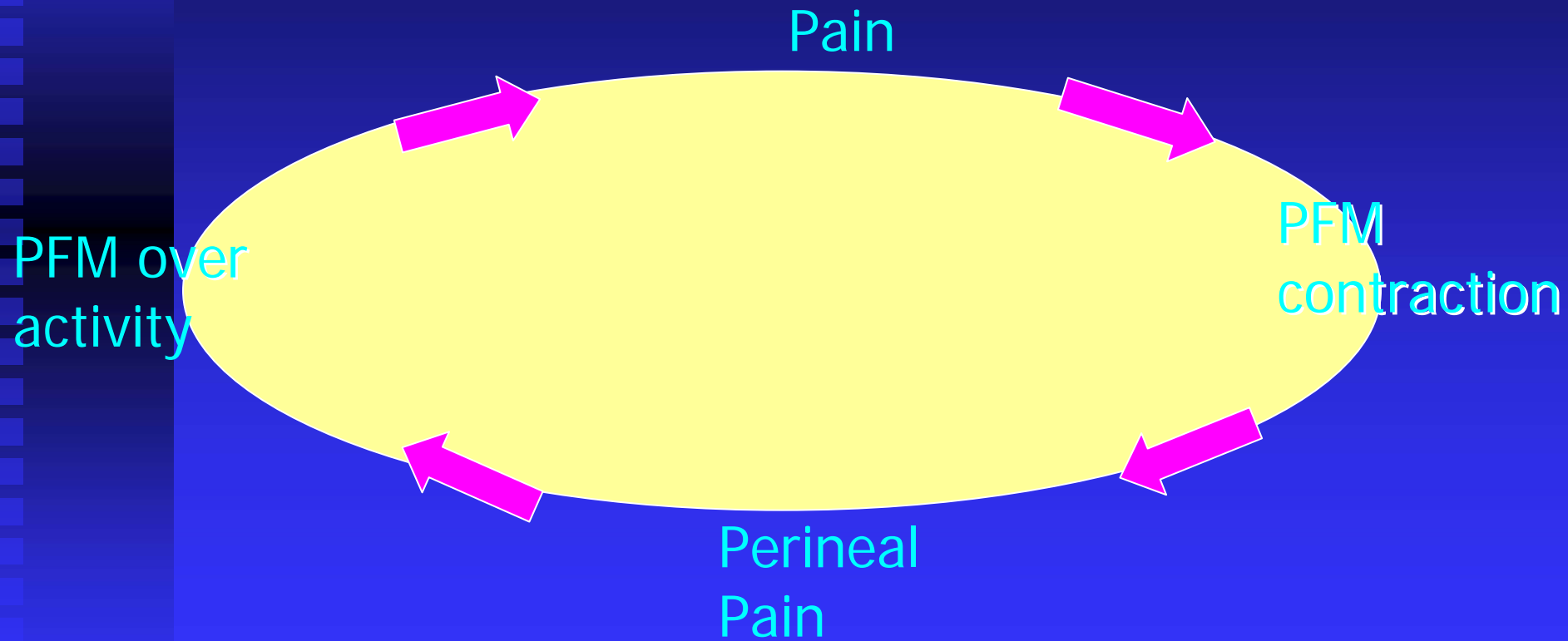
# Background

Pain & Pelvic Floor Muscle (PFM) over activity



# Background

Pain & Pelvic Floor Muscle (PFM) over activity



# Background

## Pain & Pelvic Floor Muscle (PFM) over activity

Pain / anticipation of Pain ->

Avoidance ->

Issues

# Pelvic & Perineal Pain

## Aims of management



# Pelvic & Perineal Pain

## Aims of management

- Decrease pain via elimination noxious stimulus
- Decrease PFM over activity, myalgia, MFTP
- Decrease pressure in Alcock's canal
- Pudendal nerve protection
- Address bladder, bowel, vaginal function or sexual issues as appropriate
- General exercise advice
- Give self management strategies
- Other- posture, MS, techniques for penetration
- Team work !!

