W2: Multidisciplinary Approach to Female Sexuality Based on Practical Concepts

Workshop Chair: Aparecida Pacetta, Brazil
06 October 2015 09:00 - 10:30

Start	End	Topic	Speakers
09:00	09:20	Pelvic floor anatomy, prolapse and changes induced by pregnancy and postpartum and aging: sexuallity repercussion	Aparecida Pacetta
09:20	09:35	Current physical therapy for sexual dysfunctions and evidence-based treatment	Bary Berghmans
09:35	09:50	Drug therapy applied to sexuality	Aparecida Pacetta
09:50	10:05	Drug therapy applied to sexuality video 1 - Assessment, diagnosis and treatment of female sexual disorders (vaginismus, dyspareunia, anorgasmia and dysorgasmia) Authors video 1: Helga E.M.G. Monaco	Aparecida Pacetta
10:05	10:15	Specific physiotherapeutic diagnostics for sexual dysfunctions - Authors video 2: Maura Seleme and Bary Berghmans	Maura Seleme
10:15	10:25	The most important physiotherapeutic techniques - Authors video 3: Maura Seleme and Bary Berghmans	Maura Seleme
10:25	10:30	Final discussion of the presented subjects	All

Aims of course/workshop

The approach of female sexuality dysfunction is still controversial in literature, even if physicians and physiotherapists nowadays pay more attention to this problem and the patients are demanding for more information.

The purpose of this workshop is to bring more comprehension of sexual dysfunctions based on evidences and experiences of physicians and physiotherapists.

The physiotherapeutic treatment is still unknown to the majority and the demonstration of those techniques is essential to give more therapeutic options with medical treatment.

The intention of this is to create a method in which professionals of distinct areas will be able to act more efficiently.

Learning Objectives

1. Recognize the functional anatomy and physiology of female pelvic organ support and the sexuality repercussion's of the changes induced by pregnancy and postpartum and aging.

2. To comprehend better the female sexual dysfunction based on evidences

3. To know the right approach to treat these dysfunctions according to physicians, physiotherapists and sexologists

ICS 2015 Montreal

W2 Multidisciplinary Approach to Female Sexuality Based on Practical Concepts
Tuesday 6th October 2015
09:00-10:30
Maura Seleme

ICS 2015 Montreal

Specific physiotherapeutic diagnostics for sexual dysfunctions - Authors video 2: Maura Seleme and Bary Berghmans

The most important physiotherapeutic techniques - Authors video 3: Maura Seleme and Bary Berghmans

Sexual Dysfunction 25% to 63% of women

Sexual Dysfunction in the United States
Prevalence and Predictors
Edward O. Laumann, 2009

Sexuality and Pelvic Pain

In general human sexuality has three aspects – sexual function, sexual self-concept, and sexual relationships.

Pain can affect self-esteem, ones ability to enjoy sex and relationships.

Healthy sexuality is a positive and life-affirming part of human being.

Heinberg 2004,Smith 2007

"Patients who reported having sexual, physical or emotional abuse show a higher rate of reporting symptoms of pelvic pain and sexuality"

The European Association of Urology (EAU) Guidelines

Sexual dysfunction and PFM

- Related to female sexuality the pelvic floor muscles are extremely important.

Basson et al 2000
Bourcier et al 2004
Rockwell 2002

Sexual dysfunction and PFM

The musculature is involved in the woman sexual response physiology and physiopathology

The collaboration among physiotherapists, gynecologists, and sexologists is highly recommended.

Bo et al 2007
Graziottin 2007

Assessment: history taking

Basic principles for sexual history-taking

- allow the patient to feel in control
- provide explanations for answers
- help the patient feel less abnormal (destigmatize)
- provide encouragement and positive support
- initiate the discussion of sensitive topics
- defer sensitive questions
- be aware of patient's cultural background
- ensure confidentiality
- avoid judgmentalism

Gregoire A 1999

What is wrong with you ?? What do you expect from me?

