TOO TIGHT TO FUNCTION

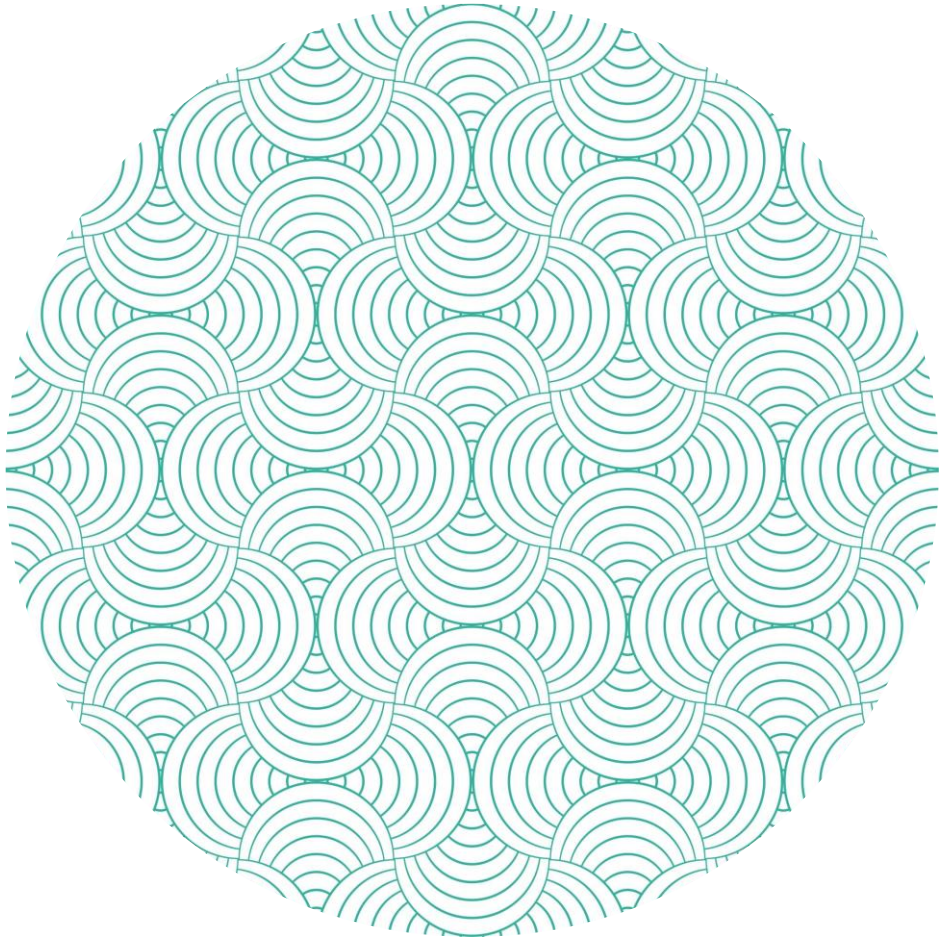
- OVERAKTIVITET OG ANDRE BEKKENBUNNSLIDELSER

