Chronic Pelvic Pain

A PHYSIOTHERAPIST PERSPECTIVE

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PELVIC PAIN -EPIDEMIOLOGY

- 15-25% of Australian women have chronic pelvic pain
- 1 in 7 women have endometriosis (14%)
- Average 6.5 years to diagnosis of endometriosis
- Fertility problems
- Time off work
- LOST PRODUCTIVITY!

On International Women's Day, Bindi Irwin re 10-year struggle with endometriosis

By Josh Dye | ABC Sunshine Coast | Endometriosis

Wed 8 Mar 2023

Bindi Irwin is urging women "quietly dealing with pain" to "keep searching for answers". *(Instagram: @bindisueirwin)*

PAIN DEFINITION

What is ***pain***?

International Association for the Study of Pain 2020

PAIN DEFINITION…

"An unpleasant sensory and emotional experience

associated with, or resembling that associated with,

actual or potential tissue damage"

(International Association for the Study of Pain 2020)

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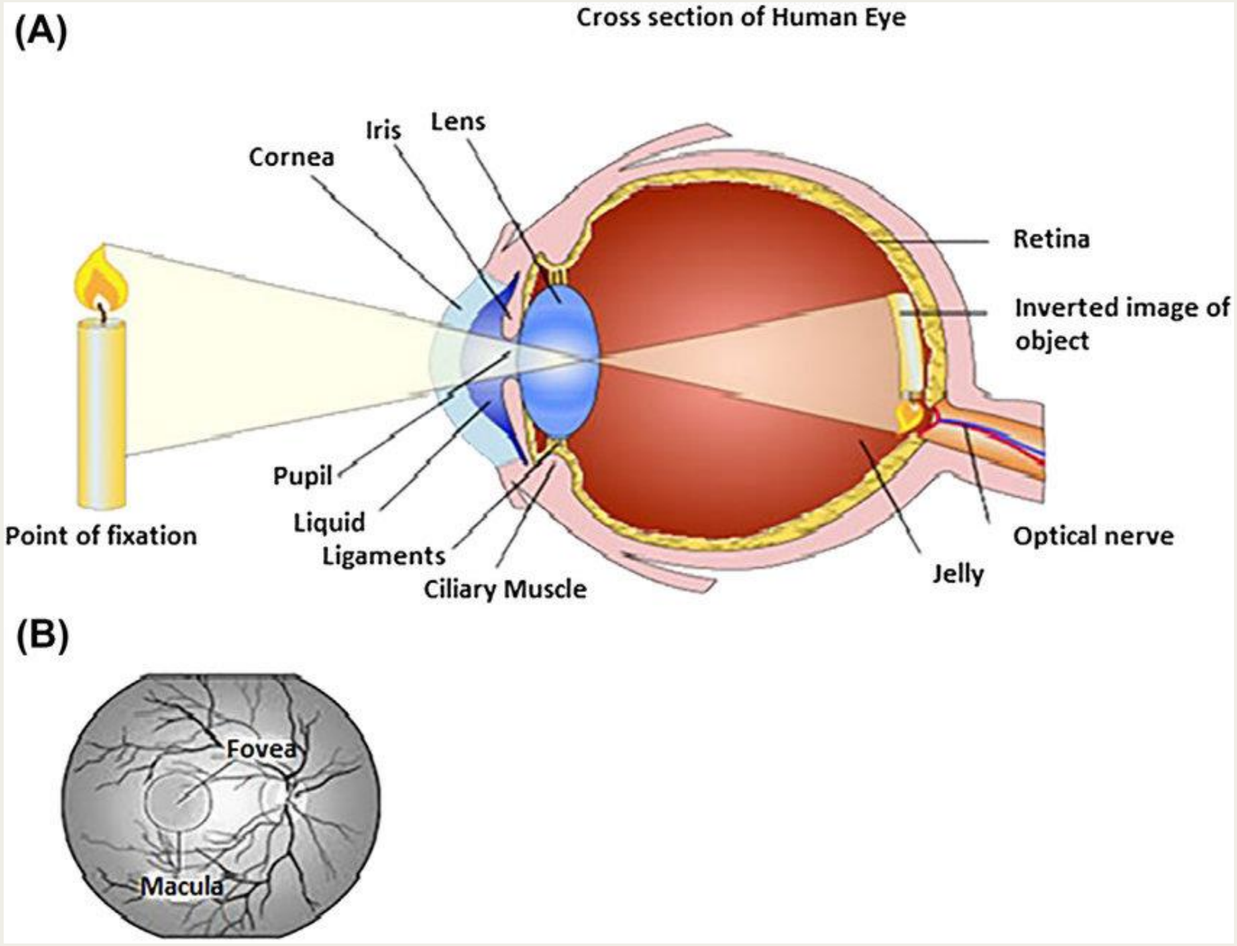
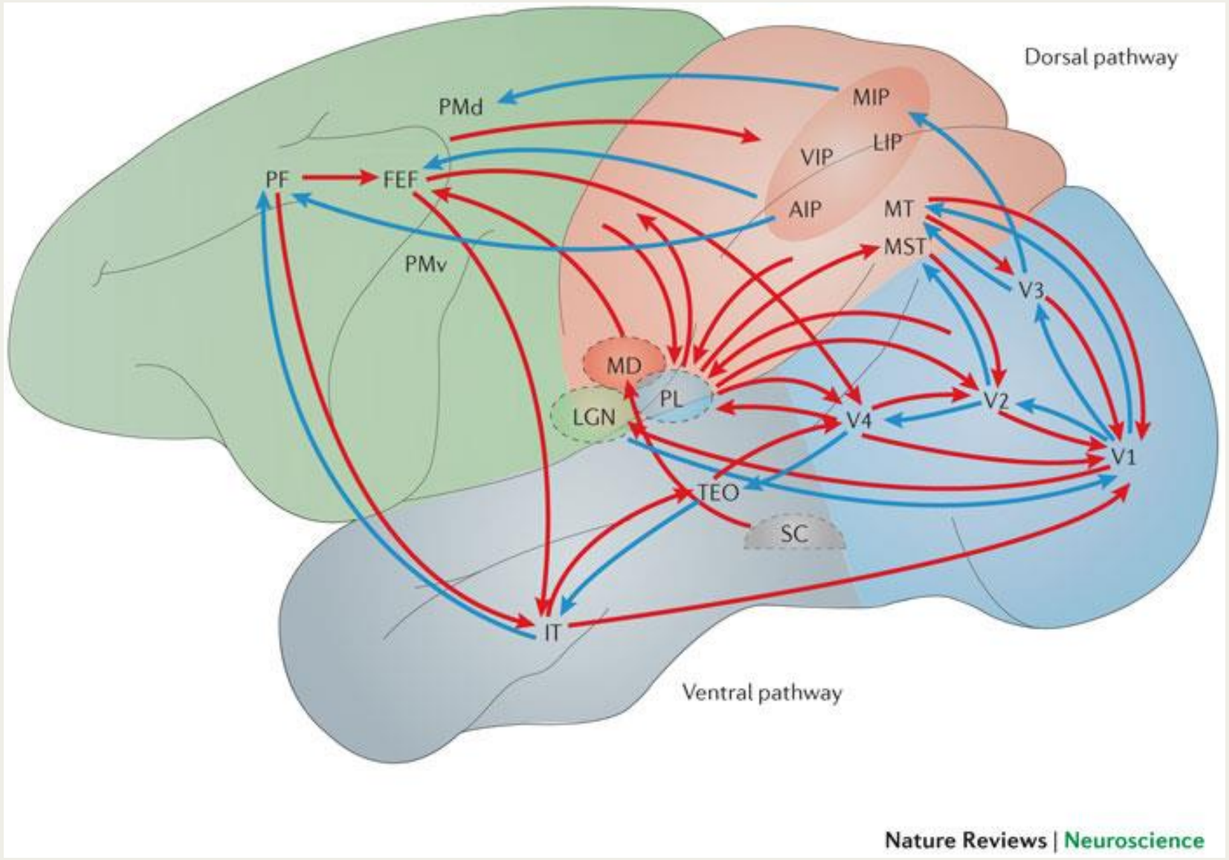
NOTES:

