Physical Therapy to Manage Pain

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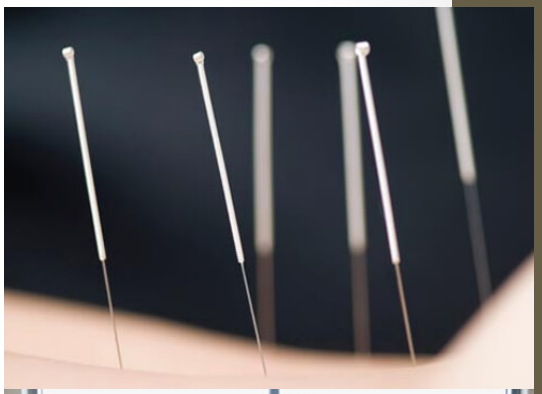
The PT Commitment to Managing Pain

- PT has long been considered a conservative approach to manage chronic pain
- The physical therapist often encounters patients using opioids long term to manage their pain
- Chronic pain is often beyond “physical”
- The APTA’s national campaign - commitment to raise awareness of the risks of opioids and to promote conservative management of symptoms with PT intervention

Physical Therapy Interventions and Chronic Pain

- PT can offer a variety of evidence-based treatment approaches for patient with chronic pain, such as
  - Manual Therapy (soft tissue/ Joint mobilization, strain/counterstrain, passive stretching, myofascial release, etc.)
  - Exercise (ROM/ stretching, strengthening/ stabilization, yoga, home programs)
  - Education (educating patients on pain theories and providing info on conservative treatment vs. medical/ drug options)
  - Guided Imagery, Body mapping, mindfulness work
  - Aquatic Therapy (deweighting, relaxation, mobility)
  - Taping/ kinesiotaping
  - Dry needling (neuromuscular re-education at the muscle spindle using needles)
  - Modalities (LLLT, Ultrasound, Electrical stim, Ice/ heat, etc.)



But What Else Do We Do??

But What Else Do We Do??

- Blogpost: Education and Advice: The Foundations of our Profession by, David Lanfranco
  - “Never forget that you are treating a person and not a pathology”
  - Dr. Lorimer Moseley – pain expert said, “Anything that changes your brain’s evaluation of danger will change the pain.”
  - Pain is not a synonym of damage. It is influenced by several factors not always body related.
  - Tests and imaging sometimes “poison the mind of the patient” to believe there is a connection between the physical damage and the pain s/he is experiencing.
- The PT is in a unique position to address all of the drivers of the pain experience- biological, psychological and social.

Chronic Pelvic Pain and Pelvic Rehabilitation

- CPPS is characterized as any pain in the pelvis, lower abdomen, vagina, perineum, anus, urethra, groin or tailbone
- Often associated with sitting, but can occur with activity
- Can result in burning during urination or urinary urgency and frequency, or pain with defecation
- Conditions associated with CPPS include:
  - Interstitial Cystitis
  - Pudendal/ilioinguinal/iliohypogastric Neuralgia
  - Levator ani Syndrome
  - Vulvodynia
  - Vaginismus

Chronic Pelvic Pain and Pelvic Rehabilitation

- CPPS is often associated with connective tissue, soft tissue, or joint dysfunction in the spine, hips or pelvic region
- Patients with these conditions are often extremely debilitated and anxious, and we employ a wide variety of treatment approaches, including relaxation and guided imagery.
- Patients often feel ***HOPELESS*** and that no one believes or understands them.
- MANY of our patients are treating pain with opioids

“It hurts ‘down there’!”

- “Natalie”- 32 y/o post partum (12 weeks) nursing female who reports onset of dyspareunia, rectal pain and severely painful bowel movements following vaginal birth
- Pain progressed to rectal pain with standing
- Abstains from sexual intercourse
- Quit job as attorney due to inability to tolerate daily activities
- Consulted with CNM – scar healed and good PFM contraction
- Referred to colorectal surgeon for consult
  - Sigmoidoscopy x 2, pelvic MRI, blood work – all neg.
- Dx’ed with anal fissure and underwent botox injections
  - Fecal Urgency became an issue for some time
- Surgery recommended: anal sphincterotomy and referred for pain management
- Friend recommended pt. try pelvic PT and pt. asked for referral

“It hurts ‘down there’!”