FYSIOTERAPEUT MSC

KJERSTI MAKHOLM-FIMREITE

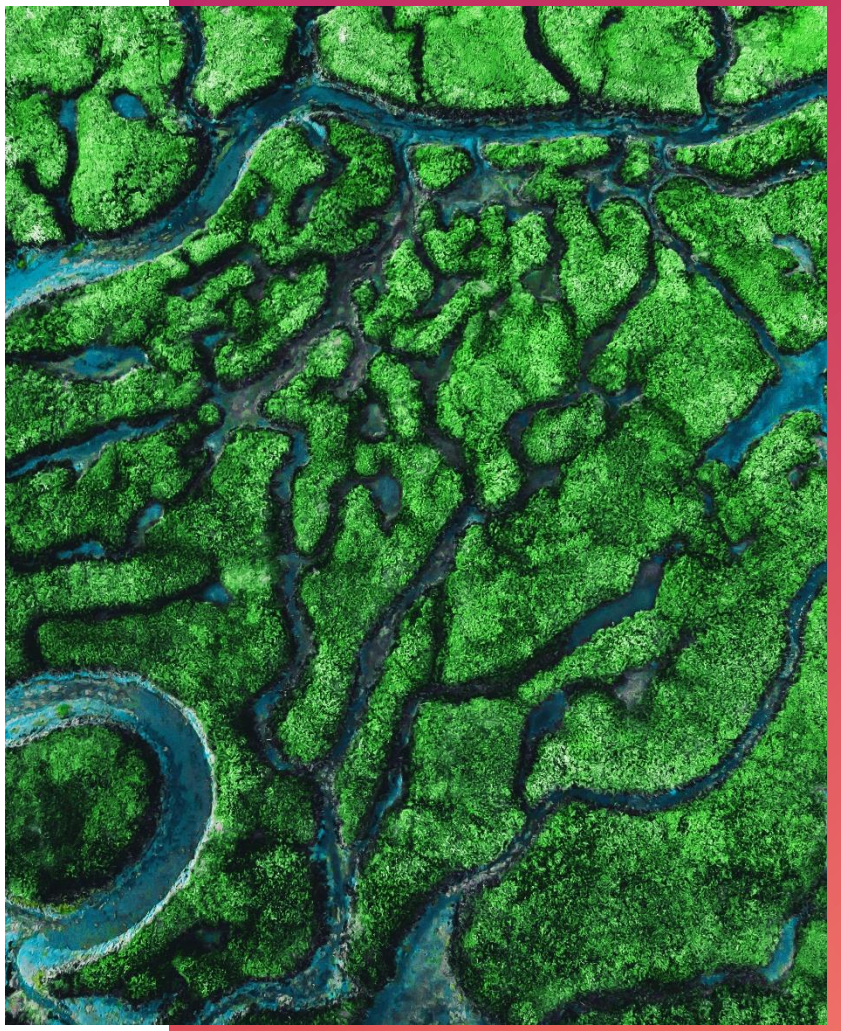
VIVUS

ÅMOT FYSIKALSKE



BEKKENBUNNPROBLEMATIKK

-ET KOMPLEKST OG UNDERFOKUSERT TEMA



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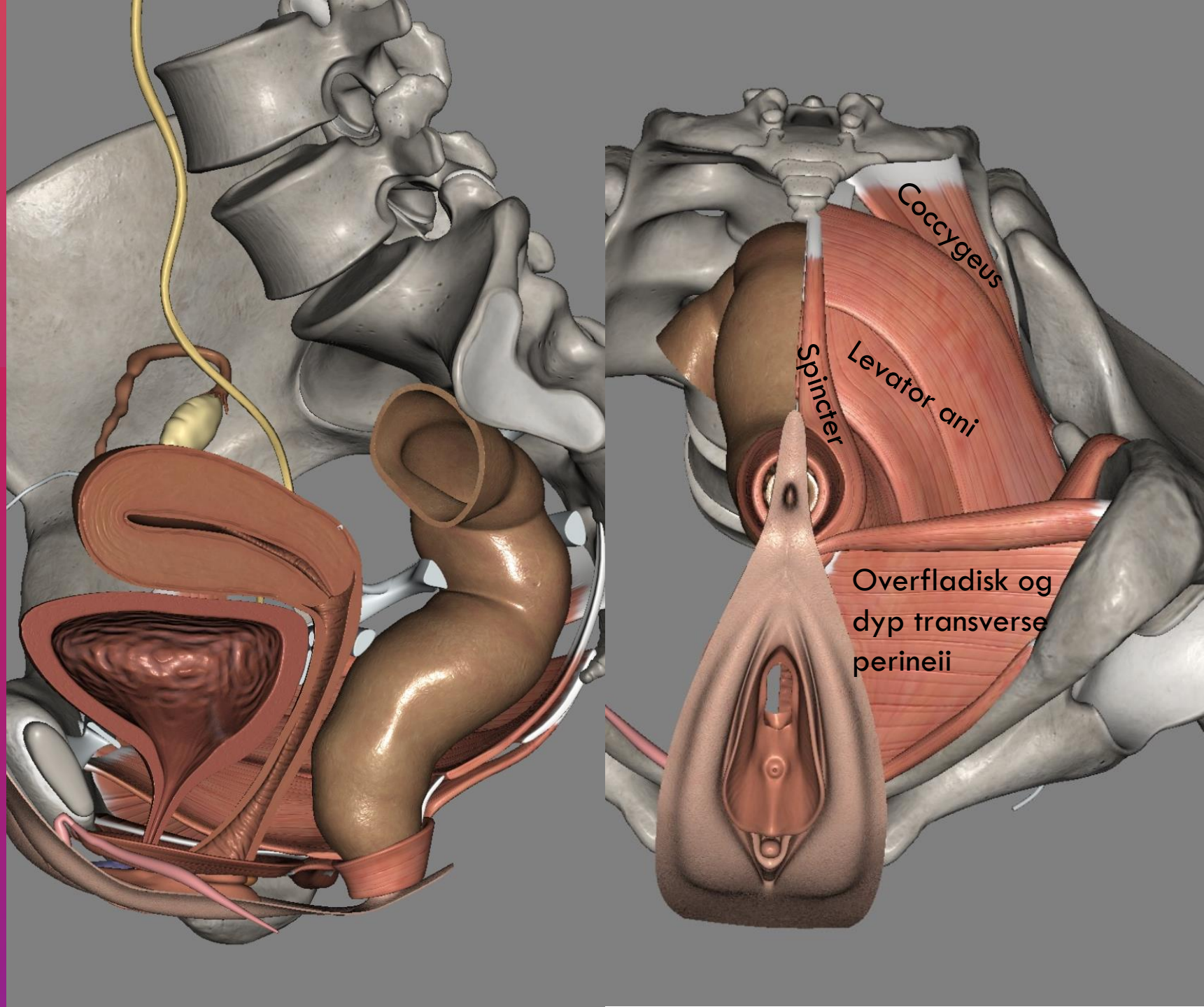
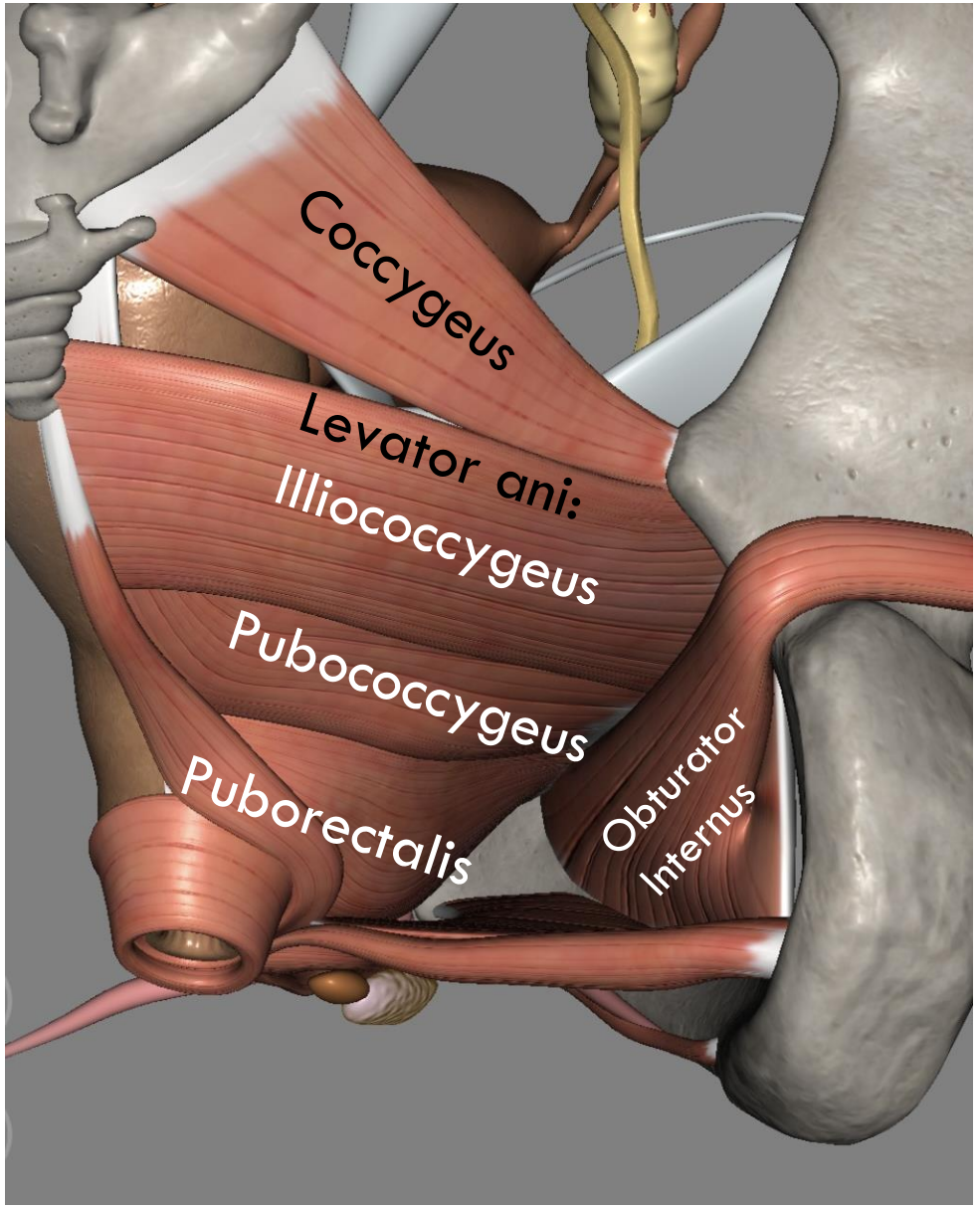
ANATOMI