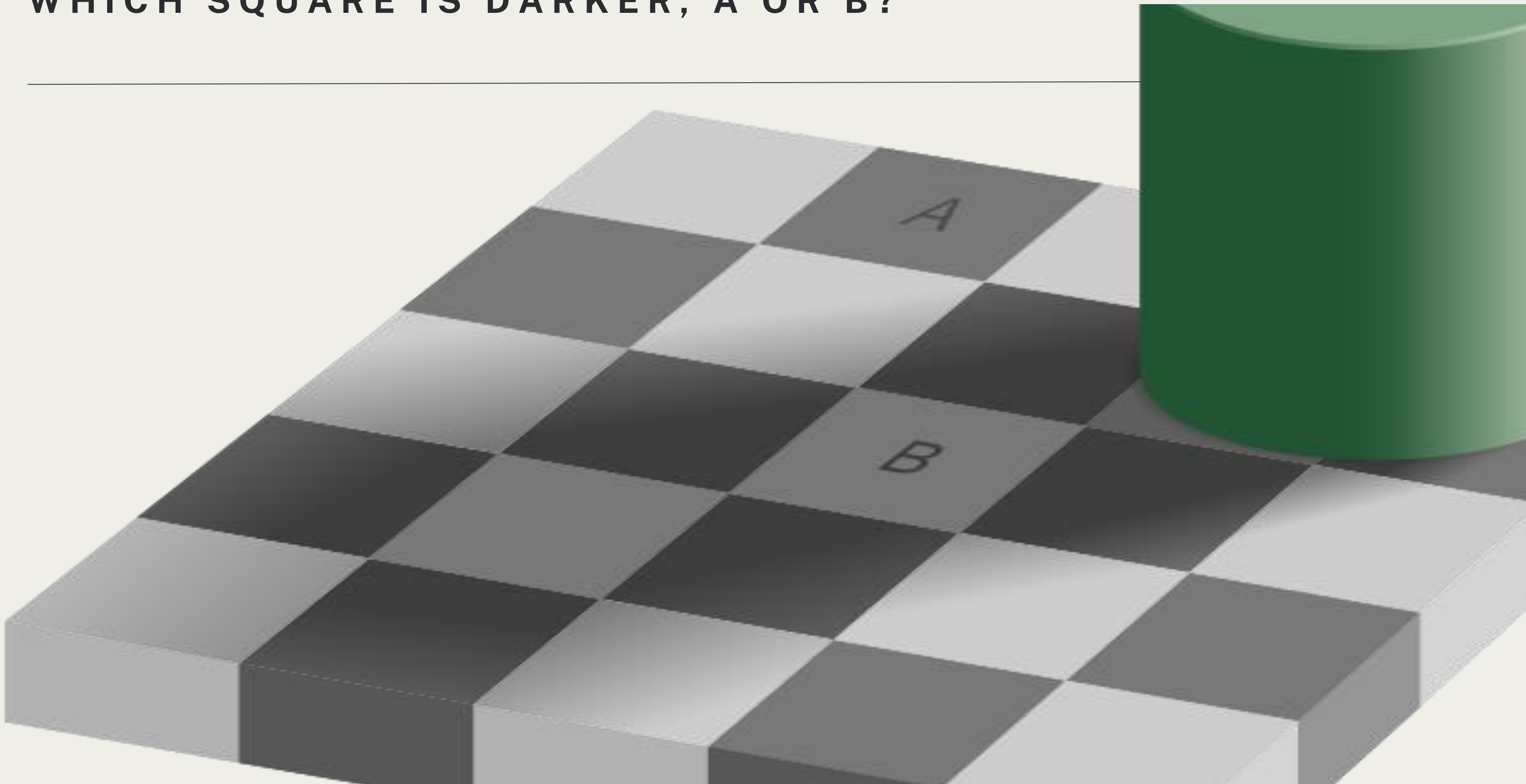
- Pain is always a personal experience that is influenced to varying degrees by **biological**, **psychological**, and **social factors**.
- Pain and nociception are different phenomena. Pain cannot be inferred solely from **activity in sensory neurons.**
- Through their life experiences, individuals learn the **concept of pain**.
- A person's report of an experience as pain should be **respected**.
- Although pain usually serves an adaptive role, it may have adverse **effects on function and social and psychological well-being.**
- Verbal description is only one of several **behaviors** to express pain; inability to communicate does not negate the possibility that a human or a nonhuman animal experiences pain.

