**Chronic Pelvic Pain Module- Learning Activity**

**Patient Case\***

Ms. P is a 26 year-old female referred to physical therapy by her gynecologist with a diagnosis of pelvic pain. Pt reports 6/10 pain between lower abdomen, left groin, and low back with radiation to right buttock and left posterior mid-thigh for over two years. She c/o increased urinary urgency and frequency (voiding hourly) and constipation. Reports hard bowel movements 2-3x/week that require a great deal of strain to evacuate and incomplete emptying. Sxs are aggravated by sexual intercourse, prolonged sitting, and prolonged standing. She has no other significant PMHx.

**Social History:**

Pt is a former college gymnast who now works as a finance administrator. Her pain is aggravated during prolonged sitting at her desk, requiring her to take hourly “standing breaks.” She lives alone in an apartment on the 2nd floor with elevator access.

**Functional Status:**

Pt reports exercising 6 days/week including regular yoga classes and a rigorous abdominal strengthening program with “crunches and planks.” She feels committed to fitness and will “push through the pain.”

**Objective Examination Findings**:

|  |  |
| --- | --- |
| Observation of Posture | * Forward-head posture
* Kyphosis
* Posterior pelvic tilt
 |
| Pelvic and Sacral Palpation and Mobility | * Pain over L PSIS and + Fortin’s sign
* Increased mobility of L (vs R) PSIS with lumbopelvic flexion
* Pain and limited mobility on L with lumbosacral extension
 |
| Tests for Load Transfer | * + Trendelenburg; L hip ABD weakness
* Active Straight Leg Raise (ASLR): difficulty lifting LLE; manual compression to iliac crests improves ASLR
 |
| Tests for SIJ pain provocation | **ALL positive for L SIJ pain:** * + FABER
* + Posterior thigh thrust
* + Gaenslen’s
* Resisted ABD
* SIJ Compression
 |
| Lumbar Mobility Testing | * Decreased lumbar extension in WB
* + prone instability test
 |
| Hip Screen | * Pain with end range L flexion; limited L IR
* Weakness in L hip ER, glut med, and glut max
 |
| Trunk Muscle Strength | * Poor TA activation and RA over-activation
* Multifidus under-activation
 |
| Internal vaginal examination | * Pain response (allodynia) and muscle spasm to palpation of bilateral LA, OI, at anterior pubic ramus
* LA weakness
* Inability to fully relax LA following contraction
 |
| Soft Tissue Palpation | * Myofascial trigger points (MTrPs) and tender points (allodynia) in abdominal muscles, pelvis, thighs, and PFM
* Diffuse pain distribution
 |

**Health and Participation Impact Questionnaires**:\*\*

|  |  |  |  |
| --- | --- | --- | --- |
| Measure | Urge-Urinary Distress Inventory (Urge-UDI) Urge-Incontinence Impact Questionnaire (Urge-IIQ) | Female Sexual Function Index (FSFI) | Oswestry Disability Index (ODI) |
| Initial Score | Urge-UDI Score: 2.7Urge-IIQ Domain Scores-Activities: 2.3Travel: 1.5Physical activities: 1Feelings: 2.25Relationships: 1.75Sexual Function: 4 | Pain subscale: 1.4 | 32% |

\*Case adapted from George et al. (2013)

\*\*Scoring interpretations for Health Participation Impact Questionnaires:

* The Urge-UDI and Urge-IIQ measure the presence of urge-related urinary incontinence symptoms and perceived symptom-related bother and the impact of these symptoms on health-related quality of life, respectively. Urge-UDI scores range from 0-4 with a greater score indicating greater symptom-related distress. Urge-IIQ scores in each domain range from 0-6 with higher scores indicated greater symptom impact on quality of life.
* The FSFI measures sexual function across 6 domains, including pain associated with intercourse. This patient was asked to answer only the FSFI Pain Domain questions. FSFI Pain Subscale Scores range from 0-6 with lower scores indicating greater pain associated with intercourse.
* The ODI measures symptoms in persons with low back pain. It is scored on a 100 points (%) scale, with lower numbers indicating fewer symptoms. The minimally clinically important difference (MCID) is defined as 6 points.

**Part A – Produce a paper that addresses the questions asked of the case study. You may use lists and bullet points where appropriate. Please provide references and a reference list. Maximum length: 500 words (excluding reference list)**

* What other questions or examination techniques do you have for this patient? Be sure to explain your clinical reasoning.
* What structure(s) or system do you think may be the patient’s primary pain generator and why? What about potential secondary pain generators/perpetuators of pain?
* Do you want to strengthen or lengthen the PFM? Provide rationale with evidence to support where available.
* What other evidence-based intervention(s) would you choose?
* List 2-3 functional goals.

**Part B -- Produce a paper that addresses the questions asked of the case study. You may use lists and bullet points where appropriate. Please provide references and a reference list. Maximum length: 500 words (excluding reference list)**

Ms. P returns for a follow-up appointment after two cancellations. She reveals that she has little optimism that physical therapy is helping resolve her pain. She reports that her pain is worsening and keeping her from sleeping at night, that she has given up her exercise routine, and now occasionally takes the elevator to her second floor apartment. You attempt to re-evaluate her, but she is too tender and irritated to complete most of the examination. You decide to administer an additional questionnaire, the Pain Catastrophizing Scale (PCS), to determine more about her pain behaviors (see below.)

* How would you respond to Ms. P’s concerns? Provide a short script that includes some concepts and principles of pain neuroscience education.
* Would you now choose or prioritize different intervention(s) than last week? If yes, explain why. If no, explain why not. Support your decisions with evidence, as available. (Check out this week’s supplementary resources for ideas.)
* Briefly outline how you might integrate your selected intervention(s) into functional activities and/or exercises that are relevant to Ms. P. Be sure to explain your clinical reasoning and support your decisions with evidence, as available.

