“Diagnostic Investigation of the Pelvic Floor”: A Helpful Tool in the Approach in Patients with Complaints of Micturition, Defecation, and/or Sexual Dysfunction

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ABSTRACT

Introduction. Pelvic floor dysfunction is recognized to be related to lower urinary tract dysfunction and to lower gastrointestinal symptoms, and is an influential factor in dysfunction and subsequent behavior of the genital system in both men and women. Caregivers should be informed regarding normal pelvic floor function in general and should be able to identify specific aspects of pelvic floor dysfunction in patients with related symptoms. In our hospital, this diagnostic consultation is indicated as Diagnostic Investigation of Pelvic Floor Function (DIPFF).

Aim. This study looked at pelvic floor dysfunction related to specific complaints.

Methods. DIPFF consists of a medical history, a physical examination, including the International Continence Society (ICS) pelvic organ prolapse quantification system in female patients, and a biofeedback registration using a vaginal or anal probe. Based on our experience, we defined an elevated rest tone as greater than 2 μV using intravaginal or intra-anal electromyography.

Main Outcome Measures. Stratification of patients with a single complaint, a combination of two or three complaints of the micturition, defecation or sexual (all compartments of the pelvic floor) resulted in subgroups of respectively 30, 74, and 133 patients.

Results. A total of 238 patients with complaints of micturition, defecation, and/or sexual function were included in this study. Electromyographic analysis revealed an elevated rest tone of the pelvic floor in 141 patients. In 184 patients, we found an involuntary relaxation of the pelvic floor.

Conclusion. In our retrospective study, we found that 77.2% of patients who presented to the clinic with urinary, gastro or sexual complaints had measurable pelvic floor dysfunction (69.3% overactive rest tone and 7.9% under active rest tone). In relation to the ICS terminology, there is a need for a well-defined normal vs. elevated rest tone of the pelvic floor. Voorham-van der Zalm PJ, Lycklama à Nijeholt GAB, Elzevier HW, Putter H, and Pelger RCM. “Diagnostic Investigation of the Pelvic Floor”: A helpful tool in the approach in patients with complaints of micturition, defecation, and/or sexual dysfunction. J Sex Med 2008;5:864–871.

Key Words. Pelvic Floor; Diagnostic Investigation; Voiding Dysfunction; Defecation; Sexual Function

Introduction

The pelvic floor controls isolated and integrated functions, sustains proper anatomic relationships between pelvic visceral organs and its outlets, and shares the basic mechanism with various visceral organs that control their function [1]. The pelvic floor, consisting of muscular and fascial components, is the binding element between these organs. Pelvic floor dysfunction is recognized to be related to lower urinary tract dysfunction and, more recently, to lower gastrointestinal symptoms as well [1]. It is also considered to be an influential factor in dysfunction
and subsequent behavior of the genital system in both men and women [1]. These multisystemic functions point to the importance of caregiver awareness regarding normal pelvic floor function in general and the need for tools to diagnose specific dysfunction in patients with related symptoms.

However, literature is scarce on the topic of the diagnostic investigation of pelvic floor and there is a lack of uniformity in the description of the anatomy per se and the nomenclature of the pelvic floor [2–4]. The pelvic floor comprises of several layers: from superior to inferior, the supportive connective tissue of the endopelvic fascia, the pelvic diaphragm (levator ani and coccygeus muscle), the perineal membrane (urogenital diaphragm), and the superficial layer (bulbospongiosus, ischiocavernosus, and superficial transverse perineal muscles) [5]. The iliococcygeus, pubococcygeus, and puborectalis muscles make up the levator ani muscle and play an important role in the prevention of pelvic organ prolapse and incontinence.

The perineal membrane is a fibrous muscular layer directly below the pelvic diaphragm. The current concept is that the muscular contents of this layer are formed by the distal part of the external urethral sphincter muscle (compressor urethrae and urethrovaginalis part of the external urethral sphincter). The bulbospongiosus and ischiocavernosus muscles of the superficial layer also have a role in sexual function, while the superficial transverse perineal muscle has a supportive role. Pelvic floor muscle contraction presumably involves the contraction of these muscles groups.