COMPLEX NEUROSCIENCE REVIEW – VISUAL PATHWAYS





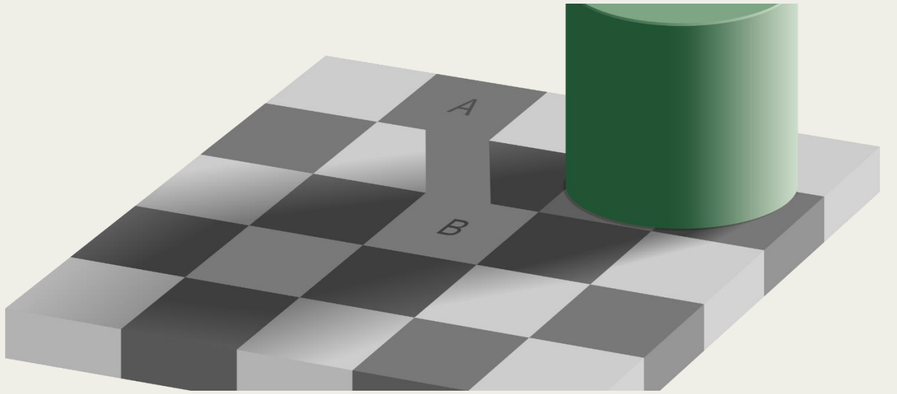
WHICH SQUARE IS DARKER, A OR B?



WHICH SQUARE IS DARKER, A OR B?

MODULATING ENTRENCHED NEUROLOGICAL PATHWAYS

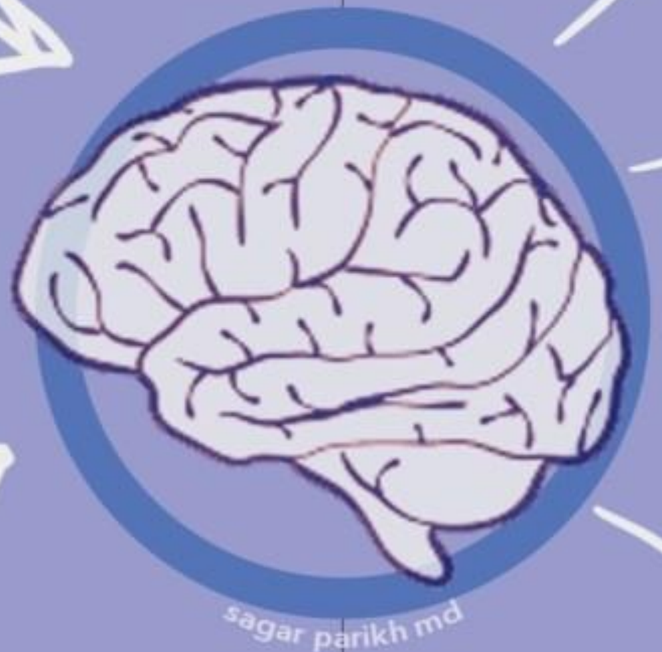
- The brain interprets stimuli and makes a *value judgment*
- Pain is an *output* rather than an input
- Goal of therapy is to apply positive pressure to the adaptive CNS through:
  - Listening, validating
  - Diagnosis and explanation
  - Pain education
  - Addressing nociceptive inputs (eg bladder, bowel, uterus, muscles)
  - Modulating pain (sleep, exercise, nutrition, mood, social, nature)
  - Multidisciplinary team
  - Self-empowerment, control, choices



INPUT

OUTPUT

PAIN NEUROMATRIX



Cognitive
"Cognitive-Evaluative"
Past Experiences and
Personality / Cultural Influences

Emotional
"Motivational-Affective"
Limbic System Driven

Physical
"Sensory-Discriminitive"
Sensory input of relating
to actual physical injury

Pain
The actual Pain Perception

Motor
Involuntary and Voluntary
Action Patterns

Stress
The body's stress response
(ie. cortisol release)

Emotion
Effects on Motivation and
regulation of the emotional
response

WHAT IS CHRONIC PELVIC PAIN?

