

# Conservative therapy of patient with dyspareunia in a post-menopausal state with co-morbidities including previous breast cancer and valve replacement: A case report



D. DiToro, DPT, MA, MS, CSCS, M. Mason-Cover, PT, MSPT, WCS, C. Hazelton, PT, MS, OCS, A. Burke-Doe, PT, PhD, M. Miller, PT, PhD, GCS

Anatomy and

libido and

Fatigue as a

normal effect

Benefits of

Re-emphasis

and function

patient's body

as a reference

Handout for

self-perineal

massage and

Results

University of Saint Augustine for Health Sciences, San Marcos, CA and Comprehensive Therapy Services, San Diego, CA

#### Introduction

Dyspareunia is defined as persistent pain in the vaginal area before, during, or after sexual intercourse.<sup>1,2</sup> The etiology is uncertain in the medical literature, but evidence proposes that pain and dysfunction of pelvic floor muscles (PFM) can contribute to dyspareunia and other forms of chronic pelvic pain.<sup>1,2</sup> The information contained in this case report is clinically relevant because it presents evidence that dyspareunia can be treated safely with physical therapy techniques on a patient with a complex medical history.

# Purpose

The purpose of this case report is to chronicle the effectiveness of a conservative physical therapy program for a woman with pelvic pain and multiple co-morbidities. A secondary objective is to increase awareness to practitioners of women's health issues improved by physical therapy intervention while striving to break down the taboo nature of the topic so patients seek out information, and treatment to improve their quality of life.

Possible factors contributing to pelvic floor muscle pain etiology **Pelvic Pain** (PFM pain syndrome) and (perineal pain syndrome) -learning

#### Methods

A single subject case report format was used to develop an understanding of the events, experiences and treatment of one person with dyspareunia. Quality of life measures included the Pelvic Floor Distress Inventory (PFDI-20) and the Pelvic Floor Impact Questionnaire-Short Form 7 (PFIQ-7).

# **Participant**

A 54 year-old female, homemaker and educator presented to a specialty pelvic physical therapy clinic with the chief complaint of dyspareunia during medical exams and intercourse. Past medical history is significant for an aortic value replacement in 2010, and breast cancer in 2011.

The patient reports pain at 5/10 and that sex is more painful due to vaginal dryness post menopause. She has been unable to have sex for the past four months due to pain.

# Interventions

The

"knack'

Patient education on pelvic floor anatomy & physiology, sexuality and intimacy alternatives, internal & external soft-tissue mobilization, manual therapy by the therapist and by the patient for home use with/without a medical dilator, biofeedback, guided imagery, manual facilitation, therapeutic exercise, & use of the "knack" or pelvic brace for use with functional tasks.



HOW TO DO 'THE KNACK'

cueing. 75/300 45.83/300 Pelvic Floor Distress Inventory-20 (PFDI-20: Combined POPDI-6, UDI-6, CRADI-8 Scores) 19.05/300 Pelvic Floor Impact 14.29 Questionnaire-Short Form 7 (PFIQ-7) Score 34/48 Not measured Pelvic Organ Prolapse/ Urinary Incontinence Sexual Questionnaire (PISQ-12)

hold, 3-5 sec holds,

accumulate 30 reps

PFM ex w/ co-

contractions,

PFM, and hip ex

ntro to cardio with 5

strategies, intro to use

functional activities

Review, focus on

PFM "knack" in more

challenging functional

The patient's initial scoring on the Pelvic Floor

Distress Inventory 20 (PFDI-20) was 75/300 and on

the Pelvic Floor Impact Questionnaire-Short Form

7 (PFIQ-7) score was 19.05/300. At the mid-point

of treatment, she scored a 45.83/300 on the PFDI-

20 and 14.29/300 on the PFIQ-7. She also reported

improved her ability to contract and relax her pelvic

a subjective improvement of 80% at her mid-term

treatment session. Objectively, the patient

floor muscles with correct effort with minimal

X: E

X: I, intro to

self-perineal

X: I

therapist with

size medium

# **Discussion & Conclusions**

This study concludes and supports that **physical** therapy intervention can successfully and effectively treat the musculoskeletal aspects as well as certain psychosocial aspects of dyspareunia. These aspects can be treated directly to the PFM or indirectly through diaphragmatic breathing, co-contraction muscles, associated hip muscles, improved posture, and improved overall fitness. While outcomes may be better with a specialized pelvic physical therapist, the previously mentioned indirect treatments could be easily applied by any physical therapist and could be attempted before referring a patient to a specialist.

#### Recommendations

Future research could be conducted to more definitively link physical therapy intervention of musculoskeletal impairments to the successful treatment of chronic pelvic pain cases. Research could also be done to assess the effectiveness of indirect or non-internal vaginal physical therapy treatment of chronic pelvic pain cases by nonspecialized physical therapists in order to further demystify pelvic pain and offer more accessible solutions to patients.

#### References

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#### **Contact details**

Dr. Dianna DiToro, PT, DPT, MA, MS, CSCS can be reached at: dianna.ditoro@gmail.com