Coccygeus
Levator ani
Spincter
Overfladisk og
dyp transverse
perineii

- En trakt med muskler
- Felles hinne også med OI
- Anorektal vinkel



LEVATOR ANI

- Inhiberer detrusor ved å øke trykket i urethra
- Øke muskelstyrke med 44% etter 6 måneders trening
- Etter trening holder seg M. Levator ani elevert fra 2 til 48 timer
- Aktiverer satellittceller som smelter sammen med muskel fibrene, øker volumet og reparere skader.
- Lineær vekst av fibre i 6 måneder.
- Ved maks kontraksjon vil mm. transverus abdominus fyre noe

FUNKSJON BEKKENBUNN

- Støtte bekkenorgener
  - blære, prostata, livmor osv.
- Holde oss kontinente
- Bidra til og vedlikeholde seksuell opphisselse og orgasme

PROBLEMER OG PLAGER KNYTTET TIL BEKKENBUNNEN

- **Lekkasje**
  - Urin
  - Luft
  - Avføring
    - Kvinner
    - Menn
    - Barn (enurese)

- **Underlivsprolaps**
  - Urinblære/cystocele
  - Endetarm/rectocele
  - Livmor/uterusdescens
  - Tynntarm/enterocele
  - Analprolaps

- **Smerte**
  - Samleie (dyspareuni)
  - Postpartum
  - Berøring
  - Sitting
  - Aktivitet
  - Eliminasjon
  - Haleben/coccyx
  - Endometriose/adenomyose
    - Kvinner
    - Menn

- **Dysfunskjonell bekkenbunn**
  - Vaginisme
  - Vansker med eliminasjon
  - Fødselskade
    - Kvinner
    - Menn
    - Barn

PREVALENS

Urininkontinens

- 1/10 Menn
- 25-35 % av kvinner
- 30-40 % i SK
- Økt risiko etter SK
- 16 % av kvinner med C-sectio
- 25-35 % av kvinner

