UNIVERSITA' DI VERONA
FACOLTA' DI MEDICINA E CHIRURGIA
PERCORSO STRAORDINARIO LAUREA IN ***FISIOTERAPIA***
A.A. 2011 – 2012

Insegnamento: **METODOLOGIE PER LA FISIOTERAPIA** *dott.ssa Cristina Scumà*

Modulo: **METODOLOGIA DELLA FISIOTERAPIA BASATA SULLE EVIDENZE** *dott. Simone Cecchetto*

Lezione: **FISIOTERAPIA DEL PAVIMENTO PELVICO: DAL QUESITO CLINICO ALLA RICERCA E IMPIEGO DELLE EVIDENZE SCIENTIFICHE**

Dott. Mag. Arianna Bortolami
Fisioterapista
www.pelvicfloor.it

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1. *ANATOMIA, FISIOLOGIA, PATOLOGIA DEL PAVIMENTO PELVICO*
2. *FISIOTERAPIA DEL PAVIMENTO PELVICO*
3. *ELABORAZIONE DEL QUESITO CLINICO*
4. *UTILIZZO DELLE BANCHE DATI*
5. *RISPOSTA FINALE*

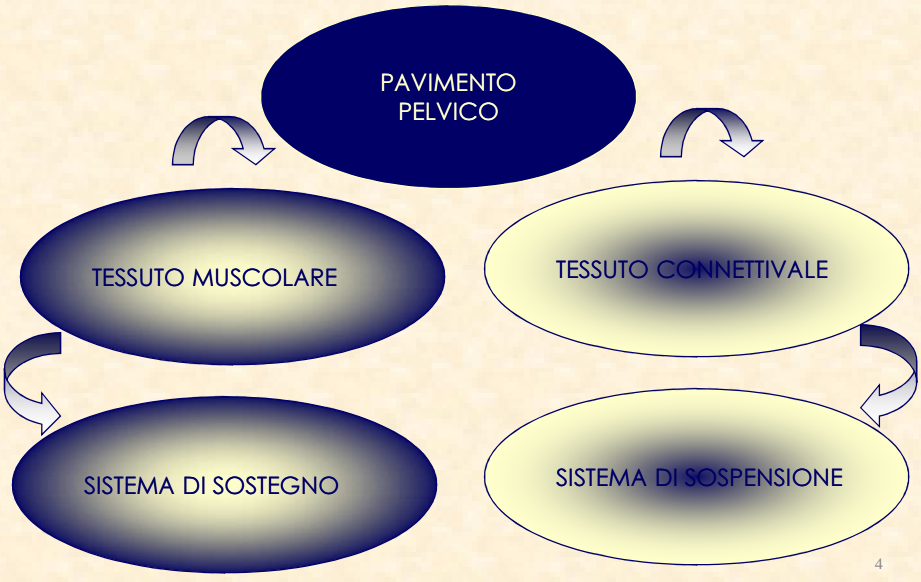
1. ANATOMIA, FISIOLOGIA, PATOLOGIA DEL PAVIMENTO PELVICO

ZONA GENITO-URINARIA-ANALE

Definizione

Il pavimento pelvico può essere definito una entità funzionale, vale a dire un insieme di strutture anatomiche che cooperano in sinergia per svolgere una o più funzioni.

1. ANATOMIA, FISIOLOGIA, PATOLOGIA DEL PAVIMENTO PELVICO



1. ANATOMIA, FISIOLOGIA, PATOLOGIA DEL PAVIMENTO PELVICO

MUSCOLI STRIATI:

✓ fibre rosse a funzione tonica (fibre poco affaticabili, contrazione lenta e mantenuta nel tempo = funzione di supporto dei visceri pelvici)

✓ fibre bianche a funzione fasica (fibre più facilmente affaticabili, contrazione veloce e mantenuta per poco tempo = protezione dei visceri conseguente agli incrementi di pressione addominale)

1. ANATOMIA, FISIOLOGIA, PATOLOGIA DEL PAVIMENTO PELVICO

NEUROANATOMIA

1. **SISTEMA NERVOSO PERIFERICO**
   a. INNERVAZIONE SOMATICA
      - nervo pudendo (radici S2 – S4)

   b. INNERVAZIONE NEUROVEGETATIVA
      - parasimpatica (radici S2 – S4; nervo pelvico); contrazione del detrusore, del retto e della parte superiore del canale anale)
      - ortosimpatica (radici T10– L2; nervo ipogastrico); mantenimento tono sfinteri interni (vescicale e anale)

2. **SISTEMA NERVOSO CENTRALE**
   a. INNERVAZIONE CENTRALE
      - area motoria detrusoriale (lobo frontale)
      - area motoria dello sfintere uretrale (lobulo paracentrale)
      - centro ponto-mesencefalico (per la minzione)
      - si ammette in letteratura con l'interpretazione dell'homunculus una scarsa rappresentazione del pavimento pelvico