International Classification of Functioning, Disability, & Health 2002

organ level = impairment

personal level = disability

social-cultural level = restriction in participation

consequences!!

Assessment: history taking

associated pathology - diabetes, obesity,lower back pain,SDT - sexually transmitted disease, depression, neurological disease, medications

urogynecology -age of sexual initiation,infection, menopause)

anorectal - constipation, hemorrhoids, anal incontinence

surgery? - hysterectomy. prolapses

obstetric history - episiotomy; vaginal delivery, baby weight

Urinary behavior

Frequency:

day:_____ night:_____

( ) dysuria ( ) abdominal strength
( ) difficulty to control urine
( ) urgency ( ) pain
( ) burning feeling

Urinary incontinence

Start Date:_____

Incontinence ( ) daytime
( ) nighttime

With some effort ( ) urgently ( )

Which kind of urinary incontinence ?

Pain

- deep into pain history:
  - site of pain confirmed by pain diagram
  - duration of pain
  - nature of onset or precipitating event
  - pain characteristics
  - response of pain to activity and associated symptoms

Hopwood 2000

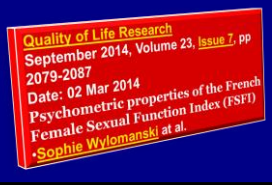
Visual analog scale

Every session:
Session 1:
Session 2:
.....
Last session:

Assessment: FSFI most used

- Female Sexual Function Index (FSFI) – 19 questions about sexual feelings (desire, arousal,satisfation, orgasm, pain)

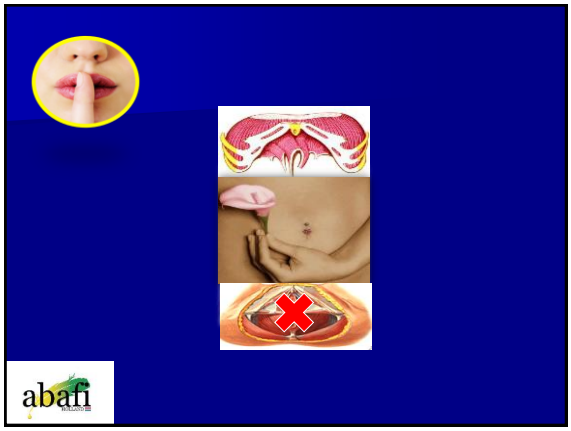
http://www.fsfiquestionnaire.com/FSFI%20questionnaire2000.pdf



Before start the treatment…

- Following initial evaluation, all patients should be provided with a detailed review of findings and **explanation** of the nature and likely causes of their problem
- if the initial findings do not preclude direct treatment for the sexual problem, patients should be **informed** as to the available treatment options and the likely benefits and disadvantages or risks of each option
- patients should always be encouraged to participate actively in the decision-making process – **motivation !**

Guidelines in Sexual Dysfunctions?



Breathing exercises

Anterversion and retroversion

Hot Bag

Aveiro at al 2009

Yes, we can start to talk.....

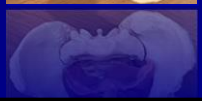
The 4 Fs

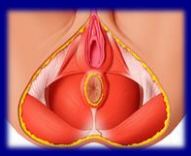
- F = find .....
- F = feel .....
- F = force .....
- F = follow through.....

- Find the pelvic floor
- Feel the pelvic floor
- Force the pelvic floor
- Follow trough, keep exercising

Information !

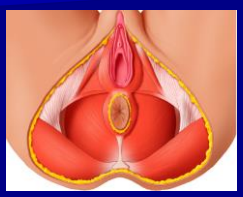
- information anatomy & PFM





Talking about perineum !!!!!

Find perineum

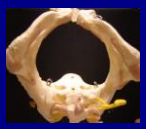


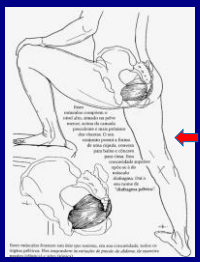
- digital palpation – show before the examination anatomy with anatomical board to localize PFM and pelvic organs

EXPLAIN & EDUCATE!!!!!