Continence is achieved when the pressure resulting from the direct action of the puborectal muscle as such and the external anal and urethral sphincters is greater than the pressure exerted on the bladder through abdominal Valsalva or bladder smooth muscle contraction [2,3,6,7]. Stress urinary incontinence is the complaint of involuntary leakage on effort or exertion, or on sneezing or coughing. Urge urinary incontinence is the complaint of involuntary leakage accompanied by or immediately preceded by urgency [8].

The assessment of the function of the pelvic floor muscles, e.g., concerning in muscle strength, tone, endurance, and coordination, is difficult because of a lack of simple to use and reliable measurement techniques, and a lack of cutoff values for pathologic conditions. Furthermore, the reproducibility of testing is questionable.

Literature describes different techniques for the evaluation of pelvic floor function using transperineal ultrasound, manual muscle testing, and squeeze pressure measurements [9–17]. A standardization of both biofeedback technology and the methodology for its application to the pelvic floor muscle assessment and rehabilitation is also lacking [18]. Kegel [19] was the first to report the efficacy of pelvic floor muscle exercises in treating urinary incontinence in women. Since then, manometric pressure measures and surface electromyography (sEMG) instrumentation have been used as a biofeedback adjunct to pelvic muscle rehabilitation. This feedback helps to isolate the specific muscles and can assist in motivation by visibly displaying pelvic floor muscle activity and progress. sEMG electrodes placed on the abdomen can help prevent the inadvertent overuse of the abdominal muscles when attempting pelvic floor contractions and help train abdominal pelvic synergy in contracting the pelvic floor muscles while experiencing intra-abdominal pressures, such as coughing [20–24]. The behavioral approach of biofeedback-assisted pelvic floor rehabilitation focuses on the healthy functioning of the pelvic floor musculature, which sets the tone for the whole micturition, defecation, and/or sexual function process.

Before beginning therapy, specialists use various diagnostic tools such as urodynamics, a voiding diary, defecogram, or even MRI. However, current diagnostic models have stressed the importance of a physical exam, as well as the assessment of the relationship between pelvic floor function, sexual function, isolated functioning, and the awareness of the relationship between structures like the bladder, rectum, anus, and vagina [7,17,25–28]. The aim of this study was, in this perspective, before starting treatment, to perform a specific diagnostic workup focused on pelvic floor function. In our hospital, this diagnostic consultation is indicated as Diagnostic Investigation of Pelvic Floor Function (DIPFF).

Materials and Methods

Patients with complaints of micturition, defecation, and/or sexual dysfunction related to pelvic floor dysfunction were retrospectively selected from the database of the Pelvic Floor Center at the Leiden University Medical Center (LUMC). We informed our medical ethical committee on this study.
Before DIPFF, all patients with complaints of micturition, defecation, and/or sexual function, underwent comprehensive evaluation, including patient history, physical examination, ultrasonography of the urinary system, a voiding diary, defecogram, or MRI [26,29].

The standardized DIPFF was carried out as follows: DIPFF was done by a pelvic floor physiotherapist and started with taking medical history using the Pelvic Floor Inventories Leiden (PelFIs) [29]. The questions in the PelFIs were related to general health, micturition, and defecation, and to gynecological, obstetrical, and sexual matters. The patients were asked about quality of life and the degree of complaints for every domain using the Visual Analog Scale. The PelFIs questionnaire has been validated in Dutch and has been translated and will be validated in English. An explanation of related relevant anatomy and (patho)physiology was offered, and finally, the patients were asked to perform a pad test (in case of incontinence) and to fill in a voiding diary.

A qualitative investigation of the pelvic floor function included a qualitative physical examination of the pelvic floor function consisting of vaginal and anal visual inspection as well as digital palpation (including the pelvic organ prolapse quantification [POP-Q]). Finally, the pelvic floor function was assessed quantitatively by biofeedback registration.