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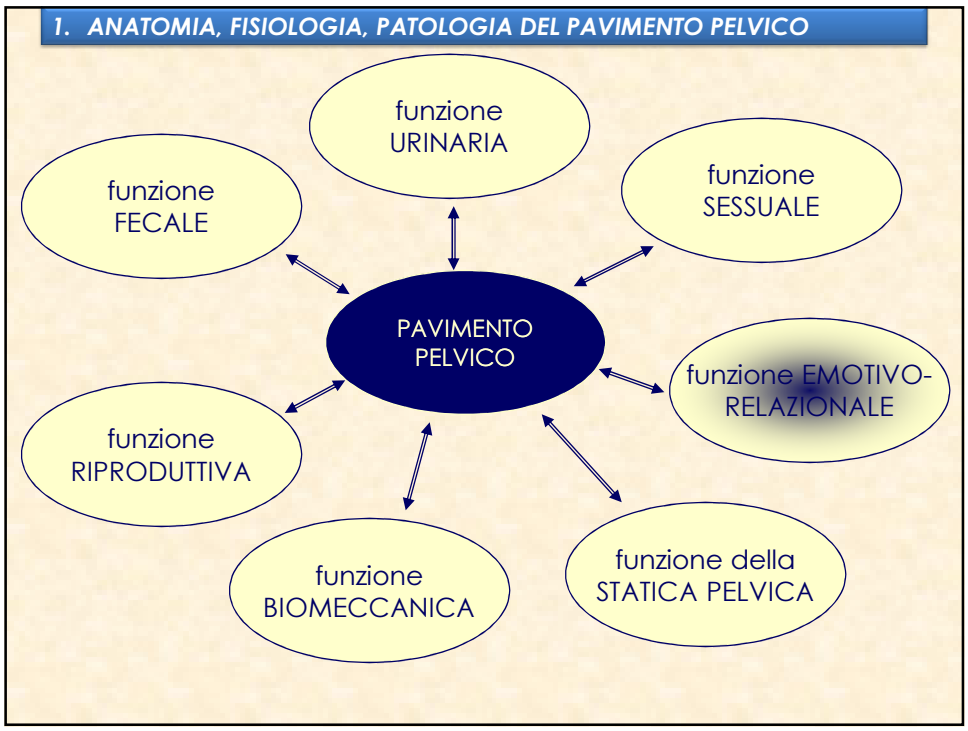
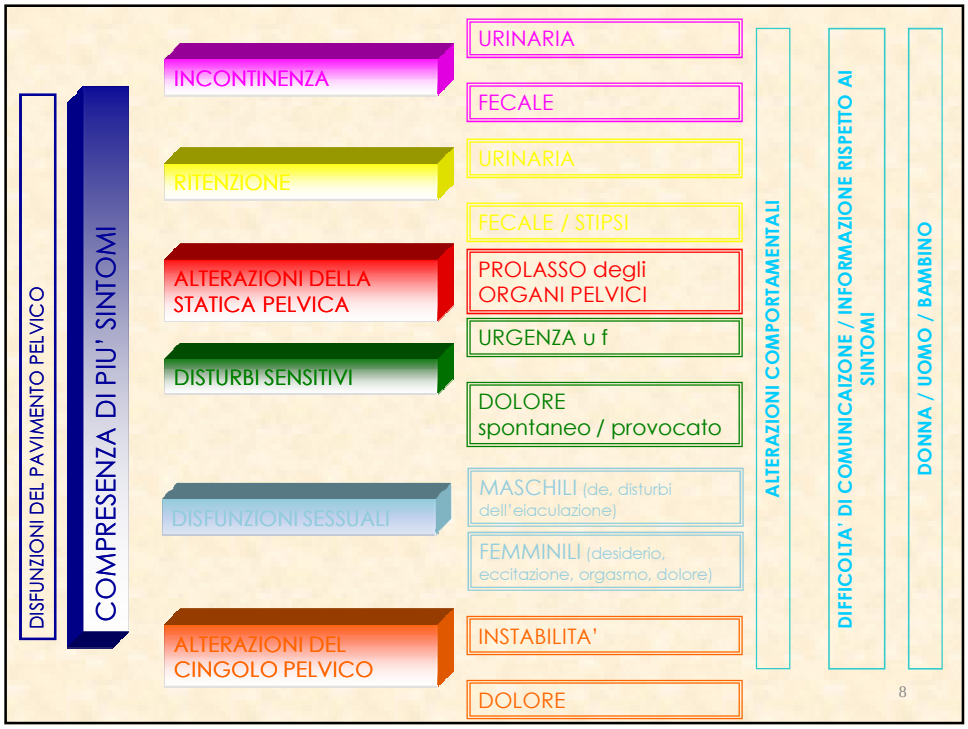

1. ANATOMIA, FISIOLOGIA, PATOLOGIA DEL PAVIMENTO PELVICO
funzione URINARIA
funzione FECALE
funzione SESSUALE
PAVIMENTO PELVICO
funzione EMOTIVO-RELAZIONALE
funzione RIPRODUTTIVA
funzione BIOMECCANICA
funzione della STATICA PELVICA

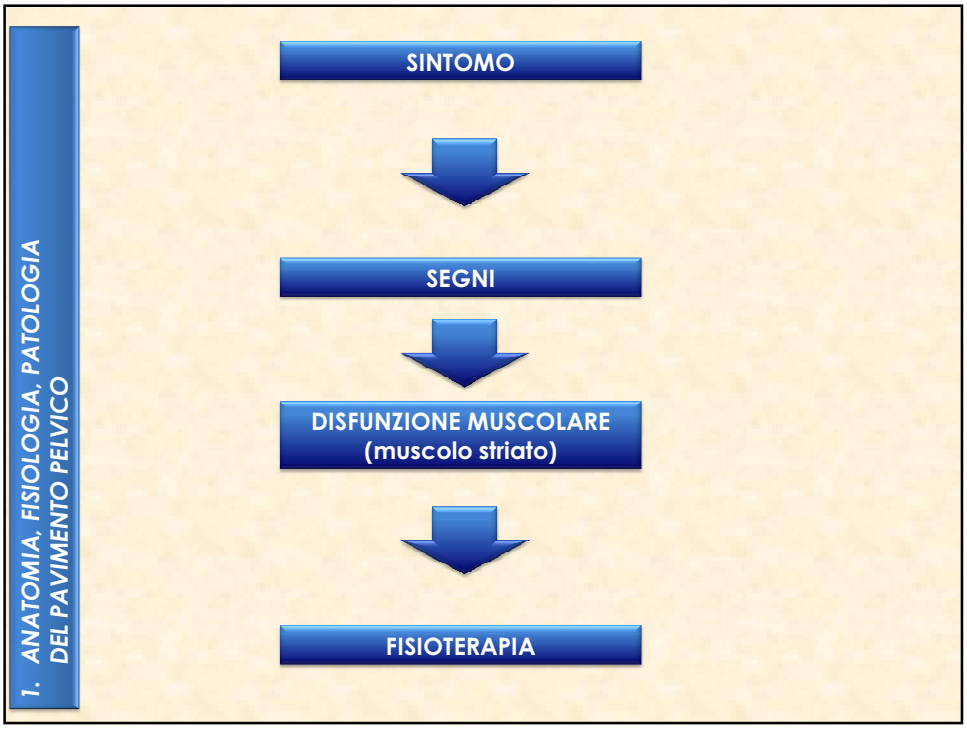

DISFUNZIONI DEL PAVIMENTO PELVICO
COMPRESENZA DI PIU' SINTOMI
INCONTINENZA
URINARIA
FECALE
RITENZIONE
URINARIA
FECALE / STIPSI
ALTERAZIONI DELLA STATICA PELVICA
PROLASSO degli ORGANI PELVICI
URGENZA u f
DISTURBI SENSITIVI
DOLORE spontaneo / provocato
DISFUNZIONI SESSUALI
MASCHILI (de, disturbi dell'eiaculazione)
FEMMINILI (desiderio, eccitazione, orgasmo, dolore)
ALTERAZIONI DEL CINGOLO PELVICO
INSTABILITA'
DOLORE
ALTERAZIONI COMPORTAMENTALI
DIFFICOLTA' DI COMUNICAIZONE / INFORMAZIONE RISPETTO AI SINTOMI
DONNA / UOMO / BAMBINO
8

MUSCOLI STRIATI:

✓ fibre rosse a funzione tonica (fibre poco affaticabili, contrazione lenta e mantenuta nel tempo = funzione di supporto dei visceri pelvici)

✓ fibre bianche a funzione fasica (fibre più facilmente affaticabili, contrazione veloce e mantenuta per poco tempo = protezione dei visceri conseguente agli incrementi di pressione addominale)

