W20: LIVE WEBINAR: ICS Institute Physiotherapy: Chronic Pelvic Pain (CPP) and postpartum post-traumatic stress disorder (P-PTSD) for physiotherapists: are we up to date?

Workshop Chair: Paula Igualada-Martinez, United Kingdom

Start	End	Topic	Speakers
		Introduction	Paula Igualada-Martinez
		Endometriosis: beyond surgery and multidisciplinary approach	Catherine Allaire
		Menstruation, pain and exercise: is there a relationship?	Jane Chalmers
		Pelvic Pain and PTSD	Anne-Florence Plante
		Pain in the butt: bowel symptoms associated with CPP	Paula Igualada-Martinez
		Questions	All

Aims of Workshop

Chronic Pelvic Pain (CPP) is often associated with negative behavioural and psychological consequences as well as with bladder, bowel, sexual, pelvic floor and gynaecological dysfunction. CPP is common and affects 1 in 6 women.

This workshop will guide physiotherapists and clinicians of all disciplines throughout the most up-to date evidence on the multidisciplinary assessment and management of endometriosis, bowel and menstrual related CPP. This workshop will also expand awareness of postpartum post-traumatic stress disorder (P-PTSD) and how to manage it in clinical practice. The audience will be invited to ask questions at the end of each presentation and will have a discussion at the end of the workshop.

Learning Objectives

This workshop aims to familiarise delegates with the mechanisms of endometriosis, menstrual and bowel related pelvic pain;

Target Audience

Urogynaecology and Female & Functional Urology, Bowel Dysfunction, Conservative Management

Advanced/Basic

Intermediate

Suggested Learning before Workshop Attendance

- Engeler D, Baranowski AP, Borovicka J, et al. EAU guidelines on chronic pelvic pain. European Association of Urology 2020 https://uroweb.org/wp-content/uploads/EAU-Guidelines-on-Chronic-Pelvic-Pain-2020.pdf
- Doggweiler R, Whitmore KE, Meijlink JM, Drake MJ, Frawley H, Nordling J, Hanno P, Fraser MO, Homma Y, Garrido G, Gomes MJ, Elneil S, van de Merwe JP, Lin ATL, Tomoe H. A standard for terminology in chronic pelvic pain syndromes: A report from the chronic pelvic pain working group of the international continence society. Neurourol Urodyn. 2017 Apr;36(4):984-1008. doi: 10.1002/nau.23072. Epub 2016 Aug 26. PMID: 27564065.
- Abrams P, Cardozo, Wagg A, Wein A. Incontinence Ch 12 Adult Conservative Management 6th Edition 2017 ISBN: 978-0-956907-3-3
- Rana N, Drake MJ, Rinko R, Dawson M, Whitmore KE. The fundamentals of chronic pelvic pain assessment, based on international continence society recommendations. Neurourol Urodyn. 2018 Aug;37(S6):S32-S38. doi: 10.1002/nau.23776. PMID: 30614061.

Dr. Catherine Allaire
Endometriosis: Beyond Surgery and Multidisciplinary Approach

Endometriosis is a chronic inflammatory condition defined as the presence of endometrial-like cells outside the uterus. It is a common condition which affects approximately 10% of reproductive-age women and an unknown number of transgender and non-binary people. Endometriosis symptoms include severe dysmenorrhea, dyspareunia, non-cyclic pelvic pain, dyschezia and infertility, causing considerable suffering. While medical and surgical options offer relief of pain symptoms for many endometriosis patients, they have an immediate failure rate of approximately 19% for medications and 20% for surgery. There is also a substantial risk of recurrence of symptoms even after initial response to treatment, with up to 50% of patients having recurrent pain within 5 years of their surgery. Some endometriosis patients develop daily and disabling pain which can be characterized as chronic or persistent pelvic pain. There is a well-recognized disconnect between stage of endometriosis and pain severity and persistence, which indicates that other factors are likely contributing to the pain experience.
There is evidence that endometriosis patients often develop comorbid pain conditions, particularly irritable bowel syndrome (IBS), painful bladder syndrome (PBS), pelvic floor myalgia and vestibulodynia. Because of this, endometriosis was one of the diagnoses included in the description of Chronic Overlapping Pain Conditions (COPCs), a term recently endorsed by the NIH that refers to a cluster of chronic pain conditions that frequently occur together and predominantly affect women. There is growing evidence of common risk factors and central mechanisms for these chronic pain conditions.