**Visual Inspection**
Before commencing the physical examination, the patients were fully informed as to what to expect during the physical examination before starting it. An assessment was discontinued if the patient experiences any symptoms of distress during examination.

In case of complaints of micturition or vaginal prolapse, women underwent the examination in supine position. Men and women with complaints of defecation or anal prolapse were examined in lateral lithotomy position.

The inspection of the vulva, perineum, and anus in women and of perineum and anus in men was performed to look for skin pathology and anatomic abnormalities. The testing for pelvic organ prolapse was an integral part of the physical examination of every patient with pelvic floor muscle complaints.

Anal/rectal or vaginal prolapse can be diagnosed by asking the patient to strain. During inspection, the patient was asked to perform one pelvic floor muscle contraction, hereby attempting to prevent the escape of gas or urine. The patient was also asked to cough.

The positions of the anus and the perineum were noted at rest and during straining. In a normal situation, a pelvic floor muscle contraction will lead to ventral and cranial movement of the perineum. Extrapelvic muscle activity was noted. Straining was classified as normal or involuntary relaxation [8].

**Digital Palpation**
A vaginal and rectal exam was part of the investigation. In female patients, the International Continence Society (ICS) POP-Q system was assessed. The POP-Q system was developed by the ICS and was introduced in 1996. It is presently widely used for research purposes but still not yet broadly introduced in clinical practice. In the POP-Q system, nine well-defined points and distances were measured: two points of the anterior compartment (Aa and Ba), two points in the middle compartment (C and D), and two points of the posterior compartment (Ap and Bp). These six points were measured during maximal protrusion of the prolapse and were measured in relation to the hymen. Three additional distances were measured: the perineal body, genital hiatus, and the total vaginal length. The nine measurements were the basis for a 5-point ordinal staging from stage 0 (no prolapse at all) until stage 4 (complete eversion of the vagina) [30,31].

Digital vaginal palpation was performed with one (index) finger because two fingers may stretch the pelvic floor muscles and thereby influence the ability to contract. For anal palpation, the patient was put in a left lateral position; for vaginal palpation, the patient was put in a supine position with one pillow under the head, with hips and knees flexed at 60°.

Digital palpation was performed to assess qualitatively the pelvic floor muscles and surrounding areas at rest, and during contraction and relaxation. The pelvic floor and related muscles, like the external and internal anal sphincter, the puborectal muscle, and the levator ani, were palpated circumferentially based on the anatomy. Digital palpation was also used to test for pain and sensitivity of the palpated areas. Digital pressure on the pelvic floor muscles may reproduce or intensify the patient’s pain. This pain-sign can be unilateral. The patient was asked to contract and to relax the pelvic floor muscles 10 times. After a 1-minute rest, the patient was asked to contract the pelvic floor muscles.
floor muscles for 10 seconds, five times with 1-minute rest in between. The patients were asked to prevent the escape of urine or gas, to cough, and to strain. The quality of the contractions and relaxation was described according to the ICS protocol of the ICS terminology procedure [8].

The quantification of a contraction is problematic. There is no validated scale to quantify the contractions of the pelvic floor muscles. Therefore, quantification, more specific than absent, weak, normal, or strong, was not recommended.

**EMG**

The *quantitative* investigation of the pelvic floor function consists of EMG registration of the behavior of the pelvic floor during an identical sequence of tests as described above. Sex-dependent differences were visible in all three planes. Because of the absence of (inter)nationally accepted reference values, we defined in women, based on our experience for 18 years, a muscle tone at rest of 1–2 μV as normal and a rest tone above 2 μV as an elevated rest tone. In men, the normal rest tone of the pelvic floor was about 2–3 μV.