# Pelvic & Perineal Pain - Assessment

## OPQRST – ASPN System

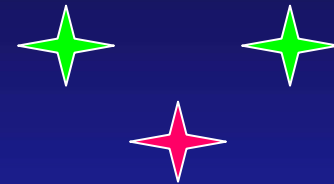
- Onset
- Provocation
- Region / Radiation
- Severity
- Time - eg night or day
- Associated Symptoms
- Pertinent Negatives
  
- +surgical, O & G history, meds, past Rx, trauma/issues

# Assessment

## Other symptoms

- Dysmenorrhoea
- Dyspareunia, a pareunia, "vaginismus"
- NMPP,
- Dyschezia
- Sexual dysfunction
- Bowel - Constipation & straining; obstruction; IBS
- Bladder –, voiding, urgency, dysuria, terminal dysuria

# PFM palpation



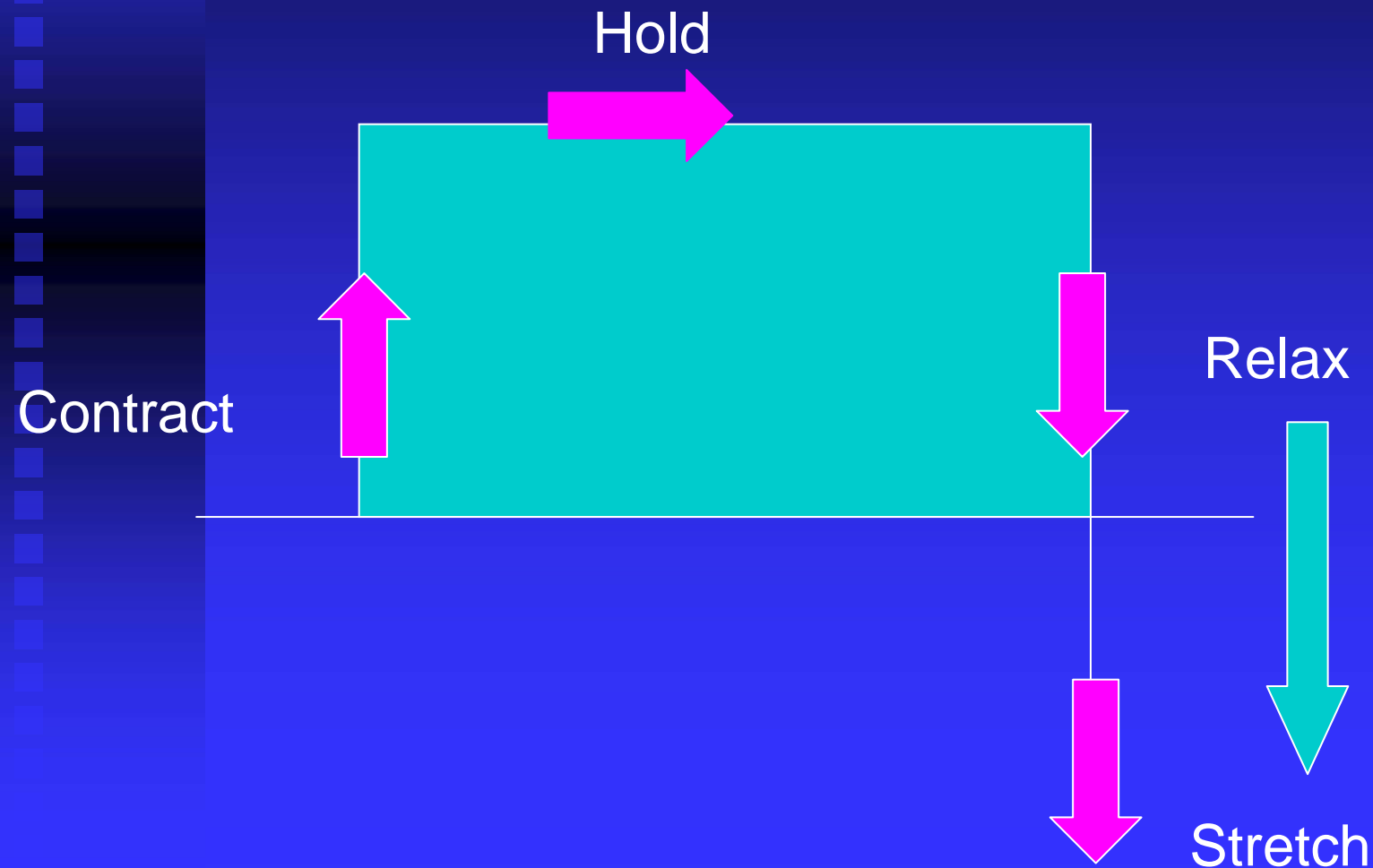
- Presence, location & type of pain in vagina
- Myalgia, over activity, trigger points, mm bulk ?
- Reproduce pt's pain?
  - Superficial perineal mms (PV, perineum)
  - Puborectalis (PR mm) esp at 6 o'clock
  - Pubococcygeus (PC mm) & PR mm from attachment to insertion
  - Palpate & evaluate PR & PC mms: at rest, contract, hold, relax & stretch i.e. normal physiological properties of voluntary skeletal mm
  - Symmetry, compare (L) w (R)

