**Getting to the Core of the Pelvic Floor**

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I remember hearing stories from women in my family who had children discussing how they would often leak urine when exercising, laughing, coughing, sneezing, and on the way to the bathroom. I grew up thinking that this misconception was normal post-partum. It wasn’t until a physical therapist that specialized in the pelvic floor gave a lecture in one of my classes that I learned the following statements were false: leaking urine after having a baby is inevitable and cannot be treated, urinary incontinence is a normal part of aging, and medication and surgery are the only successful treatments for incontinence.

Postpartum incontinence affects around seven million new American mothers every year, and even low-stress deliveries and Cesarean sections can lead to incontinence in about fifty percent of women.1, 2 In Europe, it is customary for women to be referred to a physical therapist if they report any bowel or bladder issues at their six-week post-partum check-up, which isn’t always the case here in the United States. Furthermore, urinary incontinence affects both men and women, with women being more commonly affected. In fact, 1 in 4 women over the age of 18 experience episodes of leaking urine involuntarily.3 About 25 million adult Americans experience transient or chronic urinary incontinence.3, 4 The prevalence increases with age at 30-40% of middle aged women and 30-50% of elderly women reporting urinary incontinence.3, 4 So, how can we as a healthcare professionals intervene and assist with referring our patients with urinary incontinence to the correct provider?

There are four types of pelvic floor dysfunction: weak or underactive, tight or overactive, uncoordinated or dyssynergistic, and non-functioning. For this article’s purpose, the focus will be on underactive pelvic floor dysfunction, specifically urinary incontinence and pelvic organ prolapse (POP). Some causes of urinary incontinence include pregnancy and childbirth; urinary tract infection; constipation; side effects of medication; dementia; neurological disease such as multiple sclerosis or cerebral vascular accident; mobility issues; or prostate dysfunction such as prostatitis, prostate cancer, or prostatectomy. There are three types of urinary incontinence: urge, stress, and mixed. Urge incontinence is the typical “key in door syndrome” in which there is a large volume urine loss. Patients may report that they often can’t make it to the bathroom in time thus causing some behavior changes such as fear of leaking, “just-in-casing” or “JIC-ing”, and limiting fluid intake. Stress incontinence is an involuntary loss of urine with physical exertion such as leaking during exercise, bending, changing positions, laughing, sneezing, or coughing. Pelvic organ prolapse occurs when the muscles, ligaments, and fascia that hold organs in correction positions become weakened. Between 40-50% of women are affected, with 10-20% being symptomatic.4 These patients may report that their symptoms are worse as the day progresses, an aching discomfort in pelvic region, and a dull backache which are common reports that we hear in many initial evaluations. Patients with POP may also note that they feel something when they wipe or that they feel like they are sitting on a golf ball.

First is taking a closer look at which muscles we see strength or length deficits in daily in the outpatient setting. The obturator internus and piriformis are among the many muscles of the pelvic cavity and among many hip external rotators that can be problematic in our patients. Much like the other muscles we treat on a daily basis, a healthy pelvic floor must have an active range of motion, including being able to symmetrically contract, relax, and bulge. A healthy pelvic floor also has the ability to have an element of coordinated control with functional tasks: acting as an anticipator that stabilizes the core by pre-firing with the transverse abdominis and also as a regulator that decides when to open the urethra and the anus.

Providing brief education on bladder norms and healthy bladder behaviors such as avoiding “just-in-casing” or JIC-ing for short. It is normal to go to the bathroom every 3-4 hours or 6-8 times per day in 24 hours. A normal stream is 8-10 seconds. It is uncommon to void during the nighttime if younger than 65 years of age and normal to void 1-2 times per night if older or pregnant. The urge to empty first occurs when our bladder is at 50% capacity, in which stretch receptors in the bladder signal the brain, causing the external sphincter of the pelvic floor muscles to remain contracted. The bladder continues to fill with urine until the point where the urge to void is strong. “Just-in-casing” is voiding the bladder when the urge is not strong and when someone voids just in case they have to go later on when they may not have the opportunity to such as a long car ride or a meeting at work. This ultimately resets the baselines in the bladder for 50% and 100% full, leading to urge incontinence and going to the bathroom more frequently.

So, what can we teach and encourage our patients with urinary incontinence to do after referring them to a pelvic floor physical therapy specialist? We can encourage our patients to keep a bladder diary, making a voiding schedule, teach them urge deference techniques such as “five quick flicks”, not “JIC-ing”, providing bladder health education on hydration and bladder irritants, and teaching them to perform kegels during activities that cause urinary incontinence such as performing a kegel during a sneeze. Like other scopes of physical therapy, we can utilize interprofessional assistance to create the best possible plan of care for our patients. Pelvic floor physical therapy may be part of a comprehensive treatment plan involving primary care physicians, gynecologists/urologists, sex therapists, and mental health professionals.

 As musculoskeletal experts of the healthcare community, we restore function and positively impact quality of life. The pelvic floor should hold as much importance to our patients as any other muscular or neurological impairments they may experience. As health care professionals, educating our patients and spreading more awareness of the field of pelvic physical therapy and what we can do for these types of conditions is vital, and can help to improve overall well-being. Before our patients accept the idea that their pelvic impairments are “unfixable” or “unimportant,” we can help to normalize and familiarize people with the extensive and effective interventions pelvic physical therapists can utilize to improve the quality of life of many.

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