Because of the clear difference in male and female anatomy, different electrodes are needed in the treatment of pelvic floor dysfunction [11,32]. The Myomed 932 (Enraf Nonius, Delft, the Netherlands) was used for biofeedback registration with a vaginal probe (EMG, two rings vaginal probe 2 mm, V.M.P. Bioparc) or an EMG anal probe (two rings anal probe 2 mm, V.M.P. Bioparc). The vaginal probe was inserted up to the thinnest part, at the level of the introitus, and the anal probe was inserted with the proximal bulge at the anal verge [33]. During a voluntary contraction of the pelvic floor muscles, the intensity of the EMG signal should increase.

When the patient was asked to hold the contraction, a sustained high intensity on the EMG can be observed. At subsequent relaxation, the EMG intensity fell to baseline or even below. First, the muscle tone at rest was registered during 1 minute. Then, the patient was asked to make 10 voluntary contractions (fast twitch), each lasting for 3 seconds, followed by relaxation. A voluntary relaxation after a contraction indicates that the patient was able to relax the pelvic floor muscles on demand. The pelvic floor will return to its resting state. After a 1-minute rest, the subjects were asked to perform a sustained contraction, resulting in a ventral and cranial movement of the pelvic floor muscles. They tried to hold the contraction for as long as possible up to a maximum of 30 seconds (slow twitch). The patients were asked to continue breathing as normal as possible during the pelvic floor muscle contraction.

Finally, the straining potential was investigated. We instructed the patients to strain as if they were defecating. In our institute, the results of this straining are classified as normal or paradoxal behavior of the pelvic floor.

**Results**

Two hundred thirty-eight patients with complaints of micturition, defecation, and/or sexual function were included in this study, and were analyzed at the Pelvic Floor Center of the LUMC (July 2004 and July 2006): 97 men with a mean age of 52 years (12–91 years) and 141 women with a mean age of 47 years (18–79 years). In total, 134 patients (56.3%) underwent surgery for their complaints before DIPFF: 54 men (41%) and 80 women (59%). In our patient population, there was a considerable amount of sexual abuse in women and men as assessed by the PelFIs (Table 1).

Based on the referral diagnosis, 224 patients (94.1%) had complaints of micturition, 190 of defecation (82.7%), and 154 on sexuality (64.7%, PelFIs). However, the stratification of the patients according to their complaints at the first visit resulted in three subgroups: patients with a single complaint (micturition, defecation, or sexual), a combination of two complaints, or complaints in all compartments of the pelvic floor (Table 2).

In the total group, 34 patients (14.3%) used medication for micturition during their first visit, 20 for defecation (8.4%), and four for sexual dysfunction (1.7%, men only). A total of 16 patients (6.7%) used antidepressants: seven men (7.2%) and nine women (6.4%) (Table 3).

The mean rest tone of the pelvic floor was 5 μV in men (0.0–12.0 μV) and 3.8 μV in women (0.5–16.0 μV). Based on our definition a normal rest tone, an elevated rest tone of the pelvic floor was found in 141 patients (69.3%): 79 men (81.4%) and 86 women (61.0%). In patients with complaints of micturition, an elevated rest tone was
found in 69.2% (70 men and 85 women), with complaints of defecation in 72.4% (68 men and 76 women) and with sexual dysfunction in 74% (53 men and 61 women).

A history of sexual abuse as assessed by the PelFIs questionnaire was documented in 59 patients (24.8%): 14 men (14.4%) and in 45 women (32.0%). This gender difference in sexual abuse was significant ($P = 0.002$). The mean age of women with a history of sexual abuse was 45.5 years and in men, 51.6 years.

In the group of patients with a history of sexual abuse, 47 patients (80.0%) were found to have an overactive rest tone of the pelvic floor: 13 men (92.9%) and 34 women (75.6%) (Table 4).