## Rx - education re voluntary mm

- Education re (n) physiology of skeletal mm, (n) A & P, feel own thenar eminence CHR
- Education re results of over-contraction of PFM
- Voluntary mm
- Cw biceps, hamstrings etc
- Hamstring stretches to “burning” as reference point

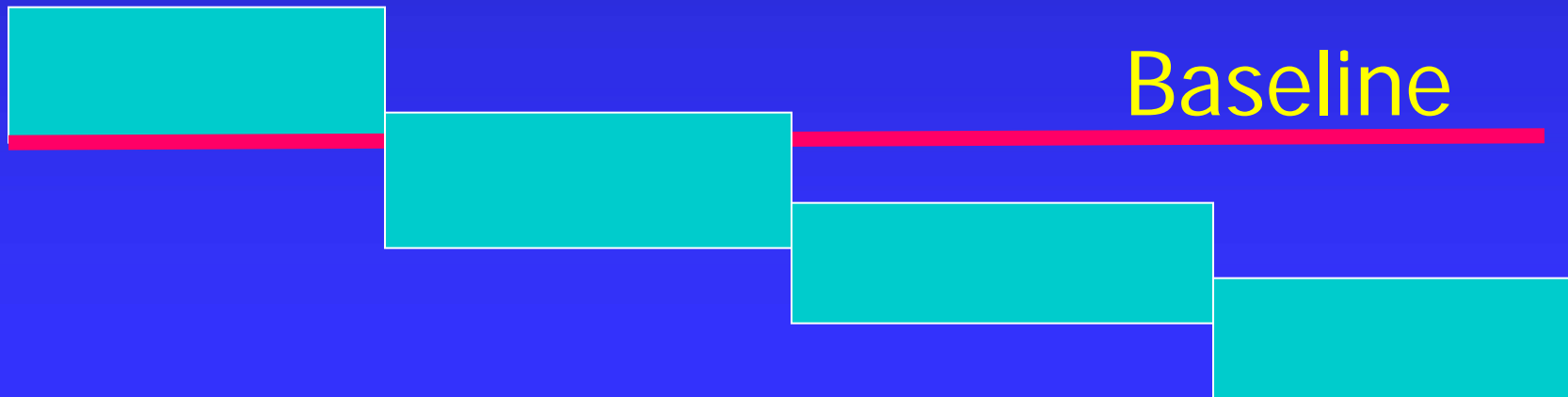
Rx – education.

PFM = Voluntary Skeletal mm



## Rx - "Down training" PFM

- Down training PFM via Contract-Hold-RELAX (CHR) exercises +/- abdo bulge +/- stretch w thumb or dialtor +/- MFTP Rx
- Role PFMC in maintaining pain & benefit of PFM CHR exs in decreasing pain



Rx: Stretches- manual or w dilator



# Rx: EMG biofeedback

Channel1 - Vaginal EMG [uV]

Channel2 - Abdominal EMG [uV]

EMG Diagnosis					
Sensor	Channel1 [uV]	<input checked="" type="radio"/> Vagina	<input type="radio"/> Anus		
Placement	Channel2 [uV]	<input checked="" type="radio"/> Abdomen	<input type="radio"/> Non-use		
Measurement Protocol	<input checked="" type="radio"/> For Contraction		<input type="radio"/> For Relaxation		
		<input checked="" type="radio"/> Channel1	<input type="radio"/> Channel2		
Step	Parameter	Amplitude [uV]		Duration [s]	
		First	Present	First	Present
1	<input checked="" type="radio"/> OFFSET		2.6		
2	<input type="radio"/> PEAK		2.2		
3	<input type="radio"/> 5sec		2.1		0.3
4	<input type="radio"/> 10sec		1.9		1.4
5	<input type="radio"/> 15sec		1.9		1.2
6	<input type="radio"/> 20sec		2.1		0.5
7	<input type="radio"/> 25sec		2.2		0.3