Find and Feel the perineum

Find and Feel the perineum





Find and Feel

Feel-in different positions

For increasing the perception Feel

Lying position on the side

Sitting position

Standing position

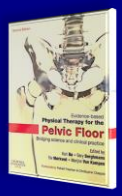
Always ask for a selective contraction of the pelvic floor muscles

Use evidence-based program!!!!!

PFM training – SUI level 1, grade A ICI 2012

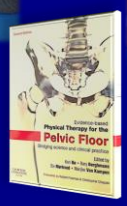
Program based on evidence Bø 1990,1999, DiNubile 1991, Mørkved 2002, 2003 , Bø 2004,Bø & Berghmans 2007

- 8-12 MAXIMAL contractions– inward & upward
- 6-8s contraction & relaxation
- 4 fast contractions– 8s of relaxation
- 3 sustained contractions 20s



respiration

contraction



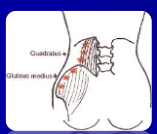
relaxation

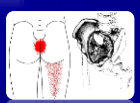
perception

PFMT and female sexual function
Promising results of PFMT on sexual function
Duration of training: minimum 8 weeks

Bo 2012

Trigger Points





Anderson et al 2009

Trigger points

Trigger point assessment and treatment for Pelvic Floor triggers M 3 Seminar

savefrom.net

Selectivity PFM contraction

> 30% of women do not contract their PFM correctly at their first consultation, even after thorough individual instruction

Benvenuti et al 1987, Bump et al 1991, Bø et al 1988

Guidelines in Sexual Dysfunctions?

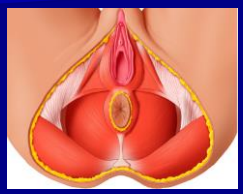
Physical examination shown by movies produced by abafi-HOLLAND 2014

Seleme, Berghmans, Uchoa 2014

CONCLUSION condition PFMF				
Overactive	Normal	Coordination disorder	underactive	Non functional

Guidelines on Stress Urinary Incontinence -Royal Dutch Society for Physical Therapy (KNGF) – 2011

Invasive Techniques



- to show before the examination and first treatment an anatomical board with the muscles and intern organs localization

Talking about perineum !!!!!

Electrotherapy

- *GOAL*
- **It can be used to reduce the pain:**

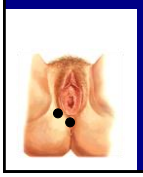
TENS !!!!!!

Conventional TENS– It will be responsible for the pain "gate closing".
Frequency between 90 e 130 Hz

Chronic pain !!!!!

TENS Endorphin liberation–besides stimulating the liberation of β-endorphin, it also causes the muscle fiber relaxation, toxins removal and local metabolism improvement. To do so, it is used frequency always lower than 10 Hz and impulse duration around 180 up to 250 µseg.

Acute pain !!!!!!!



Fall & Madersbacher 1994
AGNE, Jones Eduardo. Eu sei eletroterapia.
Santa Maria: Pallotti, 2009.

Use evidence-based program!!!!!

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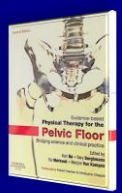
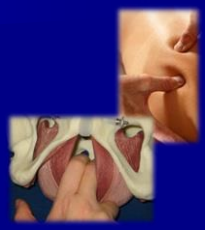


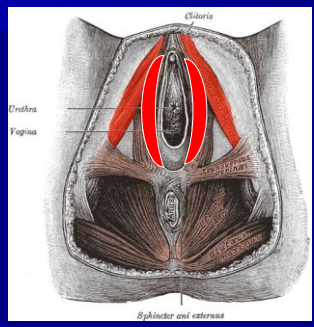
Manual therapy and sexual dysfunction

Myofacial Training Effects:
Relaxation
Enhanced flexibility
Increase of blood circulation
Pain reduction
Sensory perception
Scar tissue manipulation
Reduction of fibrotic adhensions
Reduction of hypertonicity