Analinkontinens

- 12/6 % luft
- 15 % av menn
- 15-25 % av kvinner mellom 30-39
- opp til 25 % av de over 80
- 20 % av kvinner i SK urgency 16 % 1 år PP

PoP

- 50 % av alle fødende
- 3-28 % symptomatiske
- Økt risiko etter svangerskap
- Ass. Med svakere bekkenbunn og redusert mm. Utholdenhet
- Redusert seksuell funksjon

UNDERLIVSSMERTER

- 10-28 % av kvinnelig befolkning
- 75 % er under 34
- 30-60 % PP
- 50 % søker hjelp
- Vanlig hos menn også

(NOEN) DIAGNOSER PÅ UNDERLIVSSMERTER

- Vulvondyni (tidligere vestibulitt)
  - Provosert og uprovosert
- Genito-pelvic pain/penetration disorder GPPD)
  - Dyspareuni
  - Vaginisme
- Levator ani syndrome
  - Proctalgia Fugax
- Endometriose/Adenomyose
- Pudendal nevropati
- Hudlidelser

GPPPD: VEDVARENDE ELLER TILBAKEVENDENDE VANSKELIGHETER MED:

(EGEN OVERSETTELSE)

- Vaginal penetrasjon under samleie
- Smerter under vaginalt samleie eller forsøk på penetrasjon
- Markert økt spenning av bekkenbunnsmuskler ved forsøk på vaginal penetrasjon
- Frykt eller engstelse for vulvovaginalesmerter og bekkenbunnssmerter, ved forventninger til, under eller som et resultat av vaginal penetrasjon

FORSKNING

- Få og dårlige studier
- Vaginisme og dyspareuni var tidligere psykiatriske diagnoser
- Generelt «vanskelig» med kvinnehelse og smerte

Vaginismus: a review of the literature on the classification/diagnosis, etiology and treatment

Women's HEALTH

Marie-Andrée Lahaie[1], Stéphanie C Boyer[2], Rhonda Amsel[3], Samir Khalifé[3] & Yitzchak M Binik[1,4]

Vaginismus is currently defined as an involuntary vaginal muscle spasm interfering with sexual intercourse that is relatively easy to diagnose and treat. As a result, there has been a lack of research interest with very few well-controlled diagnostic, etiological or treatment outcome studies. Interestingly, the few empirical studies that have been conducted on vaginismus do not support the view that it is easily diagnosed or treated and have shed little light on potential etiology. A review of the literature on the classification/diagnosis, etiology and treatment of vaginismus will be presented with a focus on the latest empirical findings. This article suggests that vaginismus cannot be easily differentiated from dyspareunia and should be treated from a multidisciplinary point of view.

Vaginismus is described as an involuntary vaginal muscle spasm interfering with sexual intercourse [1]. Since the term was first coined in ... require a stressful gynecological examination that sufferers might often prefer to avoid. As a result, there have been dramatically varying esti-

sensors

MDPI

Article

Characterization of Pelvic Floor Activity in Healthy Subjects and with Chronic Pelvic Pain: Diagnostic Potential of Surface Electromyography

Monica Albaladejo-Belmonte [1], Marta Tarazona-Motes [2], Francisco J. Nohales-Alfonso [2], Maria De-Arriba [2], Jose Alberola-Rubio [3,*] and Javier García-Casado [1]

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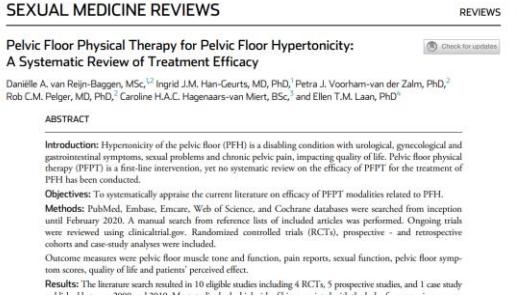
3 Unidad de Bioelectrónica, Procesamiento de señales y Algoritmia, Instituto de Investigación Sanitaria La Fe, 46026 Valencia, Spain
* Correspondence: pepe_alberola@iislafe.es

Abstract: Chronic pelvic pain (CPP) is a highly disabling disorder in women usually associated with hypertonic dysfunction of the pelvic floor musculature (PFM). The literature on the subject is not



SEXUAL MEDICINE REVIEWS

REVIEWS

Pelvic Floor Physical Therapy for Pelvic Floor Hypertonicity: A Systematic Review of Treatment Efficacy

Danielle A. van Reijn-Baggen, MSc,[1,2] Ingrid J.M. Han-Geurts, MD, PhD,[1] Petra J. Voorham-van der Zalm, PhD,[2] Rob C.M. Pelger, MD, PhD,[2] Caroline H.A.C. Hagenaars-van Miert, BSc,[3] and Ellen T.M. Laan, PhD[1]

ABSTRACT

Introduction: Hypertonicity of the pelvic floor (PFH) is a disabling condition with urological, gynecological and gastrointestinal symptoms, sexual problems and chronic pelvic pain, impacting quality of life. Pelvic floor physical therapy (PFPT) is a first-line intervention, yet no systematic review on the efficacy of PFPT for the treatment of PFH has been conducted.

Objectives: To systematically appraise the current literature on efficacy of PFPT modalities related to PFH.