When evaluating a patient with endometriosis-associated pain, these potential comorbidities and the role of central sensitization must be recognized. A thorough history and physical examination is key in identifying all potential pain contributors and devising an appropriate management plan in conjunction with the patient. Most endometriosis expert reviews and guidelines endorse the use of multidisciplinary care when a complex pain problem is identified. However, there are no specific recommendations about what the components of this approach should be and how that type of team care should be delivered. There is evidence to support the use of specific interventions such as pain neuroscience education (PNE), physical therapy, psychological therapies, and pharmacotherapies for the treatment of chronic pain. Interdisciplinary team models have been well studied and validated in other chronic pain conditions, such as low back pain. The published evidence in support of interdisciplinary teams for endometriosis-associated chronic pain is more limited but appears promising. At the BC Women's Centre for Pelvic Pain and Endometriosis, we have developed and applied a model of interdisciplinary care for endometriosis-associated pelvic pain for the past 10 years. Our interdisciplinary program and outcomes will be discussed in this seminar.

Anne-Florence Plante, Physiotherapist, France
How post-traumatic stress disorder (P-PTSD) might be changing our views on pelvic floor rehabilitation.

Post obstetrical trauma as well as childhood sexual trauma, sexual assault and domestic violence are known to be strongly associated with PTSD and have been rarely addressed and explored by physiotherapists. As this group of patients are often referred to physiotherapy with concomitant pelvic floor disorders, the physiotherapist needs an understanding of how to address trauma related pain, trauma memories and dissociated states due to trauma memories.

Their sharing brain pathways and collateral emotional impacts will obviously change our physiotherapy assessment and management. Knowing the PTSD physiology and understanding of body attunement in treating pelvic floor disorders will be part of this presentation. Trauma informational, practice and guidance for questioning trauma will be addressed. Clinical cases and interactive reflection on their assessment and treatment will be proposed.

Dr Jane Chalmers, Physiotherapist, Australia
Menstruation, pain, and exercise: is there a relationship?

Physical activity and exercise are recommended in guidelines for the management of many persistent pain conditions, such as low back pain, fibromyalgia, and osteoarthritis. Regular exercise is also recommended in the clinical practice guidelines for the management of menstrual pain (dysmenorrhea). But how should we define 'regular exercise'? And what type and intensity of exercise should we prescribe to women with dysmenorrhea? In this presentation, we will explore the current evidence on exercise for dysmenorrhea, including the frequency, intensity, type, and timing of exercise to maximise outcomes. The physiology of how different types of exercise might help dysmenorrhea and other menstrual symptoms will also be discussed. At the end of this presentation, you should have an appreciation of how exercise can help patients with dysmenorrhea and an ability to prescribe various physical activity or exercise interventions for patients with dysmenorrhea, based on their unique presentation.

Paula Igualada-Martinez, Physiotherapist, UK

Pain in the butt: bowel symptoms associated with CPP

Chronic Pelvic Pain can be caused by a variety of gastrointestinal disorders (GI) that affect the intestines and the anorectal region. The intestinal conditions that can cause CPP include irritable bowel syndrome, inflammatory bowel disease and functional constipation. Anorectal conditions that can lead and/or aggravate CPP are proctalgia fugax, levator ani syndrome, anal fissures, etc…

This presentation will briefly review these conditions, the physiotherapeutic assessment and management and onwards referral to the Colorectal and Pain teams. By the end of the presentation the participant should have an update on the effect of GI disorders on the causation and perpetuation of CPP and the latest evidence regarding its physiotherapeutic management.