**Discussion**

The lower urinary tract, the anorectal channel, and the internal genitals as well as the pelvic floor are closely related to each other, both anatomically and, what is becoming more and more apparent, functionally. Hence, it is mandatory in patients with complaints of micturition, defecation, and/or sexual dysfunction to take into account the function of all these organs including the pelvic floor rather than focusing on isolated organs. This is true for both history taking, diagnostic investigations, and treatment. The Dutch Urological Association states in its guidelines that, in cases of urge and stress urinary incontinence and urgency/frequency, pelvic floor physiotherapy is a first-choice treatment option. An overactive bladder (OAB), with or without incontinence, negatively affects women’s sexual health, reducing sexual desire and ability to achieve orgasm. Given the impact of OAB on sexual health, sexual health should be routinely assessed by clinicians and addressed by researchers [34]. In this respect, it does not make sense that medical specialists focus their diagnostic attention to the bladder, rectal, anal, and/or sexual function solely. Attention should be focused on the DIPPF.

Another issue hampering the research of pelvic floor dysfunction is the total lack of standardization of both biofeedback technology and the methodology for its application to pelvic floor muscle assessment and rehabilitation. Both the small number of studies and this lack of standardized technology and protocols are limiting factors in generalizing our findings. It is also of note that to date, the mechanisms responsible for therapeutic efficacy have not been clarified beyond doubt. Pelvic floor muscle biofeedback is effective in the treatment of urinary incontinence. In the majority of studies, biofeedback is statistically superior to comparable treatments and controls; moreover, no study was superior to biofeedback [11]. Also, electrostimulation (ES) was found to be a safe and effective therapy in women with sexual dysfunction [35]. The lack of controlled parameters has made it difficult to evaluate the true efficacy of intravaginal ES. Moreover, the stimulation equipment as well as the treatment regimens are not standardized, and it is difficult to draw conclusions about electrical parameters of frequency, pulse duration, pulse-to-rest ratio, length of treatment, power, and accurate success rates [36].

<table>
<thead>
<tr>
<th>Table 2 Complaints of patients</th>
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<tbody>
<tr>
<td>Complaints (%)</td>
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<tr>
<td>----------------</td>
</tr>
<tr>
<td>Micturation</td>
</tr>
<tr>
<td>Defecation</td>
</tr>
<tr>
<td>Sexual</td>
</tr>
<tr>
<td>One compartment of pelvic floor</td>
</tr>
<tr>
<td>Two compartments of pelvic floor</td>
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<tr>
<td>Three compartments of pelvic floor</td>
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</tbody>
</table>

*One woman became free of complaints on the waiting list.

Table 3 Medication

<table>
<thead>
<tr>
<th>Medication (%)</th>
<th>Men (N = 97)</th>
<th>Women (N = 141)</th>
<th>Total (N = 238)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Micturition</td>
<td>16.5</td>
<td>12.8</td>
<td>14.3</td>
</tr>
<tr>
<td>Defecation</td>
<td>8.2</td>
<td>8.5</td>
<td>8.4</td>
</tr>
<tr>
<td>Sexual function</td>
<td>4.1</td>
<td>0.0</td>
<td>1.7</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>7.2</td>
<td>6.48</td>
<td>6.7</td>
</tr>
</tbody>
</table>

Table 4 Biofeedback registration comparing men and women

<table>
<thead>
<tr>
<th>Biofeedback</th>
<th>Total (N = 238)</th>
<th>Men (N = 97)</th>
<th>Women (N = 141)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rest tone (μV)</td>
<td>4.4 (0.0–16.0)</td>
<td>5.0 (0.0–12.0)</td>
<td>3.9 (0.5–16.0)</td>
</tr>
<tr>
<td>Fast twitch (μV)</td>
<td>11.3 (0.0–30.0)</td>
<td>14.1 (0.0–30.0)</td>
<td>9.3 (0.5–30.0)</td>
</tr>
<tr>
<td>Slow twitch (μV)</td>
<td>8.8 (0.0–30.0)</td>
<td>10.8 (0.0–30.0)</td>
<td>7.4 (0.0–30.0)</td>
</tr>
<tr>
<td>Ivoluntary relaxation (%)</td>
<td>77.3</td>
<td>81.4</td>
<td>74.7</td>
</tr>
<tr>
<td>Elevated rest tone (%)</td>
<td>69.3</td>
<td>81.4</td>
<td>61.0</td>
</tr>
</tbody>
</table>