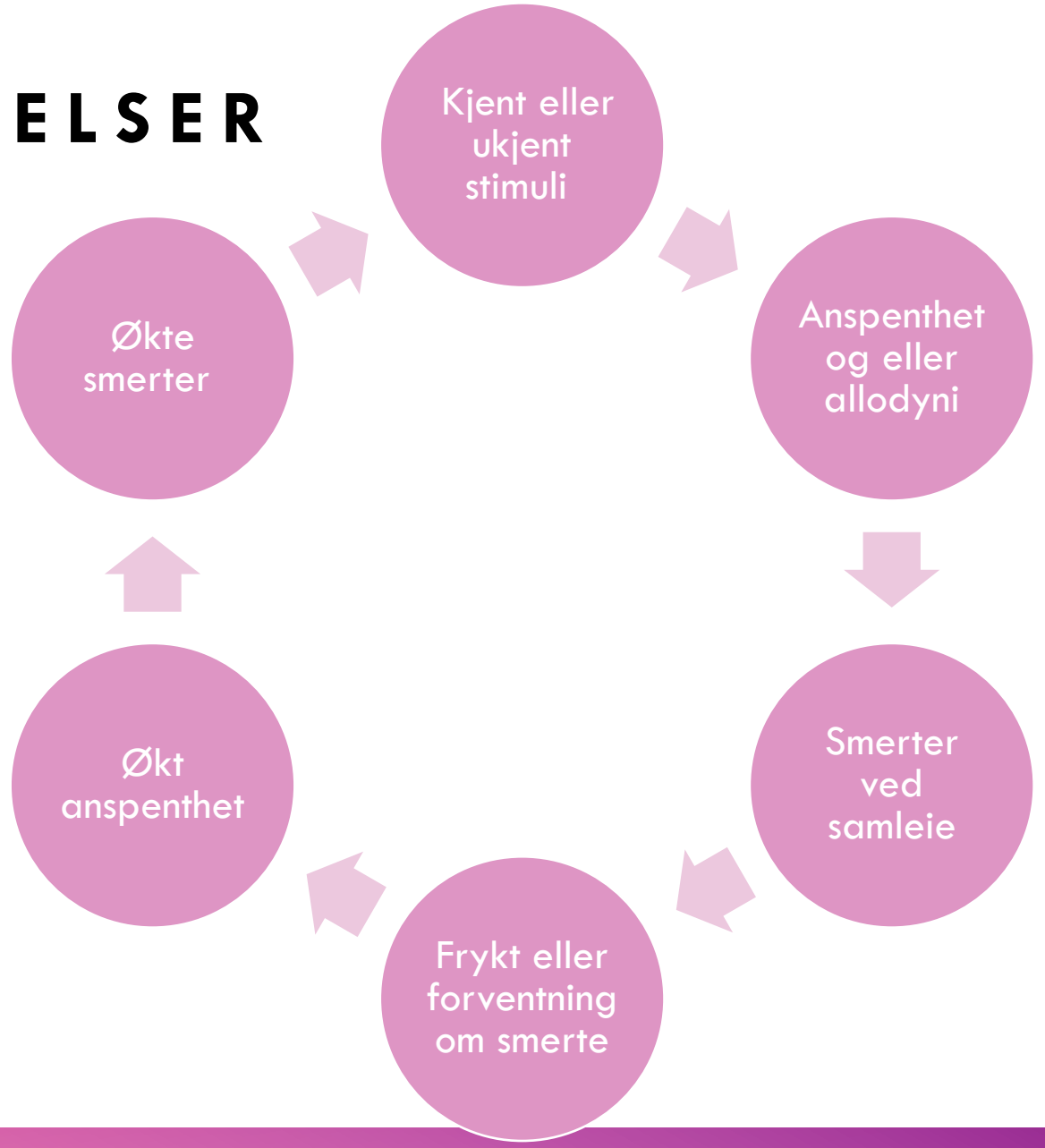
Methods: PubMed, Embase, Emcare, Web of Science, and Cochrane databases were searched from inception until February 2020. A manual search from reference lists of included articles was performed. Ongoing trials were reviewed using clinicaltrial.gov. Randomized controlled trials (RCTs), prospective - and retrospective cohorts and case-study analyses were included.

Outcome measures were pelvic floor muscle tone and function, pain reports, sexual function, pelvic floor symptom scores, quality of life and patients' perceived effect.

Results: The literature search resulted in 10 eligible studies including 4 RCTs, 5 prospective studies, and 1 case study

ÅRSAK(ER)SMERTELIDELSER

- Ofte ukjent
- Primær eller sekundær?
- Frykt/skam/uvitenhet



HELSEPERSONELL MÅ SAMARBEIDE!