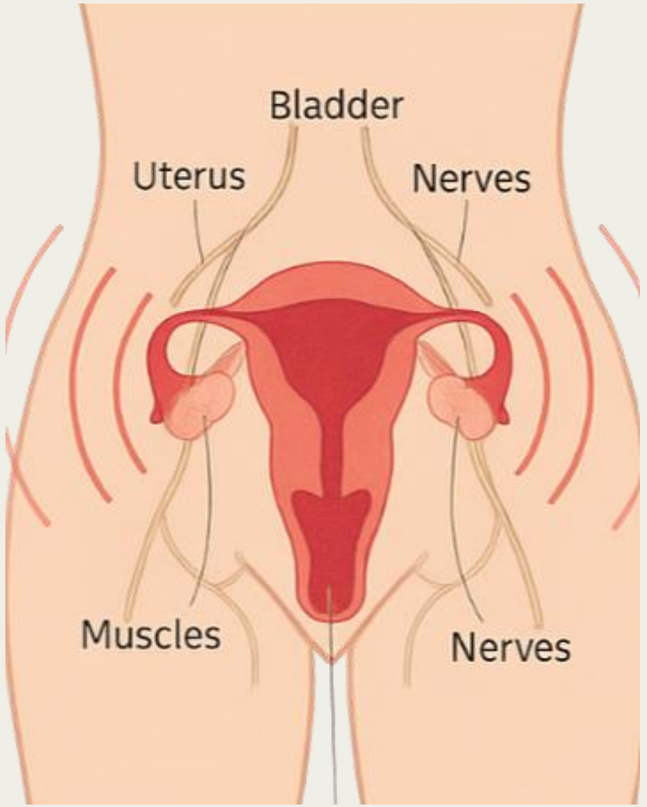
Chronic Pelvic Pain (CPP) is defined as:
Persistent or recurrent pain perceived in the pelvic region, lasting for at least 6 months, and not exclusively associated with menstruation, pregnancy, or acute conditions.

It may be:
- Cyclical or non-cyclical
- Constant or intermittent
- Localised to one structure or felt more generally across the pelvis or lower abdomen

Key Characteristics:
- Can involve the bladder, bowel, uterus, vagina, vulva, prostate, muscles, nerves, or connective tissues
- Often occurs without clear pathology, or may persist after an initial injury or medical condition has resolved

Frequently associated with other symptoms:
- Bladder or bowel dysfunction
- Sexual pain or difficulty
- Muscle tension and postural issues
- Fatigue, sleep disturbance, or emotional distress

CPP is complex and multifactorial, often involving contributions from:
- Musculoskeletal dysfunction
- Nervous system sensitisation
- Hormonal and inflammatory processes
- Psychosocial factors, including stress, anxiety, and past trauma



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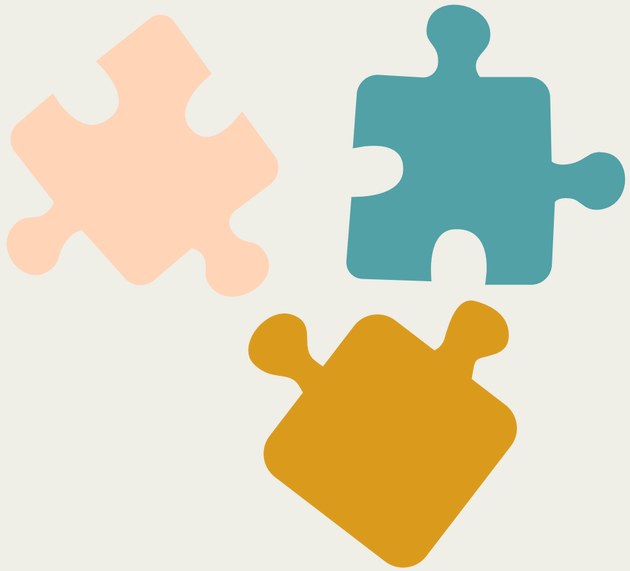
ROLE OF PHYSIOTHERAPY (WITHIN THE CONTEXT OF PELVIC PAIN)

- Physical and functional assessment
- Pain education and nervous system calming
- Pelvic floor rehabilitation
- Movement re-training
- Support for bladder, bowel, and sexual symptoms
- Collaborative, person-centred care



Sometimes it feels like we are looking at a jigsaw puzzle. We need to sort the pieces out and then workout where they fit.

