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Bladder Pain Syndrome

A Guide for Clinicians

 Springer

Chapter 20

Physiotherapy

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Introduction

Traditionally in urology, the term pelvic floor dysfunction has referred to low-tone or laxity. The majority of research has focused on proper diagnosis and treatment of lax pelvic floor muscles (PFM) and resultant disorders such as pelvic organ prolapse and incontinence. Physiotherapist-based treatment has been demonstrated to be effective for urinary incontinence via pelvic floor strengthening (1,2) and physiotherapy is a mainstay of the treatment of urinary stress incontinence (3)

More recently, clinicians have recognized the hypertonic pelvic floor and its relationship to Interstitial Cystitis/Bladder Pain Syndrome (IC/BPS). As with low-tone pelvic floor dysfunction, clinicians rely on collaboration with physiotherapists to treat high-tone dysfunction and the other musculoskeletal abnormalities that accompany IC/BPS. The Bladder Pain Syndrome International Consultation on Incontinence recommends a referring IC/BPS patients to physiotherapists or a physiotherapist as first-line therapy(4).

In 2005, the International Continence Society developed the term Overactive Pelvic Floor Muscles (OPFM). This is defined as: “a situation in which the pelvic floor muscles do not relax or may even contract when relaxation is functionally needed, for example during micturition or defecation. This condition is based on symptoms such as voiding problems, obstructed defecation, or dyspareunia and on signs like the absence of voluntary pelvic floor muscles “(5). A variety of terms have been used for this condition in the last 30 years. More recently, OPFM has also been described as high-tone pelvic floor dysfunction (6), short pelvic floor (7), and pelvic floor hypertonic disorder (8).

There has also been a developing body of literature focusing on treatment of the pelvic floor of male patients with Chronic Prostatitis/Chronic Pelvic Pain Syndrome (CP/CPPS). Both IC/BPS and CP/CPPS are conditions with similar patient symptoms and proposed similar pathophysiology. Due to the lack of differentiating criteria, IC/BPS and CP/CPPS recently has been combined and described as Urologic Chronic Pelvic Pain Syndromes (UCPPS) in recent literature and research. Therefore, UCPPS may be used in this chapter, when referring to both conditions.

Prevalence

There is extensive descriptive literature regarding the abnormalities detected in the PFM and the pelvic girdle of IC/PBS the patient but there is limited research its prevalence . Lack of common terminology across disciplines and lack of validated