1. ANATOMIA, FISIOLOGIA, PATOLOGIA DEL PAVIMENTO PELVICO



1. ANATOMIA, FISIOLOGIA, PATOLOGIA DEL PAVIMENTO PELVICO

RUOLO DELLA FISIOTERAPIA:

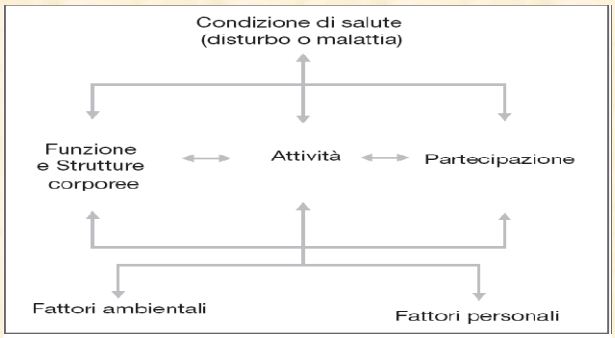
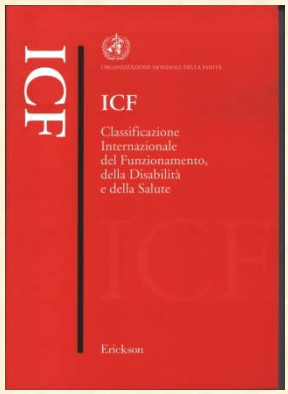


Figura 1.1 Interazioni tra le componenti dell'International Classification of Functioning, Disability and Health (ICF) (modificata da Organizzazione Mondiale della Sanità, 2001).



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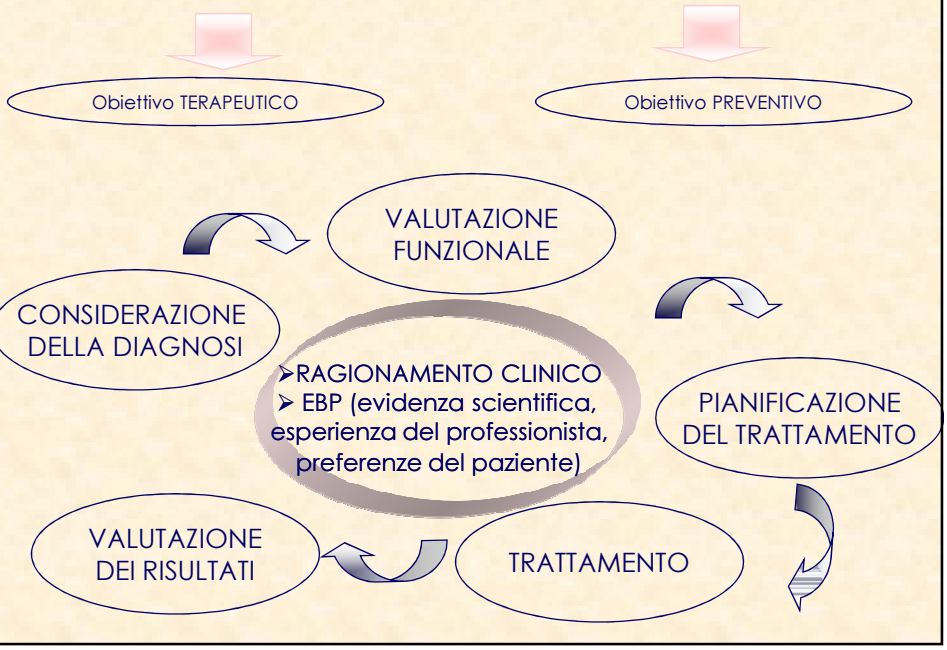
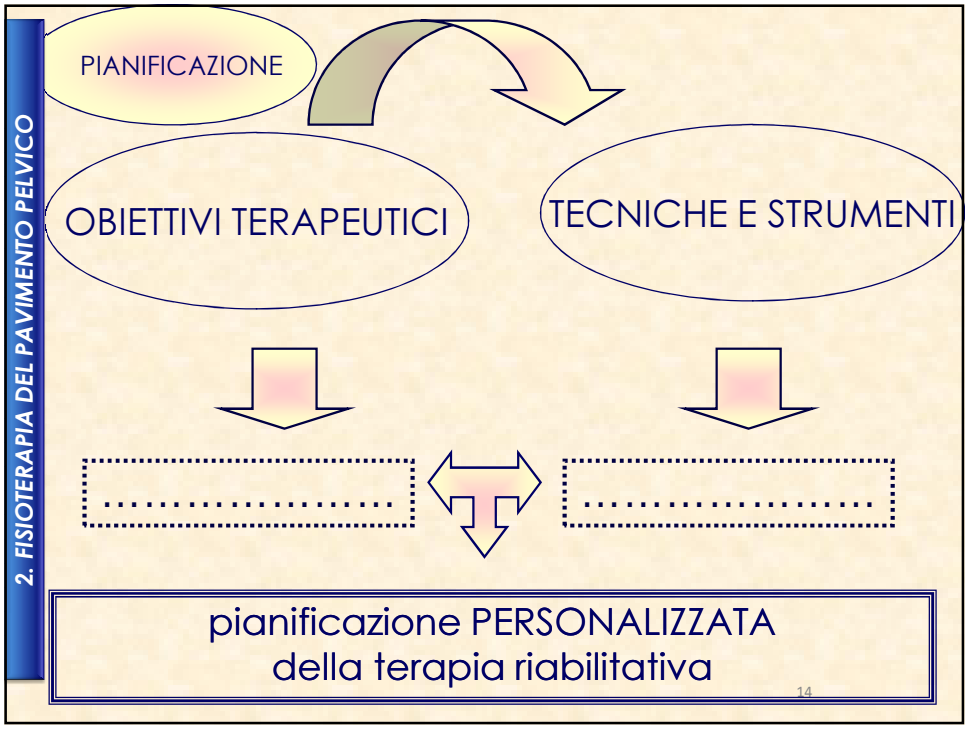
2. FISIOTERAPIA DEL PAVIMENTO PELVICO




2. FISIOTERAPIA DEL PAVIMENTO PELVICO
VALUTAZIONE FUNZIONALE
diagnosi medica
VALUTAZIONE FUNZIONALE
SINTOMI
aspetto soggettivo
PAZIENTE
SEGNI
aspetto oggettivo
FISIOTERAPISTA
Programmazione individualizzata del trattamento terapeutico riabilitativo
13


2. FISIOTERAPIA DEL PAVIMENTO PELVICO
PIANIFICAZIONE
OBIETTIVI TERAPEUTICI
TECNICHE E STRUMENTI
pianificazione PERSONALIZZATA della terapia riabilitativa
14

