Standardization of Terminology of Pelvic Floor Muscle Function and Dysfunction: Report From the Pelvic Floor Clinical Assessment Group of the International Continence Society

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STANDARDIZATION

This report presents a standardization of terminology of pelvic floor muscle function and dysfunction. No earlier documents contained definitions on this terminology. These definitions are descriptive and do not imply underlying assumptions that may later prove to be incorrect or incomplete. By following this principle, the International Continence Society aims to facilitate comparison of results and enable effective communication by investigators performing pelvic floor muscle studies.

It is suggested that acknowledgment of these definitions in written publications be indicated by a footnote to the section “Materials and Methods” or its equivalent, to read as follows: “Terminology used is conform the definitions recommended by the International Continence Society, except where specifically noted.”

MULTIDISCIPLINARY

The pelvic floor is related to more than one organ system. Dysfunction of the pelvic floor therefore influences different functions at the same time. This report is on pelvic floor muscle function and dysfunction, and not on pelvic floor disorders. It contains no terminology on pelvic organ prolapse, urinary, or fecal incontinence. Other reports refer to these subjects [Bump, 1996; Weber et al., 2001; Abrams et al., 2002a]. This report on terminology of the pelvic floor muscles is written for use, in daily clinical practice, by every health care provider working with patients who have pelvic floor muscle problems. It facilitates the communication between different carers in the field of pelvic floor muscle pathology. Because it has been developed by a multidisciplinary group, it

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can be used by different specialties. This document is based on our current knowledge of physiology and pathophysiology of the pelvic floor muscles.

PELVIC FLOOR

The term pelvic floor relates to the compound structure, which closes the bony pelvic outlet. The term pelvic floor muscles refers to the muscular layer of the pelvic floor. The pelvic floor consists of different layers, the most cranial being the peritoneum of the pelvic viscera and the most caudal being the skin of vulva, scrotum, and perineum [DeLancey, 1992]. The middle layers of the pelvic floor are made up of predominantly muscular tissue. Apart from the pure pelvic floor muscles, fibro-muscular and fibrous elements, like the endo-pelvic fascia are found in this layer. Different well recognizable muscles together form the muscular layer of the pelvic floor: levator ani, striated urogenital sphincter, external anal sphincter, ischiocavernosus, and bulbospongious. All these muscles are working together to seal off the lower aspect of the pelvic cavity. Urethra, vagina, and rectum pass through the pelvic floor and are surrounded by the pelvic floor muscles. The pelvic bones are the structures to which the muscular layer is attached. The function of the pelvic floor is to support the pelvic organs. The function of the pelvic floor muscles is performed by contraction and relaxation. In its resting state, the pelvic floor gives support to the pelvic organs. Whether the support function is normal depends on the anatomical position of the muscles, on the activity of the pelvic floor muscles at rest (active support) and on the integrity of the fascia (passive support). During intra-abdominal pressure rise, the pelvic floor muscles must contract to maintain the support function of the pelvic floor. A contraction of the pelvic floor muscles results in a ventral and cranial movement of the perineum, and an upward movement of the pelvic organs together with an anterior movement caused primarily by the vaginal and rectal parts of the levator ani. When the pelvic floor muscles contract the urethra closes, as do the anus and the vagina. This contraction is important in preventing involuntary loss of urine or rectal contents. For women it can also function as a defense mechanism against sexual intercourse. For maintaining continence, it is also important to realize that detrusor activity is inhibited by pelvic floor muscle contraction.

Pelvic floor muscle relaxation following contraction results in a reduction in the support given to the urethra, vagina, and anus. The perineum and the pelvic organs return to their anatomical resting position. The pelvic floor muscles must relax in order to remove the passive continence mechanisms, thereby favoring normal micturition. The same is true for relaxation before and during defecation, allowing the anorectal angle to become obtuse, favoring rectal emptying.1

1In the literature, there is discussion on the action of the pubococcygeal muscle as to whether this muscle plays a role in giving rectal support against an increased abdominal pressure [Fucini et al., 2001].

Terminology

At this moment, there is no existing international agreement on terminology of pelvic floor muscle dysfunction. In the literature most studies are clinical studies for example on the effect of pelvic floor muscle therapy for urinary incontinence. Basic studies on the different aspects of the pelvic floor muscles are not available. When considering standardization of terminology, many problems have to be faced. The different aspects of the pelvic floor muscles and their function are hard to define. Furthermore even when they can be defined, they cannot be easily measured. And even when they can be measured, there is no agreement as to what is considered to be normal values.

This report adheres to the ICS principle that symptoms, signs, and conditions are separate categories and adds a category of additional tests.