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INITIAL CONSULT

Detailed History & Symptom Review

- Pain history – type, location, duration, aggravating/relieving factors
- Bladder, bowel, and sexual function
- Menstrual, hormonal, surgical, and medical history
- Lifestyle factors – stress, sleep, movement, daily impact
- Personal concerns and treatment goals

Pain Education

- Understanding how chronic pain works
- Introduction to nervous system sensitisation
- Exploring pain triggers and reassurance
- Clarifying myths or previous beliefs about pain

Physical Assessment (where appropriate and with consent)

- Observation of posture, movement, and breath
- Abdominal wall and pelvic floor muscle assessment
- Internal exam (if appropriate and consented)
- Musculoskeletal and joint screening

Collaborative Goal Setting and Planning

- Identifying meaningful goals
- Education on pacing, movement, and pain relief strategies
- Breathing, relaxation, and home care instructions
- Tailored plan to support self-management

Support Tools and Next Steps

- Symptom tracking (e.g., bladder diary, pain scales)
- Coordination with GPs or specialists
- Resources for follow-up and ongoing care
- Questionnaires

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PELVIC FLOOR ASSESSMENT

Identifying overactivity, tension, or weakness

Teaching pelvic floor relaxation and coordination

Desensitization

Graded exposure

Tools:

- Manual therapy
- Biofeedback
- Dilator use (when indicated)
- Release tools
- Stretches
- Home exercises

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PAIN EDUCATION

Why It Matters

- Helps reduce fear and worry
- Supports understanding of chronic pain mechanisms
- Encourages active participation in recovery

Key Concepts

- Pain ≠ Damage – Longstanding pain doesn't always mean ongoing injury
- Sensitised Nervous System – The body's 'alarm system' may become overprotective
- Complex Influences – Stress, sleep, activity, and emotions can affect pain
- Knowledge Builds Confidence – Understanding pain reduces fear of movement and helps reclaim function

How We Teach It

- Diagrams and metaphors (e.g. "alarm system", "amplifier")
- Exploration of beliefs and concerns
- Reassurance through assessment
- Take-home resources: videos, handouts, reading

Physio Goals

- Calm the nervous system
- Reduce pain-related fear and avoidance
- Support pacing, relaxation, and movement
- Create a foundation for meaningful progress

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PHYSICAL ASSESSMENT

Whole-Body, Individualised Assessment

A physical assessment helps identify musculoskeletal, postural, and pelvic floor factors contributing to pain. All assessments are guided by informed consent and comfort.

Posture and Movement

- Observing static posture and habitual positions
- Noting tension-holding patterns (e.g. bracing, breath-holding)
- Watching functional movements like sitting, bending, walking

Breathing Mechanics

- Assessment of diaphragm movement and breath patterns
- Identifying upper chest breathing or breath-holding
- Coordinating breath with pelvic floor function

Musculoskeletal & Myofascial Assessment

- Checking abdominal, hip, back, and pelvic muscle tension
- Identifying tender points, guarding, or reduced mobility
- Noting any pain referral patterns or sensitivity

Pelvic Floor Muscle Evaluation (if appropriate and consented)

- Checking tone, coordination, and strength of pelvic floor muscles
- Assessing for overactivity, pain on palpation, or difficulty relaxing
- May involve external and/or internal examination depending on symptoms and consent

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OTHER CONSIDERATIONS

Collaborative Goal Setting & Planning

- Defining priorities together
- Introduction to home strategies (e.g., breathing, relaxation)
- Early advice on pacing and activity modification

Support Tools (optional based on need)

- Screening tools (e.g., pain questionnaires, bladder diary)
- Referrals to other professionals if indicated

Education+++

Listening

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WHAT CAN BE DONE PRIOR TO PHYSIOTHERAPY

Education and Reassurance

- Reinforce that chronic pelvic pain is real and treatable, even when imaging is normal
- Introduce some basic pain science education.
- Avoid fear-based language
- Emphasise that movement is safe

Symptom Management Options

- Check current medications and consider if there are any changes to be made
- Not within physio scope to prescribe medications, however I often encourage patients to discuss things like topical oestrogen with GPs
- Alternative COCP, Mirena ect

Screening and Baseline Tools

- Pelvic Pain Questionnaire
- Bristol stool chart or bowel diary if constipation is a concern
- Mental health screening:

– DASS-21 (Depression, Anxiety and Stress Scales) – useful in identifying underlying emotional contributors

-Pain Catastrophizing Scale (PCS) or Brief Pain Inventory (if available)

MSU/ Ultrasounds/ Blood tests where appropriate

Self-Care & Lifestyle Advice

- Encourage gentle daily movement: walking, yoga, stretching
- Introduce diaphragmatic breathing and relaxation techniques

Generate Appropriate Referrals

- Psych
- Gynae
- Pain Specialist

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HOW TO FIND A SUITABLE PHYSIO