The nomenclature of the ICS does not define the rest tone of the pelvic floor and no reference values are available [8]. In literature, protocols of biofeedback showed a wide variation in descriptions on patient education, contraction parameters, numbers of training sessions, numbers of repetitions, duration of training, use of accessory muscles, patient positioning, etc. [11].

Using our definition of the normal rest tone, we were impressed by the number of patients with an elevated rest tone of the pelvic floor. Remarkable as well was the high prevalence of patients with a history of sexual abuse (24.8%: men 14.4%, women 32.0%).

Being a referral center, sexual dysfunctions are presented as quite prevalent and multifaceted problems, but they are continuously underrecognized and undertreated in mixed patient populations [37]. Pelvic-floor complaints are correlated with sexual abuse and asking about abuse should be a routine part of screening as well. Considering the fact that many practitioners have difficulty inquiring about abuse, we have suggested earlier that a questionnaire may be helpful in improving the recognition and management of patients who have a history of sexual abuse. In our center, the use of these questionnaires is standard of care [38,39].

In contrast to our population, the frequency of sexual abuse was mentioned to be rare on routine screening for sexual abuse by health care practitioners and gynecologists (respectively 1.3 and 0.5%) [37,40].

In relation to the technique of pelvic floor investigation, the placement and design of probes are relevant in pelvic floor dysfunction [33], and the resulting rest tone measurements may vary depending on the type of probe used, the placement of the probe, and used equipment. To our knowledge there is no means of calibrating the different types of probes and equipment used in pelvic floor practice. Furthermore, literature provides scarce knowledge and consensus on the treatment of an elevated pelvic floor rest tone.

In the standardization on terminology of pelvic floor dysfunction by the ICS, it is stated that overactivity of the pelvic floor muscles is a situation in which the pelvic floor muscles do not relax, or even may contract when relaxation is functionally needed, for example, during micturition or defecation. This condition is based on symptoms such as voiding difficulty, obstructed defecation, or dyspareunia, and on signs like the absence of voluntary pelvic floor muscle relaxation.

In daily practice, this definition is not sufficient to explain the findings in patients. We feel it is important to be able to differentiate between the activities of the pelvic floor in terms of relax capacity and contract capacity. We believe that the elevated rest tone is related to symptoms as mentioned in the ICS definition and not the activity of the pelvic floor as such.

Although we describe a relationship between an elevated rest tone and a dysfunction of the bladder, vagina, and/or rectum, the exact mechanism of this relationship remains unclear. However, we are convinced that in order to break through the vicious circle of an elevated rest tone, treatment should be focused on pelvic floor relaxation instead of straining (“pelvic floor exercises”) [11,33,41,42].

Based on this conviction, we recommend an individual assessment of patients rather than treatment solely based on complaints. In case of an elevated rest tone, the primary target is relaxation and restoration of the coordination of pelvic floor muscles [43]. In contrast, when a weakness of the pelvic floor is diagnosed, the primary target is strengthening and training of the endurance of the pelvic floor. Biofeedback therapy is known to be effective in conditions as mentioned above [13,27,33,42,44,45].

The DIPFF may be a helpful diagnostic tool, but further randomized controlled studies are necessary to validate this intervention.

Conclusion

Pelvic floor dysfunction is correlated with urinary, sexual, or gastroenterological complaints. In our retrospective study, we found that 77.2% of patients who presented to the clinic with urinary, gastro, or sexual complaints had measurable pelvic floor dysfunction (69.3% overactive rest tone and 7.9% underactive rest tone). In relation to the ICS terminology, there is a need for a well-defined normal vs. elevated rest tone of the pelvic floor.

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References