2. FISIOTERAPIA DEL PAVIMENTO PELVICO

TRATTAMENTO
Tecniche e Strumenti

TRATTAMENTO

- Esercizio Terapeutico (chinesiterapia, pelvic floor muscle training)
- Terapia Manuale
- Autotrattamento e Trattamento Domiciliare
- Trattamento Comportamentale e modificazioni dello stile di vita
- Biofeedback
- Stimolazione Elettrica Intravaginale / Intra Anale
- Coni Vaginali
- Dilatatori vaginali
- Dilatatori anali
- Ausili e presidi per l'incontinenza
- Prodotti topici non farmacologici
- Prodotti per la motilità intestinale

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2. FISIOTERAPIA DEL PAVIMENTO PELVICO

VALUTAZIONE DEI RISULTATI

- aspetto **soggettivo**, costituito dai sintomi riferiti e dal loro impatto sulla qualità di vita (colloquio verbale, questionari, confronto)
- aspetto **oggettivo** (segni, es.: parametri muscolari del pavimento pelvico), (test,strumenti, scale di valutazione muscolare, ecc.)
- termine della terapia, momento individuato quando, a fronte di pianificazione e di utilizzo di tecniche e strumenti, le modificazioni di sintomi e segni possono essere considerate definitivi
- eventuale invio verso altri approcci terapeutici

3. QUESITO CLINICO

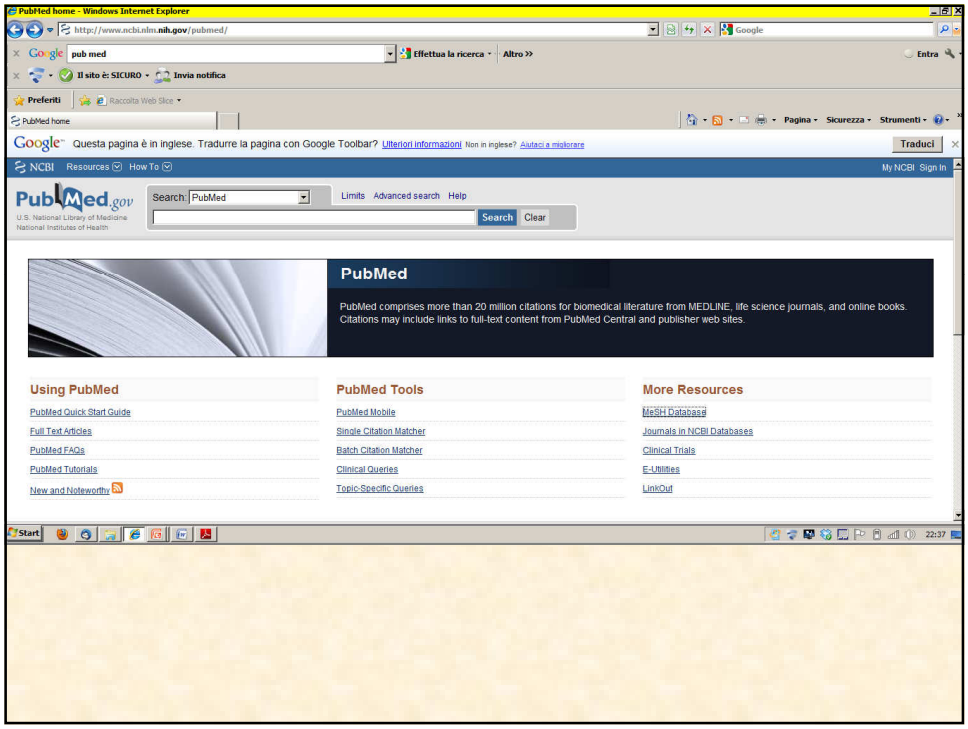
P.I.C.O.:

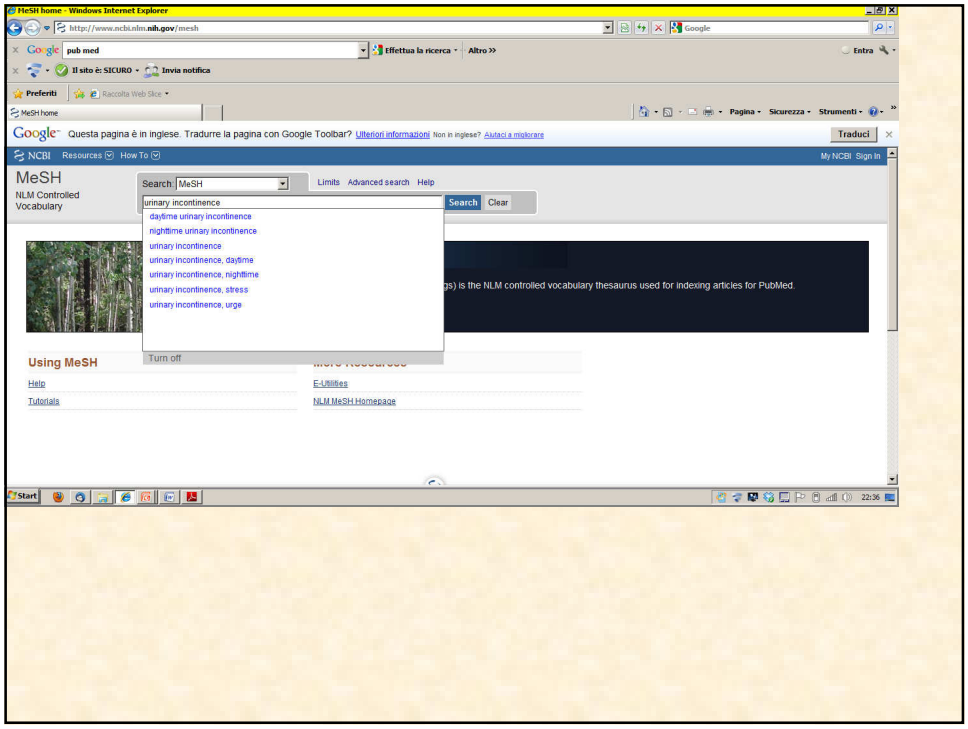
Paziente o popolazione: *pazienti di sesso femminile in età fertile affette da incontinenza urinaria da sforzo*

Intervento: esercizio terapeutico (pelvic floor muscle training) biofeedback (bfb), stimolaizone elettrica funzionale (sef), coni vaginali (vaginal weight)

Comparazione: all

Outcome: 1. *qualità della vita, misurata con indicatori (Sf 36, King's Health Questionnaire)*
2. *quantità della perdita urinaria (pad test 1/24 h)*