- Look for a physiotherapist with “APA titling” in Pelvic Health or alternatively post graduate training in Pelvic Health
- Should have some evidence of further training or education regarding pain science
- Willingness to learn if needed and collaborate with other health professionals
- Can build a rapport and communicate well your patient
- Provides evidence based treatment and offers regular follow contact with patient
- should be able to work with patient to address barriers to compliance
- Looks at client from BPS model

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REFERENCES

Aibel, K., Choi, S., & Moldwin, R. (2023). Pelvic mapping to explore patterns of chronic pelvic pain. Neurourology and Urodynamics, 42(4), 837–844. Body

Alappattu, M., & Bishop, M. (2011). Psychological factors in chronic pelvic pain in women: Relevance and application of the fear-avoidance model of pain. Physical Therapy, 91(10), 1542–1550.

Bergeron, S., Khalifé, S., Dupuis, M.-J., et al. (2016). Randomized controlled trial comparing group cognitive-behavioural therapy and a topical steroid for women with dyspareunia. Journal of Consulting and Clinical Psychology, 84(3), 259–268.

Bush, D., Evans, S., & Vancaillie, T. (2011). The $6 Billion Woman and the $600 Million Girl: The Pelvic Pain Report. Pain Australia.

Chalmers, K., Catley, M. J., Evans, S. F., et al. (2017). Clinical assessment of the impact of pelvic pain on women. Pain, 158(3), 498–504.

Dansie, E., Turk, D., Colvin, L., et al. (2013). Assessment of patients with chronic pain. British Journal of Anaesthesia, 111(1), 19–25.

Fall, M., Baranowski, A. P., Elneil, S., et al. (2010). EAU guidelines on chronic pelvic pain. European Urology, 57(1), 35–48.

Fajardo, O., Cook, E., Grebenyuk, E., & Yunker, A. (2023). Pelvic floor myalgia: Diagnosis and management. American Journal of Obstetrics and Gynecology, 228(3), S936.

FitzGerald, M., Payne, C., Lukacz, E., et al. (2012). Randomized multicenter clinical trial of myofascial physical therapy in women with interstitial cystitis/painful bladder syndrome and pelvic floor tenderness. Journal of Urology, 187(6), 2113–2118.

Gatchel, R., Peng, Y., Peters, M., et al. (2007). The biopsychosocial approach to chronic pain. Psychological Bulletin, 133(4), 581–624.

Goldfinger, C., Pukall, C., Thibault-Gagnon, S., et al. (2016). Effectiveness of cognitive-behavioral therapy and physical therapy for provoked vestibulodynia: A randomized pilot study. Journal of Sexual Medicine, 13(1), 88–94.

Goldstein, A., Pukall, C., Brown, C., et al. (2016). Vulvodynia: Assessment and treatment. Journal of Sexual Medicine, 13(4), 572–590.

Kang, Y., Trewern, L., Jackman, J., McCartney, D., & Soni, A. (2023). Chronic pain: Definitions and diagnosis. BMJ, 381, e076036.

Lee, H., McAuley, J., Hubscher, M., et al. (2016). Does changing pain-related knowledge reduce pain and improve function through changes in catastrophizing? Pain, 157(4), 922–930.

Masheb, R., Kerns, R., Lozano, C., et al. (2009). A randomized clinical trial for women with vulvodynia: Cognitive-behavioral therapy vs. supportive psychotherapy. Pain, 141(1–2), 31–34.

Morin, M., Dumoulin, S., Bergeron, S., et al. (2016). Efficacy of multimodal physiotherapy treatment compared to overnight topical lidocaine in women with provoked vestibulodynia: A bi-center randomized controlled trial. Journal of Sexual Medicine, 13(6), S243.

Peterson, T., Karp, D., Aguilar, V., et al. (2010). Validation of a global pelvic floor symptom bother questionnaire. International Urogynecology Journal, 21(9), 1129–1135.

Schubert, R., Song, S., Everist, R., Nesbitt-Hawes, E., & Abbott, J. (2024). The impact of multimodal physiotherapy in an interdisciplinary setting for the management of women with persistent pelvic pain and pelvic floor tension myalgia. European Journal of Physiotherapy, Advance online publication, 1–6.

Thibault-Gagnon, S., & Morin, M. (2015). Active and passive components of pelvic floor muscle tone in women with provoked vestibulodynia: A perspective based on a review of the literature. Journal of Sexual Medicine, 12(

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