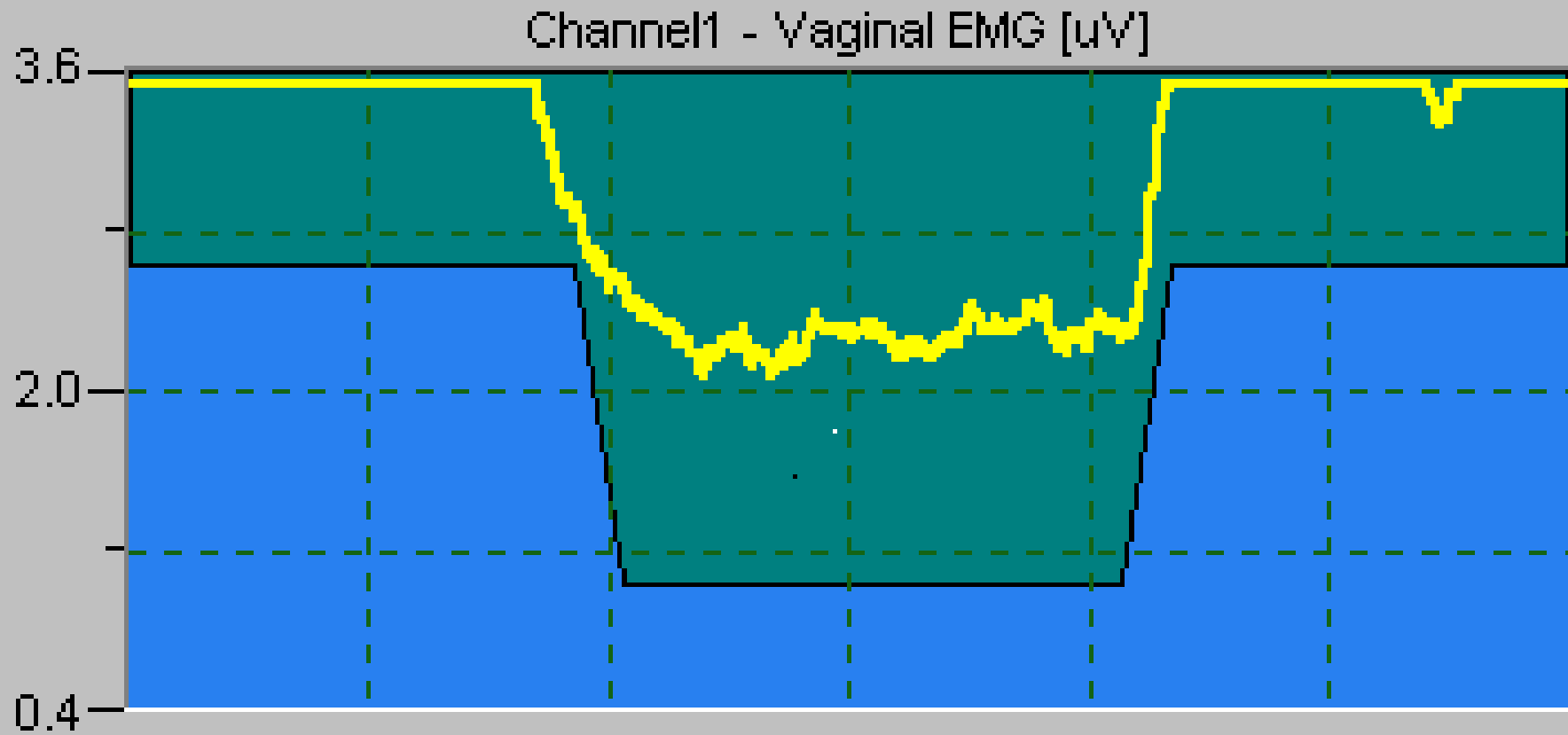
Vagina

Amplitude [uV]	Duration [s]