Symptoms associated with pelvic floor muscle dysfunction. Symptoms are the subjective indicator of a disease or change in condition as perceived by the patient, carer, or partner, and may lead him/her to seek help from health care professionals. Symptoms are the complaints mentioned by the patient during the patient interview or stated on questionnaires filled in by the patient. Symptoms alone cannot be used to make a definitive diagnosis nor can they denote the pathophysiological mechanism. Because the pelvic floor muscles act as an entity, it is often the case that dysfunction of the pelvic floor muscles will lead to dysfunction of more than one organ system. Therefore, in the patient interview it is mandatory to ask about symptoms of the different tracts influenced by the pelvic floor muscles [Abrams et al., 2002b]. During the interview the following categories of questions should be asked: those relating to micturition, defecation, vaginal and sexual function, and pain.

Symptoms associated with pelvic floor muscle dysfunction are divided into five groups: lower urinary tract symptoms, bowel symptoms, sexual function, prolapse, and pain.2

Lower urinary tract symptoms.
- urinary incontinence
- urgency and frequency
- slow or intermittent stream and straining
- feeling of incomplete emptying

Bowel symptoms
- obstructed defecation3
- functional constipation4

2The definitions of lower urinary tract symptoms, vaginal symptoms, and pain can be found in: The Standardization Report of Terminology of Lower Urinary Tract Function [Abrams et al., 2002a].

3Obstructed defecation can be described as having the urge to defecate but being unable to completely empty the rectum with or without straining.

4Following the diagnostic criteria for functional gastrointestinal disorders (Rome II), functional constipation presents as persistent difficult, infrequent, or seemingly incomplete defecation [Thompson et al., 1999] (www.romecriteria.org).
• fecal incontinence
• rectal/anal prolapse

Vaginal symptoms
• pelvic organ prolapse

Sexual function
• in women: dyspareunia
• in men: erectile and ejaculatory dysfunction
• in both: orgasmic dysfunction

Pain
• chronic pelvic pain
• pelvic pain syndrome

Signs suggestive of pelvic floor muscle dysfunction. Signs are observed by the examiner, including simple means, in order to verify symptoms and quantify them. It should be remembered that not all signs have associated symptoms (e.g., pelvic organ prolapse). Some functions of the pelvic floor muscles can be tested during physical examination. For instance a voluntary contraction of the pelvic floor muscles can be assessed by inspection and palpation. Quantification of the function of the pelvic floor muscles is not easy, due to the lack of simple to use and reliable measurement techniques, and the lack of cut-off values for pathological conditions. Furthermore, the reproducibility of testing is questionable.

Visual inspection.

5Fecal incontinence in the Rome II criteria is defined as: recurrent uncontrolled passage of fecal material [Whitehead et al., 1999].
6Pelvic organ prolapse is frequently associated with a feeling of rectal fullness of pelvic heaviness or a bearing down sensation especially when standing [Bump et al., 1996].
7Dyspareunia is the symptom of painful sexual intercourse.
8Chronic pelvic pain is non-malignant pain perceived in structures related to the pelvis of either men or women [Fall et al., 2004].
9Pelvic pain syndrome is the occurrence of persistent or recurrent episodic pelvic pain associated with symptoms suggestive of lower urinary tract, sexual, bowel, or gynecological dysfunction. There is no proven infection or other obvious pathology [Abrams et al., 2002a].
10Apart from contraction and relaxation other terms are also thought to be appropriate to the pelvic floor muscles: tone, volume, and force. Tone of the pelvic floor muscles is difficult to define and cannot be measured. The volume of the pelvic floor muscles can probably be measured with an MRI but the definition of what is to be considered as pelvic floor muscles is not well defined. The force of the pelvic floor muscle contraction and related terms like strength, power, endurance, and exhaustion are yet not applicable in clinical practice.
11It is mandatory to give the patient a full explanation as to what to expect during the physical examination, before starting it. An assessment must be discontinued if the patient exhibits any symptoms of distress during the examination. Patient dignity must be considered and maintained at all times (www.gmc-uk.org/standards/intimate.htm).
12The condition of the vulva and vagina (atrophy, inflammation) should be noted. A touch test is advised. In this test, the introitus is touched lightly with a cotton swab at different points. Normally this does not hurt but in patients with a vulval pain syndrome it will be classified as painful.
13In female patients, the ICS POPQ system is advised [Bump et al., 1996]. In female and male patients attention should also be focused on the anus, looking for rectal or anal prolapse.
14The two muscle groups, pelvic floor, and transversus abdominis are now understood to be part of the local muscle system of lumbo-pelvic stability. The other components are the diaphragm and the deep fibers of musculus multifidus. Increase in abdominal muscle activity is synergistic with increase in pelvic floor muscle activity [Sapsford et al., 2001; Neumann and Gill, 2002].
Digital palpation