- Multifaktorelt problem
- Mange år før rett diagnose settes
- Kun 50 % søker hjelp
- Et team av behandlere bør involveres:
  - Fastlege
  - Gynekolog (evt. Urolog og gastrolog)
  - Terapeuter (fysioterapeuter, kiropraktorer, osteopater osv.)
  - Psykolog
  - Sexolog

Understanding vaginismus: a biopsychosocial perspective

Maria McEvoy[a], Rosaleen McElvaney[b,c] and Rita Glover[b]

[a]Department of Psychology, Waterford Institute of Technology, Waterford, Ireland; [b]Department of Psychotherapy, Dublin City University, Dublin, Ireland; [c]Department of Psychotherapy, Children's Health at Connolly, Dublin, Ireland

ABSTRACT

Despite its universal prevalence, vaginismus remains under-researched. This paper explores various understandings of vaginismus, including the medical understanding of vaginismus as a spasmic response, which has underpinned much of the symptom focused approaches of behavior and cognitive therapies that have dominated the field of sex therapy to date. This symptom-focused approach has been criticized as reductionist with many authors supporting a more holistic approach to both understanding vaginismus and treating this condition. One of the predictors of successful treatment for vaginismus is the attribution of the problem to psychological causes rather than physical. In order to fully understand vaginismus, it must be explored at intra-personal, interpersonal and cultural levels and of all of these the

ARTICLE HISTORY
Received 23 October 2020
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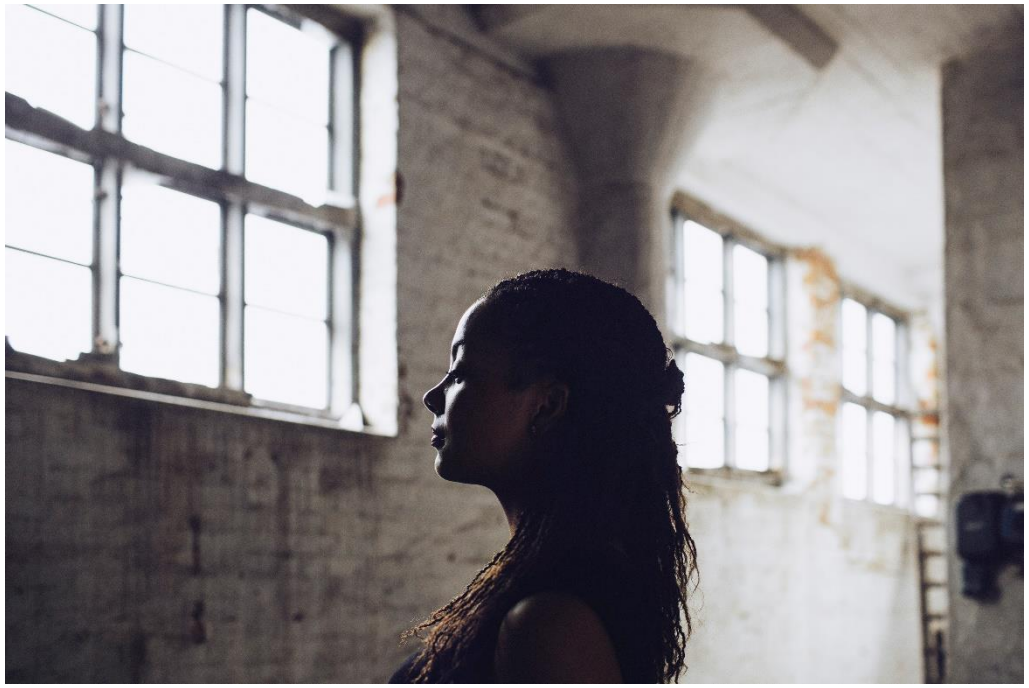
KEYWORDS
Vaginismus; dyspareunia; genito-pelvic pain/ penetration disorder; painful sex; female sexual dysfunction

KJERNEPASIENTEN



- 75 % er under 34 år
- "Flink pike" ??
- Halvparten oppsøker helsesystemer, 1 % får "riktig" diagnose
- Vulvodyni er den ledende grunnen til dyspareunia hos kvinner under 50 år.
- PUST:
  - 55 % er i arbeid
  - 80 % har andre underlivsdiagnoser

ANAMNESE

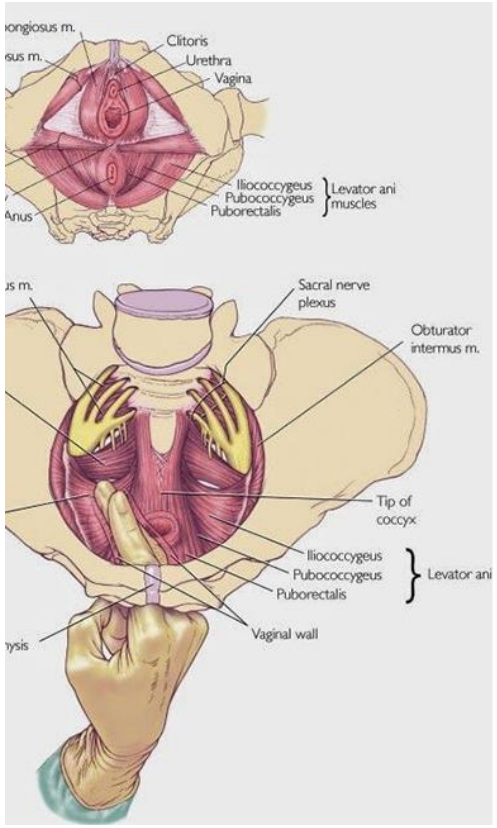
- Historie
  - Onset; primær eller sekundær
- Smertenes karakter;
  - Samleiesmerter inntrening/dype
  - Svie, brennende, kløende, dyp, strålende etc.
- Kan en få inn tampong/finger/penis?
- Historie med uønsket seksuell aktivitet
- Seksualspesifikk anamnese