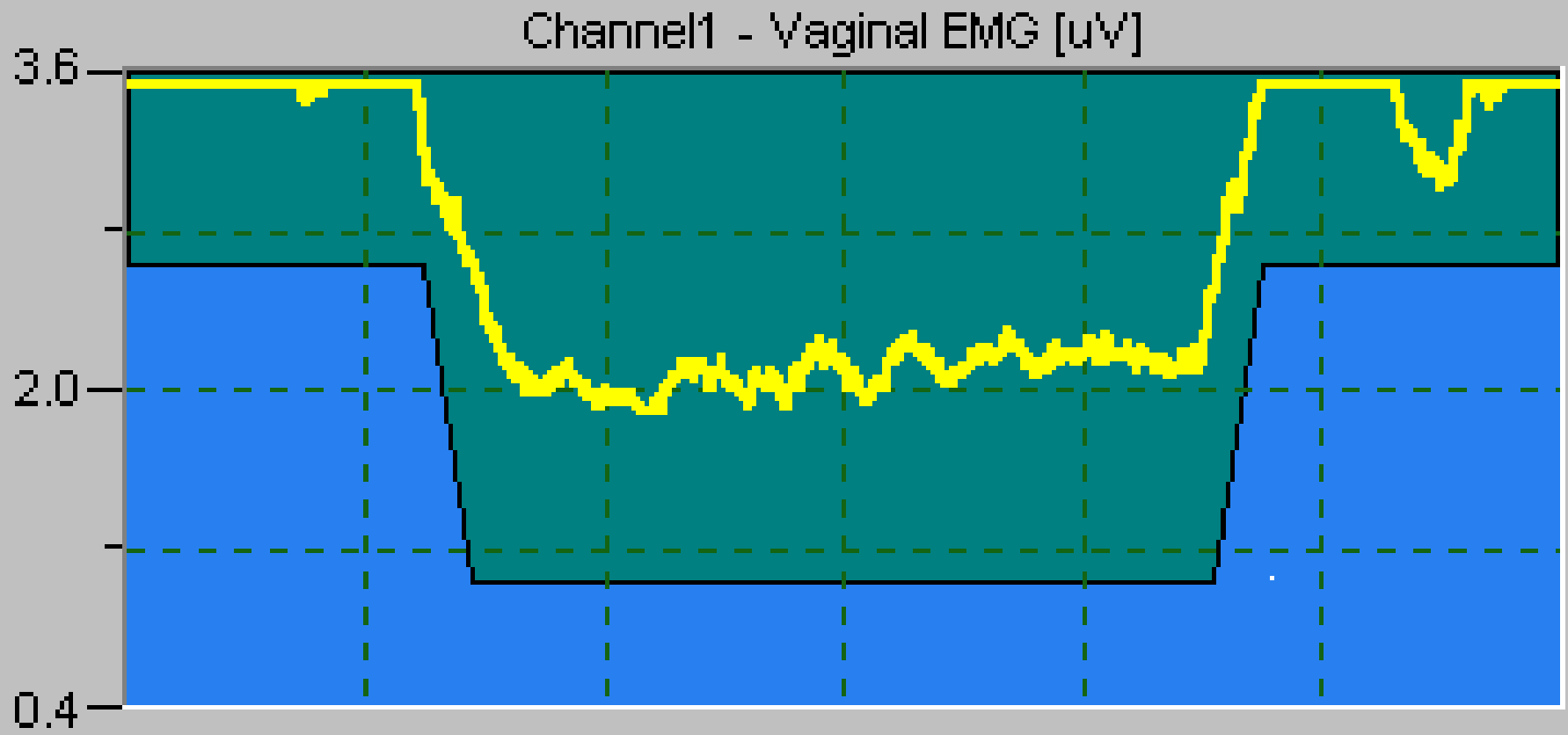
Abdomen

Amplitude [uV]	Duration [s]

# Rx : EMG biofeedback



# Rx : EMG biofeedback



## Rx: Techniques for penetration

- SI, tampons, VE, US, Pap smear, dilator
- Techniques for penetration:
  - Jaw relaxed
  - Hands relaxed
  - Breathing - exhale "O" shaped mouth
  - Very slowly, in stages, 1cm @ a time, with ea exhale or each relax of CHR ex

## Treatment: Other

- Vulval skin care
- Appropriate lubricants
- Trigger point therapy, MF releases
- Medications- Endep, Lyrica, Botox, E2
- Gen ex advice: Nerve protection - dec sitting; no straining, abs, sit ups, rowing, cycling
- Posture; other musculo-skeletal Rx; acupuncture, massage
- Research