GRIESE, Maurenne. Preparing for Birth: Perineal Massage. 2000
CASSAR, Mario-Paul. Manual de massagem terapêutica. São Paulo: Manole, 2001.
BECK-GALLAGHER, Krista. Episiotomy – Is It Necessary? 2000.

bulbospongiosus and ischiocavernosus muscle



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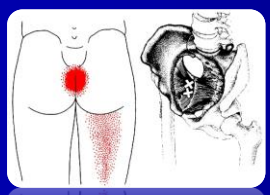
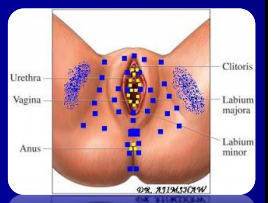
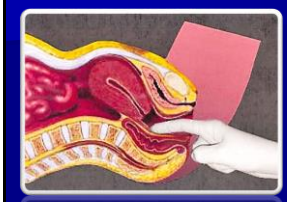


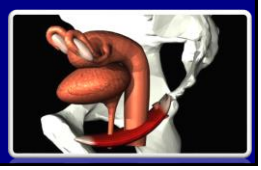


Anderson et al 2009

Trigger points in the levator ani



At a minimum, single-digit palpation for chronic pelvic pain should include the levator ani



Butrick CW. Pathophysiology of pelvic floor hypertonic disorders. *Obstet Gynecol Clin North Am.* 2009;36(3):699-705.

Biofeedback & Sexual dysfunctions

As for other pelvic dysfunctions we may deduct that biofeedback provides:

- Larger perineal muscles perception.
- Progressive increase or reduction of the muscle activity (Hypoactivity or hyperactivity)
- Neuromuscular re-education +++ use of antagonists
- Relaxation – as important as the work

Kegel AH,1948 Bridges et al,1988, Peattie et al 1988; Laycock,1988,2002;Hahn et al,1991,Whitehead WE, Wald A, Norton NJ,2001; Haslam J,2002 Bo K,2003; Morkved,2003; Hay-Smith et al,2006.Bo et al ,2007;Dumoulin, Hay-Smith ., 2007; Berghmans,2008.

Biofeedback through manometry

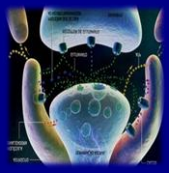
- Biofeedback through manometry – a good device, can be useful for sexual physiotherapeutic treatment (allows better adaptation to the vaginal canal size, muscle stretching on the big opening)

Dabbadie at al, 2005

Biofeedback through EMG

- Biofeedback through EMG – nowadays it can be as stable as the pressure registration.
- It allows the use of small probes, applying biofeedback and electrotherapy at the same time (ideal on dyspareunias)
- It doesn´t allow variables of muscle stretching and can be modified according to hormonal impregnation and vaginal opening size.

Dabbadie e Seleme,2005



Receive the action Potential of the Motor Unit Muscle fiber depolarization - contraction - repolarization – rest

Binder,2002

Biofeedback

Biofeedback

Vaginal Cones

- *Theory*: the cone weight intend to motivate the training so that the women contract firmly with progressive weight.
- Use Period (15-20 min) adequate
- It can cause ↓ blood supplement↓ O2 consumption, fatigue & muscle sore
- Synergist contractions instead of MAPs contractions
- Refined protocol if used as BF

Arvonen et al 2001,
Plevnik 1985,
Hay-Smith et al 2001,
ICI 2005

Desensitization - Dilators Vaginismus

Due to the scarcity of studies found, no metanalysis was done, only a critical review. No consistent evidence could thus be found on satisfactory clinical physical therapies for vaginismus.

Aveiro at al 2009

Conclusion Rehabilitation Techniques


Thank you very much !
Maura Seleme
www.abafi.com.br
www.abafiholland.com

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Notes