

PHYSICAL THERAPY CAN REDUCE SYMPTOMS OF PAINFUL BLADDER SYNDROME

Hypothesis / aims of study

Clinically, it has long been recognized that interstitial cystitis/ Painful Bladder Syndrome (PBS) is associated with connective tissue and muscular abnormalities of the pelvic floor, abdominal wall and hip girdle. This recognition has led to reports of PBS symptom relief by therapeutic efforts directed at those muscular and connective tissue abnormalities. Whether these musculoskeletal abnormalities of the abdominal wall and pelvic floor musculature found in IC/CPP sufferers represent primary or secondary phenomena remains unknown. Although pelvic floor physical therapy (PT) is widely utilized for treatment of PBS there has been very little documentation of the effectiveness of PT for this indication, as measured by validated scales. Our objective was to review our experience with PT for treatment of PBS and report the degree of change in the O'Leary-Sant score that was observed during the first three months of treatment.

Study design, materials and methods

We performed a retrospective chart review of patients with PBS symptoms of urinary urgency, frequency and pain who were treated with physical therapy. It is our usual clinical practice to administer the O'Leary-Sant scale¹ to patients with PBS before treatment begins, and approximately monthly during treatment. The O'Leary-Sant scale includes the Interstitial Cystitis Symptom Index (ICSI, range 0-20) and the Interstitial Cystitis Problem Index (ICPI, range 0-16). Patients were included in this review if they had a clinical diagnosis of PBS, had completed the O'Leary-Sant scale before treatment and at least one more time within the first three months of therapy. If more than one post-treatment scale had been completed, the last scores within the three-month window were used as outcome measures. Not all patients had completed treatment by the time the 3-month score was obtained. We used a repeated measured Sign Test to compare scores before and after treatment. Physical therapy treatments included connective tissue mobilization over trunk, thighs and buttocks, release of any trigger points, resolution of any adverse neural tension along the course of pudendal nerve, elongation and rehabilitation of pelvic floor and hip girdle musculature, education and exercises for abdominal muscle recruitment/coordination and optional behavioral modification and relaxation training as appropriate.

Results

Data from 37 patients was included in this review.

ICSI scores fell from median (range) of 12 (6-19) before treatment, to 6 (2-17) after therapy (Figure 1; Sign test $z=3.8$, $p<0.001$). ICPI scores fell from median (range) of 10 (4-16) before treatment, to 7 (0-16) after therapy (Sign test $z=3.8$, $p<0.001$).

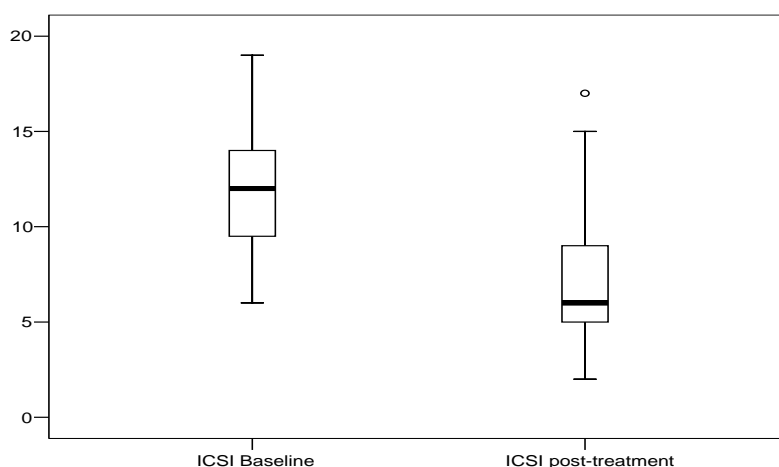


Figure 1: ICSI scores fell during 1-3 months' treatment with physical therapy. Median ICSI score was 12 at baseline, falling to 6 after treatment.

Interpretation of results

Broadly, our review suggests that the physical therapy techniques described are effective in resolving some of the symptoms of PBS. Our study is limited by its retrospective nature, lack of control group, and lack of data concerning the pain of PBS. With these limitations, this is one of very few case series documenting any objective outcomes with PT for treatment of PBS.

Concluding message

Physical therapy techniques designed to resolve painful tissue restrictions and rehabilitate the pelvic floor were associated with a reduction in O'Leary-Sant scores in this sample of women. Prospective studies are warranted.

Reference

1. O'Leary MP, Sant GR, Fowler FJ, Whitmore KE, Spolarich-Kroll J. The interstitial cystitis symptom index and problem index. Urology 1997;49(Suppl 5A):58-63.