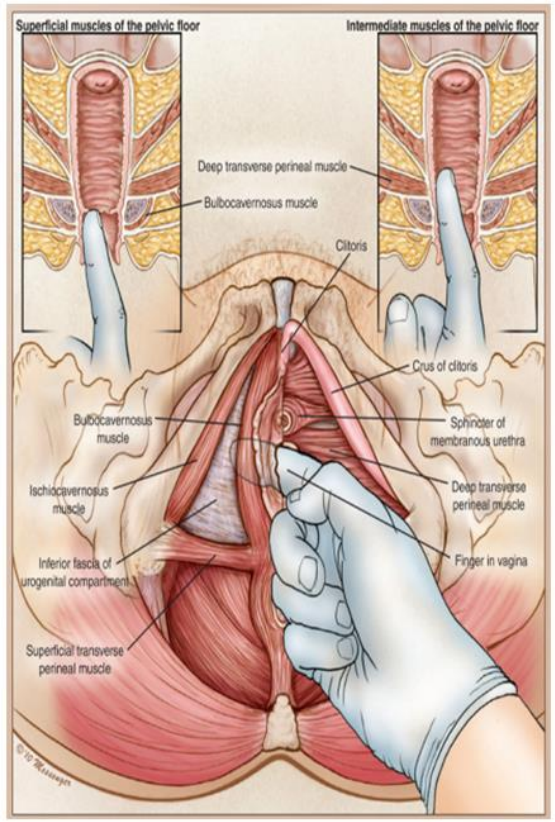
UNDERSØKELSE

- Nærliggende ledd; rygg, bekken, hofte
- Pustemønster
- Ekstern undersøkelse
- Inspeksjon av vulva og anus
- Blunt/skarp og q-tip test
- Intern/intravaginal undersøkelse
    - Behandler må være komfortabel med dette!

ALLTID INSPEKSJON OG VAGINAL PALPASJON

- Hud
- Arrvev
- Slimhinner
- Symmetri
- Behåring





- Tonus
- Evne til kontraksjon
- Evne til avslapning
- Prolaps
- Tiggerpunkter

BEHANDLING

- Ut i fra funn
  - Spenningsmønstre
  - Intimveiledning
  - Evnen til slipp?
    - Øvelser
  - Pusteveiledning
  - Desensitivisering
  - Tøyninger/manuelle tekninkker
  - Botox?

Utstyr:

- EMG
- ESTIM
- Dilatorer
- Vibratorer
- Seksualtekninske hjelpemidler
- Quintet.no

"JEG ER LITT USIKKER PÅ OM JEG KNIPER RIKTIG..?"

- Opp mot 30 % av kvinner med urinlekkasje klarer ikke å kontrahere bekkenbunnen riktig på tross av individuell opplæring (Bø et al. 1988)

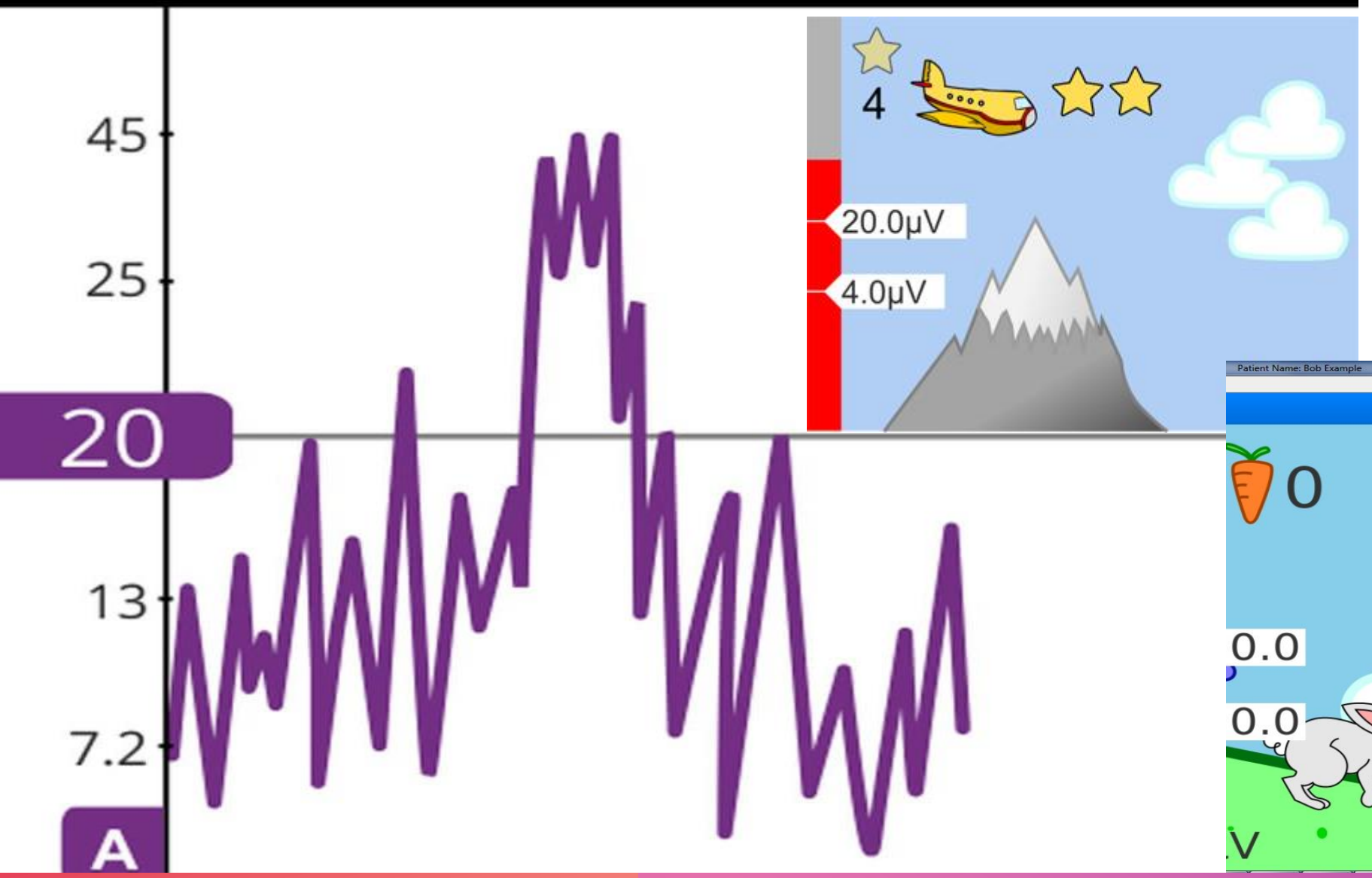
- 50 % av kvinner som får riktig kontraksjon ikke gjør det godt nok for å få effekt på urethratrykket (Bump et al.)

