Pelvic PT Telehealth Assessment and Treatment - Assessment of the PFM

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Assuming people already have PFM knowledge
Assessment / evaluation / treatment – starting with PFM assessment – mining the data, detective
Very most important - must be able to recognize the symptoms (what the patent says) that lead you to the possibility they may have increased activity in the PFM or a decreased ability to relax the PFM

How to evaluate the PFM through telehealth
Gold standard is vaginal / rectal palpation, EMG and or US
Goal is to restore normal PFM function in both contract and relaxation

- Elevate PFM with contraction
- Decent PFM with relaxation and bearing down

Patient report of symptoms can lead you to the status of the PFM - listen to the patient, ask loads of questions

Patient I stated this week on telehealth

- MUI – mostly urgency
- Hx – IBS, Fibro, HA, GERD, poor sleep, sever pain after a hemorrhoid surgery 9 years ago
- Soc – teacher with increased stress at work
- During stress patient noted HA, increased tension and restricted breathing

- PFDI
- No pad use – changes undees 4 times per week
- Most UI is on walk to BR with urge
- SUI with jump and cough

- UIQ
- No influence of bladder on work, entertainment, exercise
- Moderate frustration

- Bowel – soft but sometimes hard to pass

- This patient has a sensitive nervous system – would do CS inventory
- Suspect increased PFM tone and need for relaxation
- Patient was given a measured bladder dairy, encouragement to increase relaxation and do some aerobic exercise

How do you "test" the PFM in telehealth – 40 to 60% of patients can do a correct PFM contraction with verbal instruction (could be even higher with self-assessment). Also ask patient to notice tenderness in any area and to make notes about that

Sitting – I would ask the patient to feel the pressure of the perineum on the chair (some use the corner of the treatment table or something similar at home), use a model to show the location of the PFM

- Female – "hold back gas" should result in movement of the perineum up toward the head (elevation)
- Male – "shorten the penis" "hold back pee"
- Can they feel the perineum elevate away from the chair (male the movement of the penis)
- Also when you bear down as if moving the bowel, can you feel the perineum go toward the chair

Visual feedback – mirror

- Female – look at the perineal body in a mirror (lying down) – watch it move in toward the head with contraction and down to feet with relaxation
- Male – watch the penis move up (standing).
- It is very small movement

Self-palpation (could suggest the patient self palpate while they are with you and describe what they feel, I would not have the patient with their perineum on camera)

- Female
  - lightly touch the perineal body on the outside, feel for movement up toward head
  - Place finger inside vaginal, touch a side wall, feel for elevation
- Male
  - Lightly touch at pubic bone near dorsal start of penis, beside penis
  - Press firmly on the perineal body between penis and testicles, should feel PFM press into your finger
  - Gentle traction on penis and feel it pull back on contraction

Watch the patient doing a PFM contraction – sitting or standing usually

- Watch for overflow movements – legs, abdomen, shoulders, eyes, jaw
- Breathing holding
- Overall posture

<u>PFM treatment</u>

Bladder training – toilet position, fluid intake, urge suppression

Strength training

- Start with very short contractions
  - 3 to 4 seconds contraction, 10 seconds relaxation, 10 to 15 reps, lying down?
  - Technique is key – sub max might be best first
- At second session
  - If the patient is still very confused, provide other information through telehealth and get patient into clinic
  - If you feel fairly sure they do not have increased tone, try overflow exercises – plank and bird dog are safest. Make sure they are not bearing down – watch them do the exercises
  - If symptoms are improved and patient reports they feel pretty go about the exercises – gradually increase PFMT as usual

Relaxation training – must individualize

- Diaphragm breathing
- Bowel function – toilet position, bearing down technique, consistency of BM (food and OTC)
- Trunk and leg stretches
- Pain education – can be used for urgency also, https://www.bethshelly.com/online-and-distance-learning.html#pelvic
- Aerobic exercise for release of endorphins
- Sitting posture (and more)
- Correct fluid in and correct bladder pattern (visero – visceral convergence
- Anti-Kegel – small contract with big relaxation for the purpose of relaxing better
- Self vaginal massage - tool

References for remote treatment of SUI

Conlan L, Thompson J, Fary R. An exploration of the efficacy of telehealth in the assessment and management of stress urinary incontinence among women in rural locations. Aus and NZ Continence Jnl, Spring 2016, Vol 22 No3, pp 58-64.

Sjostrom M, et al. Internet-based treatment of stress urinary incontinence: a randomised controlled study with focus on pelvic floor muscle training. BJU 2013;112(3):362-372.

Sjostrom M, et al. Internet-based treatment of stress urinary incontinence: 1 and 2 years results of a randomised control trial with focus on pelvic floor muscle training. BJU Int 2015;116(6):955-964.

Barbato KA, et al. Web-based treatment for women with stress urinary incontinence. Urol Nurs 2014;34(5):252-257.

PFM telehealth – 5 week post prostatectomy
Patient has been seen twice in the office with EMG biofeedback training of PFM.
Started session with review of lifting restrictions, how much walking for exercise he is doing and how his previous LBP is (now better because he changed his PFM exercise technique after our last in office session).
Patient then described his PFMT – "I take a deep breath in, lift my chest up and pull my belly in and my pelvic out". I hope your antenna is going up (and it would even more if you saw him demonstrate this). There is a lot to change here and I am not going to go into it all but you know I changed his breathing, abdominal and PFM technique.
I described in detail – keep breathing, do not move the chest, do not pull the belly in tight, never normal to have "pelvis out", shorten the penis and lift the rectum.
In the end the patient stood in my full view and I counted out for him a 10 second max squeeze and a 60 second submax squeeze. He said he could feel the penile retraction and rectal lift (this is not my focus but he seems to need it). There was some further discussion of submax hold during walking.
As a board certified PFM EMG therapist I greatly value the input the EMG and imaging ultrasound (just got a new DP50 in my office less than a month ago) gives me and my patients. However, I do believe we can give good instruction through a video feed.

PFM telehealth - 19 yo vaganismus
19 yo female with vaginismus, seen in the office once last week. Taught PFM relaxation with contract relax. Mild symptoms.
Today in telehealth - Patient notes decreased symptoms with decreased stress (less responsibility and more time to relax at home) and gabapentin. Bladder dairy was explained to patient (and emailed after the session) for her to complete. Patient was encouraged to keep her bladder and bowel calm (she has IBS-D) as much as possible to decrease the irritated signals in the pelvis. Diaphragm breathing was described and practiced with the patient in sitting. She can feel the perineum descent toward the chair with diaphragm inhale.
Patient was given the workbook "Why do I Hurt?" while in the clinic last week and has read some. Therapeutic neuroscience education given using the chapters she has reviewed. This progressed into discussion of the vaginal dilators how they are used and what they do (with and without EMG). Patient feels confident she can do some dilator training on her own and was given resources to buy them on line.
I will do another telehealth session in 2 weeks with the understanding she is to contact me if her symptoms increase. This is a mild case and the patient is still having intercourse.

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