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nighttime urinary incontinence
urinary incontinence
urinary incontinence, daytime
urinary incontinence, nighttime
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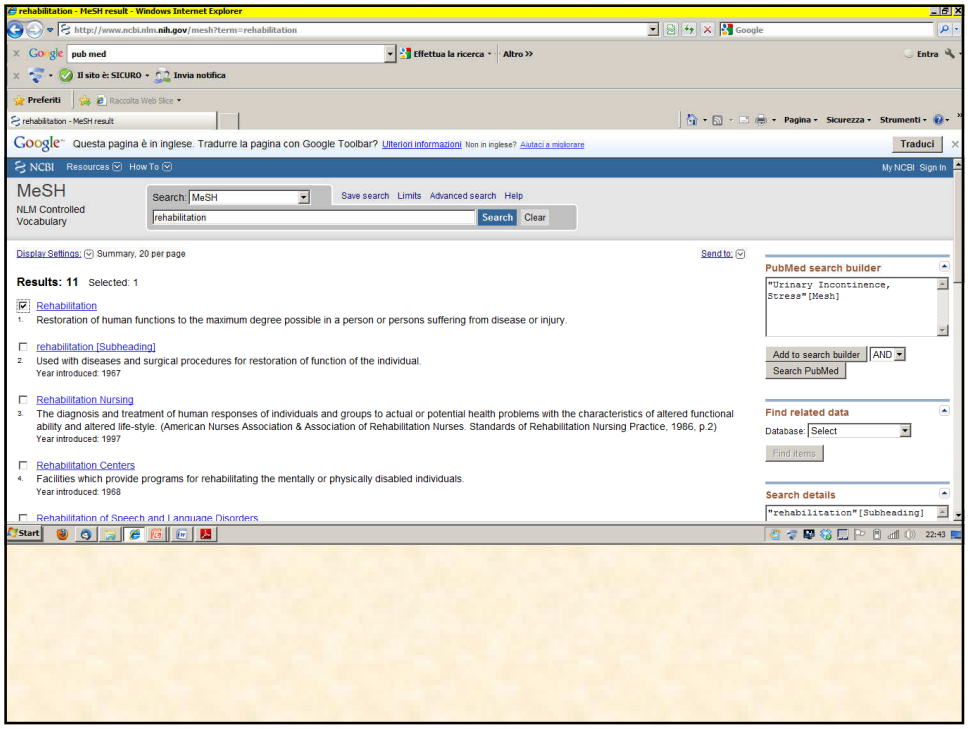
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http://www.ncbi.nlm.nih.gov/mesh?term=rehabilitation
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rehabilitation
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Rehabilitation
1. Restoration of human functions to the maximum degree possible in a person or persons suffering from disease or injury.
rehabilitation [Subheading]
2. Used with diseases and surgical procedures for restoration of function of the individual.
Year introduced: 1967
Rehabilitation Nursing
3. The diagnosis and treatment of human responses of individuals and groups to actual or potential health problems with the characteristics of altered functional ability and altered life-style. (American Nurses Association & Association of Rehabilitation Nurses. Standards of Rehabilitation Nursing Practice, 1986, p.2)
Year introduced: 1997
Rehabilitation Centers
4. Facilities which provide programs for rehabilitating the mentally or physically disabled individuals.
Year introduced: 1968
Rehabilitation of Speech and Language Disorders
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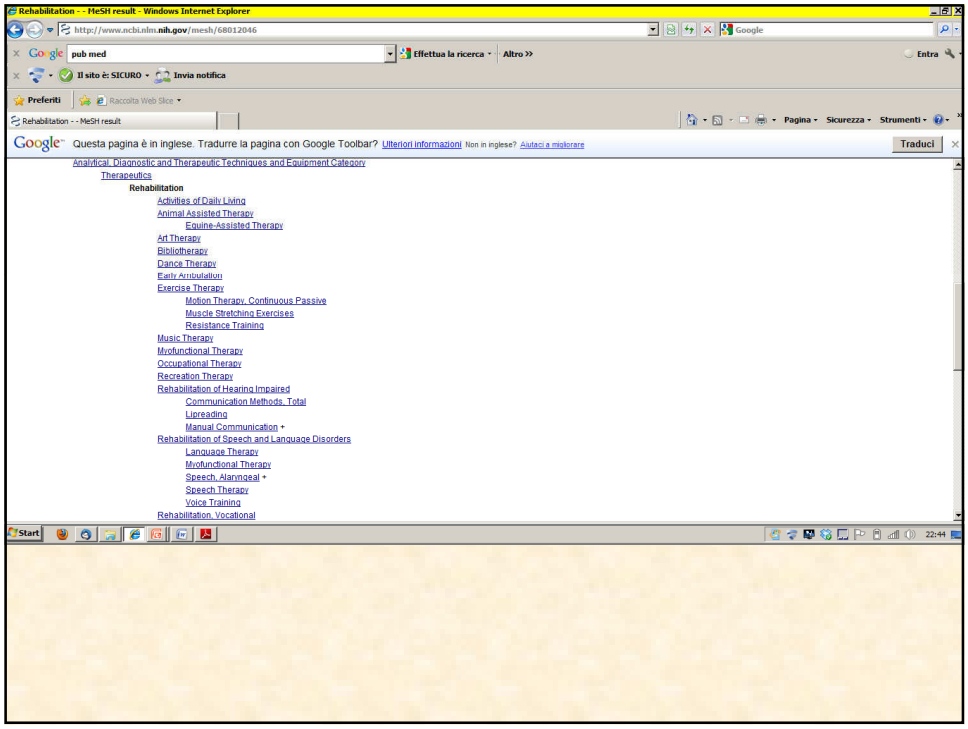
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Equine-Assisted Therapy
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Bibliotherapy