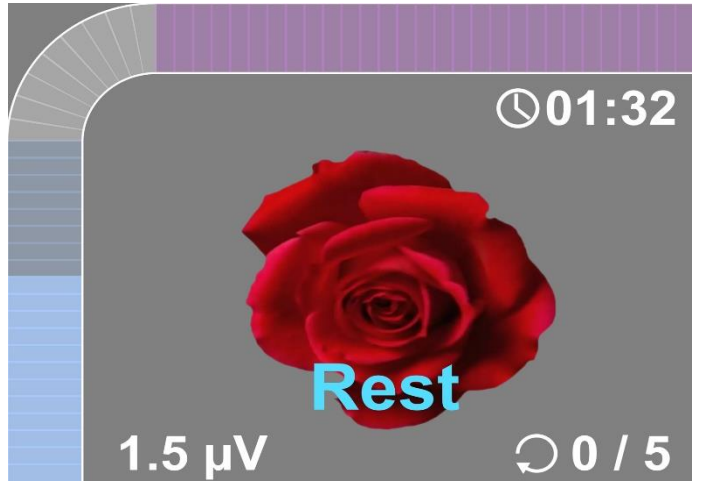
TRENE EN ANSPENT MUSKEL?

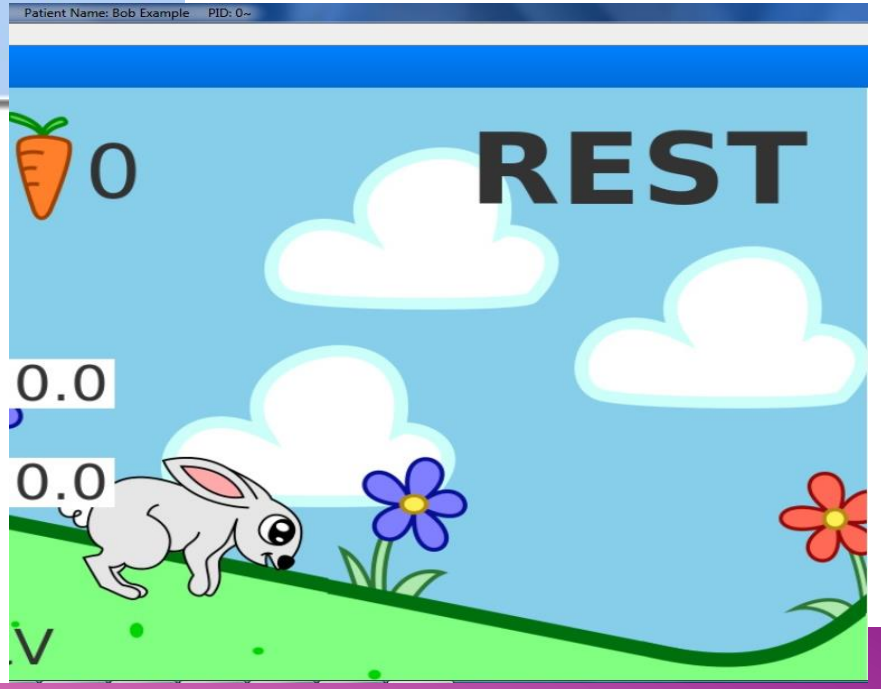
- Øke muskelbevisthet og propriosepsjon
- Bedre avspenningsevne og forskjell på spenninger
- Normalisering av muskeltonus
- Økt elastisitet og muskulatur og vaginalt vev
- Desenitisering av de smertefulle områdene
- Redusere frykt for vaginal/rektal penetrasjon

Open Display

EMG







TÅLMODIGHET (FOR BEHANDLER OG PASIENT..)

- Tar tid
- «Hele» pasienten må være med
- De aller fleste blir bra nok til å gjennomføre smertefrie samleier eller GU

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TAKK FOR MEG!