- Investigators reporting pelvic floor muscle studies should state the position of the patient (supine, lithotomy, lateral, standing) and the time of the day. When appropriate the verbal instructions given to the patient should be literally written down. Also additional instruments used should be described. In the case of digital palpation, the number of fingers used should be noted.
- Digital palpation of the pelvic floor muscles is an easy to perform physical examination. Digital palpation is used to assess the pelvic floor muscles and surrounding areas at rest, and during contraction and relaxation. The pelvic floor muscles are palpated circumferentially.
- Digital palpation is also used to test for pain. Digital pressure on the pelvic floor muscles may reproduce or intensify the patient’s pain. This pain-sign can be unilateral.
- Voluntary contraction of the pelvic floor muscles means that the patient is able to contract the pelvic floor muscles on demand. A contraction is felt as a tightening, lifting, and squeezing action under the examining finger. A voluntary contraction can be absent, weak, normal, or strong.
- Voluntary relaxation of the pelvic floor muscles means that the patient is able to relax the pelvic floor muscles on demand, after a contraction has been performed. Relaxation is felt as a termination of the contraction. The pelvic floor muscles should return at least to their resting state. A voluntary relaxation can be absent, partial, or complete.

Digital palpation is also used to test for pain. Digital pressure on the pelvic floor muscles may reproduce or intensify the patient’s pain. This pain-sign can be unilateral.

Additional tests for pelvic floor muscle dysfunction.

- Investigators reporting pelvic floor muscle studies should state the position of the patient, the type of electrode, and the recording equipment used. When appropriate the verbal instructions given to the patients should be literally written down.
- EMG of the pelvic floor muscles may be performed using surface- or needle-electrodes. The techniques are quite different, as is the inconvenience for the patient. The results are also quite different in nature. Surface electrodes are non-selective because of their large surface area; they yield information on normal function and dysfunction (either neurological or non-neurological). Needle electrodes are

The Oxford scale is used most frequently, but inter-observer variability has been reported to be high. Modified scales have been used but the simplest classification is absent, weak, normal, and strong. With every scale one has to realize that there is no gold standard to refer to [Bo and Finckenhagen, 2001].

- In an effort to raise abdominal pressure the thoracic, diaphragmatic, and abdominal muscles act together with the pelvic floor muscles. Anticipatory or feed forward contractions help to increase urethral closing pressure before the increase in abdominal pressure.
more selective and can also be used to assess neurological conditions that may involve the pelvic floor muscles.

- Intra-vaginal or intra-anal EMG probes will give the same (functional) information as surface electrodes.\(^\text{21}\)
- During a voluntary contraction of the pelvic floor muscles, the intensity of the EMG signal should increase. When the patient is asked to hold the contraction, a sustained high intensity on the EMG can be observed. At the subsequent relaxation, the intensity will fall to or even below baseline.

**Pressure measurements**

- Investigators reporting pelvic floor muscle studies should state the position of the patient and the type of transducers, balloons, and EMG was used.
- Urodynamics can be done to obtain insight into the function of the lower urinary tract. Special attention should be paid to the function of the pelvic floor muscles in relation to the bladder. Simultaneous measurement of the pelvic floor EMG, during the micturition phase can demonstrate the mechanism of dysfunctional voiding.
- Anorectal manometry assesses continence mechanisms by determining: (a) rectal volume required for sensation of distension and urgency to defecate, (b) rectal compliance, (c) voluntary contractions of the external anal sphincter, and (d) the resting pressure in the anal canal. Water perfused and solid state pressure transducers are used in combination with a balloon positioned in the anal canal. EMG of the anal canal can be added but should not be used alone.\(^\text{22}\)

**Imaging**

- Investigators reporting pelvic floor muscle studies should state the position of the patient and the type of equipment used. For measurements, it should be stated which referral points and lines are used, and how for example the decent is computed. For ultrasound and MRI the type of transducer or coil should be stated. When appropriate the verbal instructions given to the patient should be literally written down.
- Several imaging techniques are used to assess the pelvic floor and the organs of the pelvis. Most techniques are radiological and many still have to be classified as experimental.\(^\text{23}\)
- Ultrasound can be performed with an endovaginal or endoanal probe, or with an external probe on the introitus or perineum. The position of the bladder neck in relation to the symphysis pubis is an important landmark. During the investigation, the patient can be asked to contract the pelvic floor muscles and this can be seen to result in an elevation of the bladder neck. Anal ultrasound is used to define structural defects in the anal sphincter.
- Fluoroscopy is the oldest technique used to indirectly image the pelvic floor and the pelvic organs. Filling of the intestine, colon, rectum, and vagina with contrast medium is known as evacuation proctography or defecography. A lateral projection is important to get the best information. At rest the anatomical position of the pelvic organs and the pelvic floor can be visualized. Subsequently the patient can be asked to strain and can be asked to contract the pelvic floor muscles. The changes in the anatomical positions can then be observed.
- Video-urodynamics combines the techniques of urodynamics and fluoroscopy. This will give extra insight into the relationships between pelvic floor anatomy and function of the bladder and urethra.
- MRI is the newest technique for imaging of the pelvic floor. The use of endoluminal coils is advised in order to obtain adequate images of the pelvic floor and the related structures. Dynamic MRI can be used to observe the movement of the pelvic floor during Valsalva manoeuvre, a defecatory effort and during pelvic floor muscles contraction. It can also be used for the detection of pelvic organ prolapse.
- Different imaging techniques are used for different indications.\(^\text{24}\)