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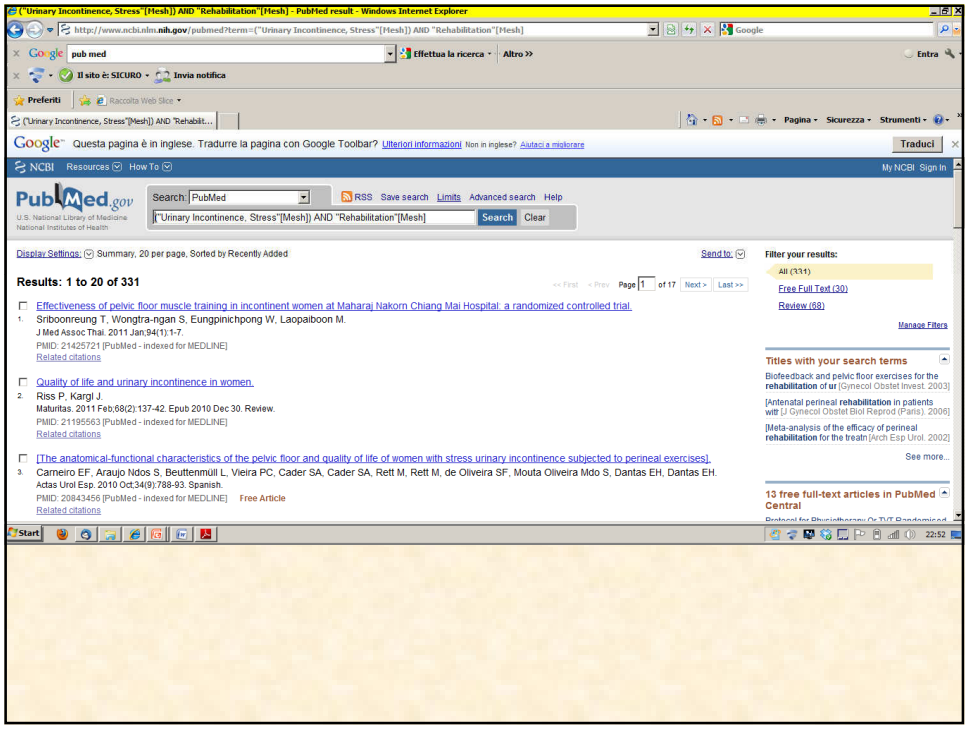
Resistance Training
Music Therapy
Myofunctional Therapy
Occupational Therapy
Recreation Therapy
Rehabilitation of Hearing Impaired
Communication Methods, Total
Lipreading
Manual Communication +
Rehabilitation of Speech and Language Disorders
Language Therapy
Myofunctional Therapy
Speech, Alaryngeal +
Speech Therapy
Voice Training
Rehabilitation, Vocational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Effectiveness of pelvic floor muscle training in incontinent women at Maharaj Nakorn Chiang Mai Hospital: a randomized controlled trial.
Quality of life and urinary incontinence in women.
[The anatomical-functional characteristics of the pelvic floor and quality of life of women with stress urinary incontinence subjected to perineal exercises].
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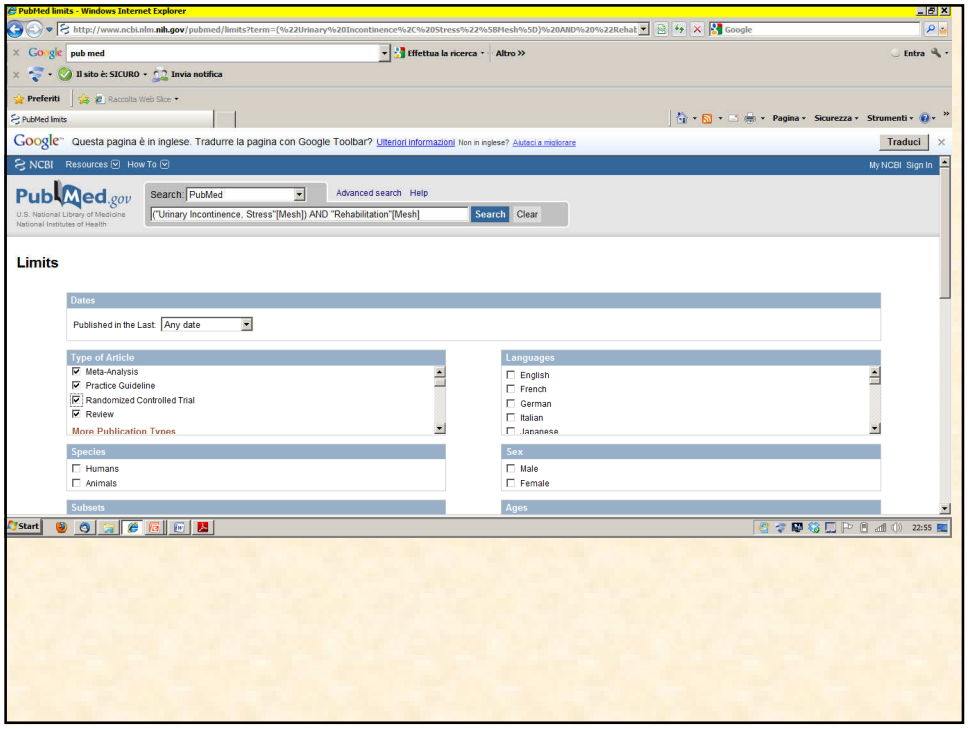
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Practice Guideline
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Animals
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Male
Female
Subsets
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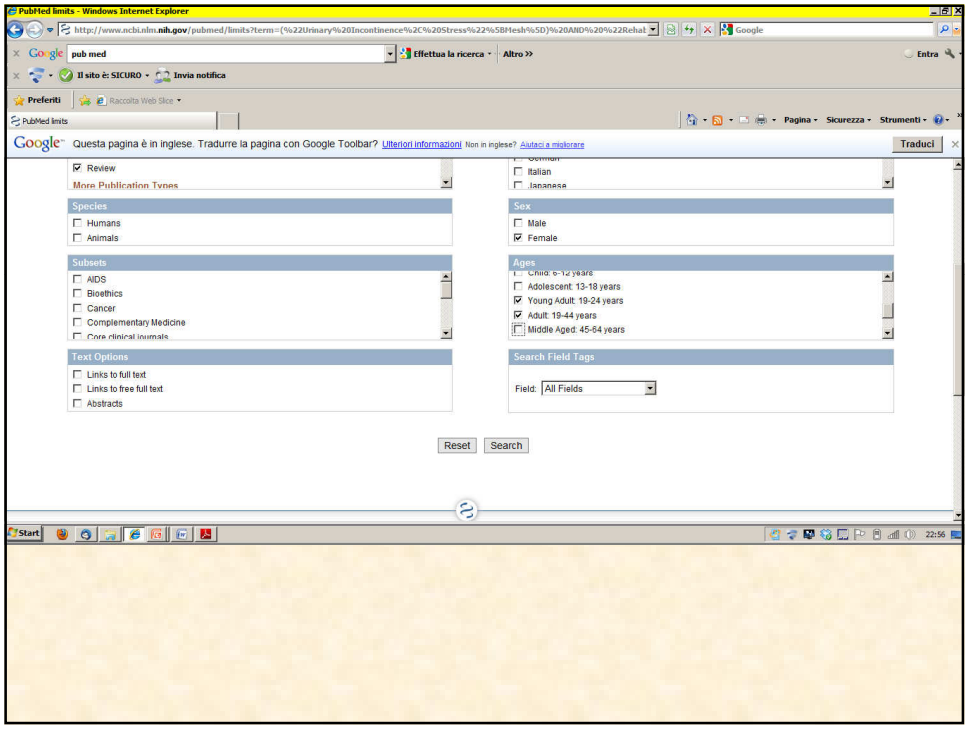
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Young Adult: 19-24 years
Adult: 19-44 years
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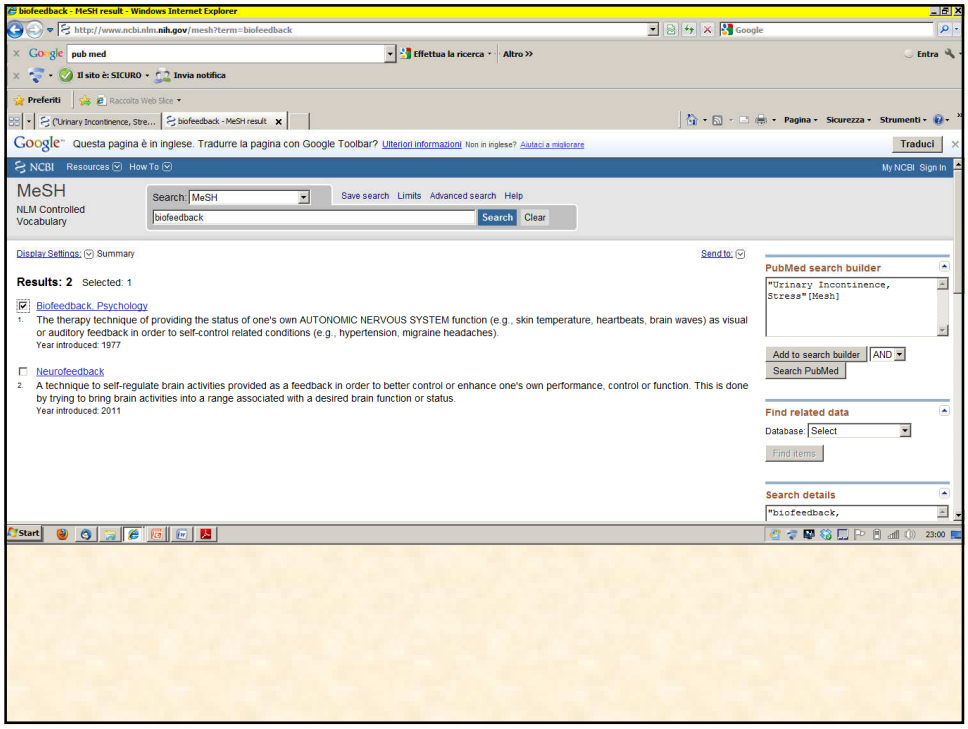
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biofeedback