- Problem List:
  - Perineal hypomobility/ tender scar
  - Soft tissue hypertonicity with severe TTP
  - Decreased PFM coordination with attempts at relaxation
  - Lumbopelvic asymmetries
  - Decreased bowel health/ poor defecation dynamics
  - Inability to tolerate bowel movements or intercourse without pain.
  - Having difficulty caring for her baby due to inability to stand
- Goals:
  - Improve soft tissue condition/ activity/ ROM to WNL
  - Restore optimal LP alignment/ ms balance and stabilize
  - Decrease pain with penetration and BM’s to 0-3/10 worst
  - Restore functional, pain-free voiding through adequate PFM relaxation
  - Prevent need for surgical or further medical intervention

“It hurts ‘down there’!”

- Assessment:
  - Signs and symptoms did not suggest anal fissure as source of pain
  - Recommended 12-15 PT sessions before consideration of surgery
- Treatment
  - Myofascial release and strain/ counterstrain to all painful structures with emphasis on deep transverse perineal
  - Joint mobilization/ alignment corrections to sacrum and spine
  - Bladder/ bowel health training (fiber, colon massage, water intake)
  - Chronic pelvic pain education (Fear/Tension/ Pain cycle)
  - Relaxation/ downtraining/ diaphragmatic breathing/ defecation dynamics
  - Perineal Massage, dilators, stretching for home program

“It hurts ‘down there’!”

- Intervention – 1x/wk, 45 min sessions (17 total)
  - Focus on manual therapy
  - At visit #5, pt. was in tears, reporting that she was “going to have surgery”.
  - Treatment focused on vaginal portion of deep transverse perineal, which REPRODUCED rectal pain
  - By visit #6, pt. reported 75% improvement in symptoms
  - By visit #12, sex was painless and pt. could stand to care for baby for most of the day without pain
  - Discharge at visit #17, at which pt. reported complete resolution of symptoms, including painful BM’s

“It hurts ‘down there’!”

- Why did we do it? Any evidence?
  - Fitzgerald, et al (2012): RCT of 87 women with pelvic pain/ urinary issues with trial of myofascial PT
    - 59% reported improved or completely resolved symptoms by visit 10, including urinary urgency and frequency
  - Rosenbaum and Owens (2008): J of Sex Med – The role of pelvic floor physical therapy in the treatment of pelvic and genital-pain-related sexual dysfunction
    - PT Rx of pelvic pain should be considered an integral component of the team approach to CPP/ sexual dysfunction
  - Bortoloni, et al (2015): J of Sex Med
    - sexual dysfunction appears to be significantly correlated with age and high pelvic floor muscle tone.
  - Vandyken & Hilton (2016): Sex Med Rev
    - “It is reasonable for physical therapists to utilize evidence based strategies such as CBT, pain biology education, Mindfulness Based Stress Reduction (MBSR), yoga and imagery based exercises to address the biopsychosocial components of female sexual pain”

Key Points to Consider

- This patient may have suffered long term without PT intervention
- This pain was difficult to assess and find!
- In this case, physical therapy offered the patient
  - Time with a medical provider on a regular basis for ongoing assessment of symptoms
  - Access to health care weekly in the event a referral had to be made
  - Education and assurance that her symptoms were treatable
  - An opportunity to take control of her symptoms via a home program

How Is PT Accessed?

- All physical therapists are prepared through education and experience to treat conditions that carry the symptom of pain. However, when seeking a provider, you may want to consider:
  - A PT who is a board-certified specialist or who has completed post-graduate residency
  - A PT who is well-versed in the bio-psycho-social model of care
  - A PT who has come highly recommended by a friend or provider, or one through the “find a PT” link on the APTA website.
- A health care provider can make a referral to physical therapy, but in some practices, a referral is not necessary. Check with your health insurance and the therapist’s office to find out what is needed.

References

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