**Other techniques.** Several diagnostic tests can be used to get more indirect proof of the function of the pelvic floor muscles.

- A bladder diary is an important investigation in lower urinary tract symptoms.
- A defecation diary will help in investigating anorectal symptoms.
- Neurophysiological investigations like pudendal nerve latency is time used when there is suspicion of a neurological problem causing pelvic floor muscle dysfunction.

\(^{21}\)EMG of the pelvic floor muscles using surface electrodes gives insight into the function of the pelvic floor muscles both to the examiner and to the patient. It should be kept in mind that with the use of surface electrodes other muscles will contribute to the EMG signal.

\(^{22}\)For a complete description see the Rome II report: functional disorders of the anus and the rectum [Whitehead et al., 1999].

\(^{23}\)In a state of the art article in Radiology, an overview of the imaging techniques that are available, their indications and limitations was presented [Stoker et al., 2001].
Conditions. Conditions are defined by the presence of characteristic symptoms associated with specific signs. Based on symptoms and signs the following conditions can be determined.

Normal pelvic floor muscles. A situation in which the pelvic floor muscles can voluntarily and involuntarily contract and relax. Voluntary contraction will be normal or strong and voluntary relaxation complete. Involuntary contraction and relaxation are both present.

Overactive pelvic floor muscles. A situation in which the pelvic floor muscles do not relax, or may even contract when relaxation is functionally needed for example during micturition or defecation. This condition is based on symptoms such as voiding problems, obstructed defecation, or dyspareunia and on signs like the absence of voluntary pelvic floor muscle relaxation.

Underactive pelvic floor muscles. A situation in which the pelvic floor muscles cannot voluntarily contract when this is appropriate. This condition is based on symptoms such as urinary incontinence, anal incontinence, or pelvic organ prolapse, and on signs like no voluntary or involuntary contraction of the pelvic floor muscles.

Non-functioning pelvic floor muscles. A situation in which there is no pelvic floor muscle action palpable. This condition can be based on any pelvic floor symptom and on the sign of a non-contracting, non-relaxing pelvic floor.

Directions for future research.
The ICS wants to stress the need for future research in the field of pelvic floor muscle function and dysfunction. The following directions are thought to be important.

- Studies on inter- and intra-observer variability for testing of the pelvic floor muscle signs as described in this report.
- Studies on the development of disease specific pelvic floor muscle dysfunction questionnaires.
- Studies on the normal values for pelvic floor muscle function when measured with EMG.
- Studies on the possibility to measure and quantify pelvic floor muscle tone, force, and volume.
- Studies on the relation of pelvic floor muscle dysfunction as described in this report and the symptoms mentioned by the patients.

ADDENDUM

The ICS Pelvic Floor Clinical Assessment group was announced at the ICS meeting in Denver in 1999. The members of the committee were invited to be active in the group right after that meeting. The members invited are all experts on their own field of healthcare in relation to pelvic floor muscle function. Members are from seven different disciplines: urology, gynaecology, surgery, gastro-enterology, physical therapy, sexology, and neurology. Members came from seven different countries reflecting the worldwide covering of the ICS. The group had a yearly discussion during every ICS meeting. The first draft of the report was put on the Internet at the ICS website (www.icsoffice.org) in 2001 and presented in 2002 in Heidelberg. As a result of the discussion with the members of ICS, the report was rewritten and made more compact. This version was then commented on by 25 ICS members and put on the website. During the meeting in Florence in 2003, the new version based on this comments was discussed and accepted by the ICS general meeting. The document was than again put on the internet for further comments.

Members of the committee were: John Benson, Bary Berghmans, Kari Bø, Jacques Corcos, Clare Fowler, Jo Laycock, Peter Lim Huat Chye, Rik van Lunsen, Guus Lycklama, Bert Messelink (chairman), John Pemberton, Alex Wang, Alain Watier.

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