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Biofeedback, Psychology
1. The therapy technique of providing the status of one's own AUTONOMIC NERVOUS SYSTEM function (e.g., skin temperature, heartbeats, brain waves) as visual or auditory feedback in order to self-control related conditions (e.g., hypertension, migraine headaches).
Year introduced: 1977
Neurofeedback
2. A technique to self-regulate brain activities provided as a feedback in order to better control or enhance one's own performance, control or function. This is done by trying to bring brain activities into a range associated with a desired brain function or status.
Year introduced: 2011
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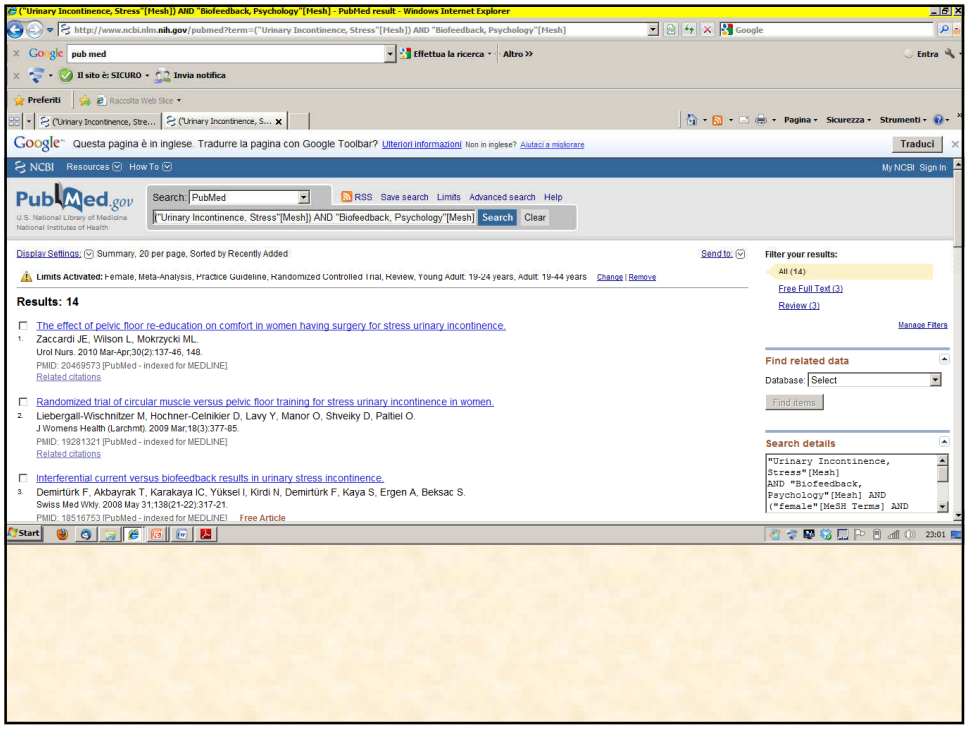
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Results: 14
The effect of pelvic floor re-education on comfort in women having surgery for stress urinary incontinence.
1. Zaccardi JE, Wilson L, Mokrzycki ML.
Urol Nurs. 2010 Mar-Apr;30(2):137-46, 148.
PMID: 20469573 [PubMed - indexed for MEDLINE]
Related citations
Randomized trial of circular muscle versus pelvic floor training for stress urinary incontinence in women.
2. Liebergall-Wischnitzer M, Hochner-Celnikier D, Lavy Y, Manor O, Shveiky D, Paltiel O.
J Womens Health (Larchmt). 2009 Mar;18(3):377-85.
PMID: 19281321 [PubMed - indexed for MEDLINE]
Related citations
Interferential current versus biofeedback results in urinary stress incontinence.
3. Demirtürk F, Akbayrak T, Karakaya IC, Yüksel I, Kirdi N, Demirtürk F, Kaya S, Ergen A, Beksac S.
Swiss Med Wkly. 2008 May 31;138(21-22):317-21.
PMID: 18516753 [PubMed - indexed for MEDLINE] Free Article
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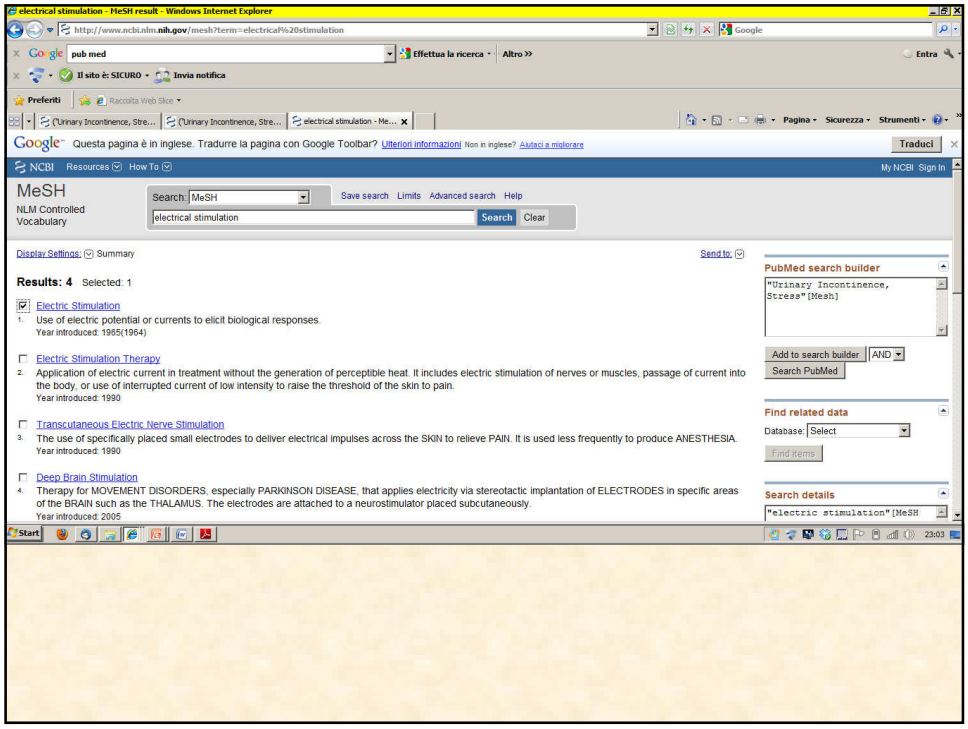
electrical stimulation - MeSH result - Windows Internet Explorer
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Electric Stimulation
Use of electric potential or currents to elicit biological responses.
Year introduced: 1965(1964)
Electric Stimulation Therapy
Application of electric current in treatment without the generation of perceptible heat. It includes electric stimulation of nerves or muscles, passage of current into the body, or use of interrupted current of low intensity to raise the threshold of the skin to pain.
Year introduced: 1990
Transcutaneous Electric Nerve Stimulation
The use of specifically placed small electrodes to deliver electrical impulses across the SKIN to relieve PAIN. It is used less frequently to produce ANESTHESIA.
Year introduced: 1990
Deep Brain Stimulation
Therapy for MOVEMENT DISORDERS, especially PARKINSON DISEASE, that applies electricity via stereotactic implantation of ELECTRODES in specific areas of the BRAIN such as the THALAMUS. The electrodes are attached to a neurostimulator placed subcutaneously.
Year introduced: 2005
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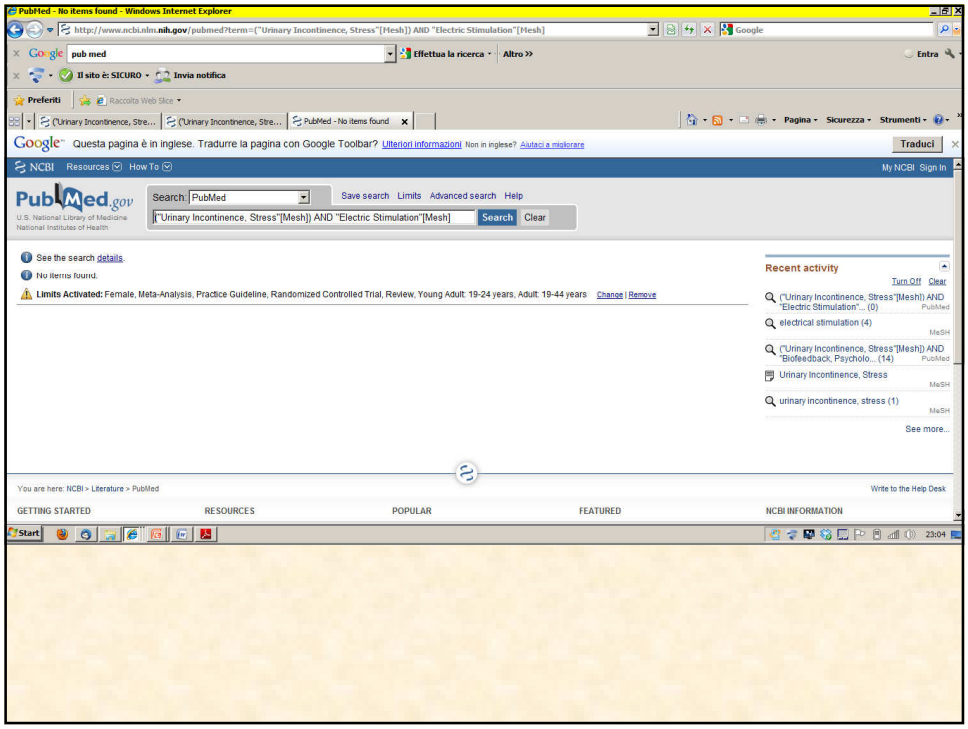
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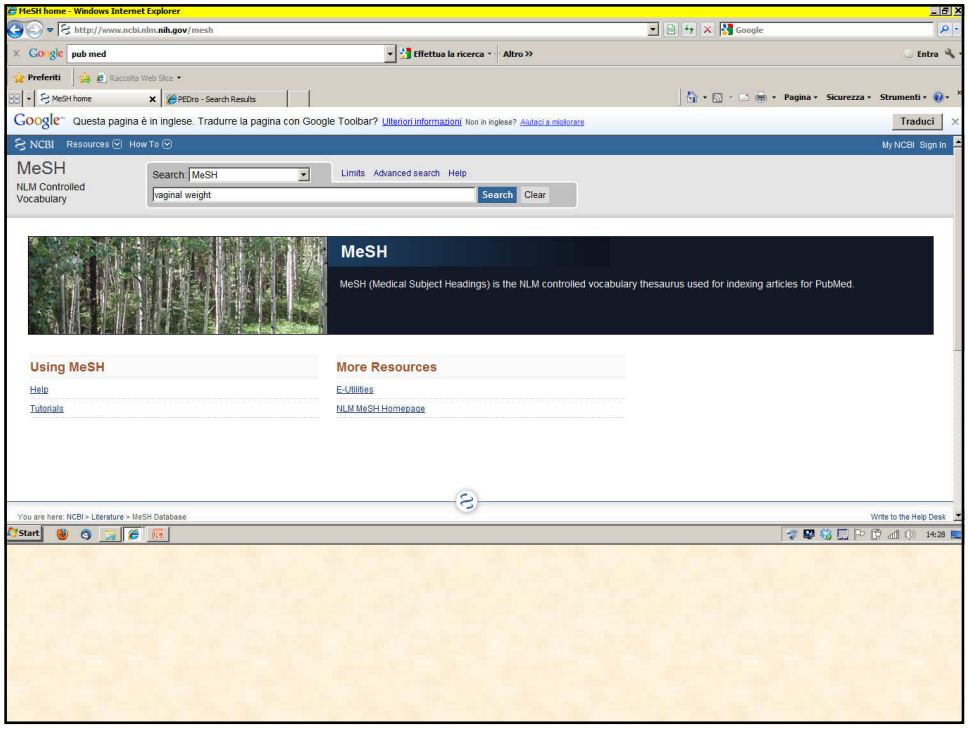
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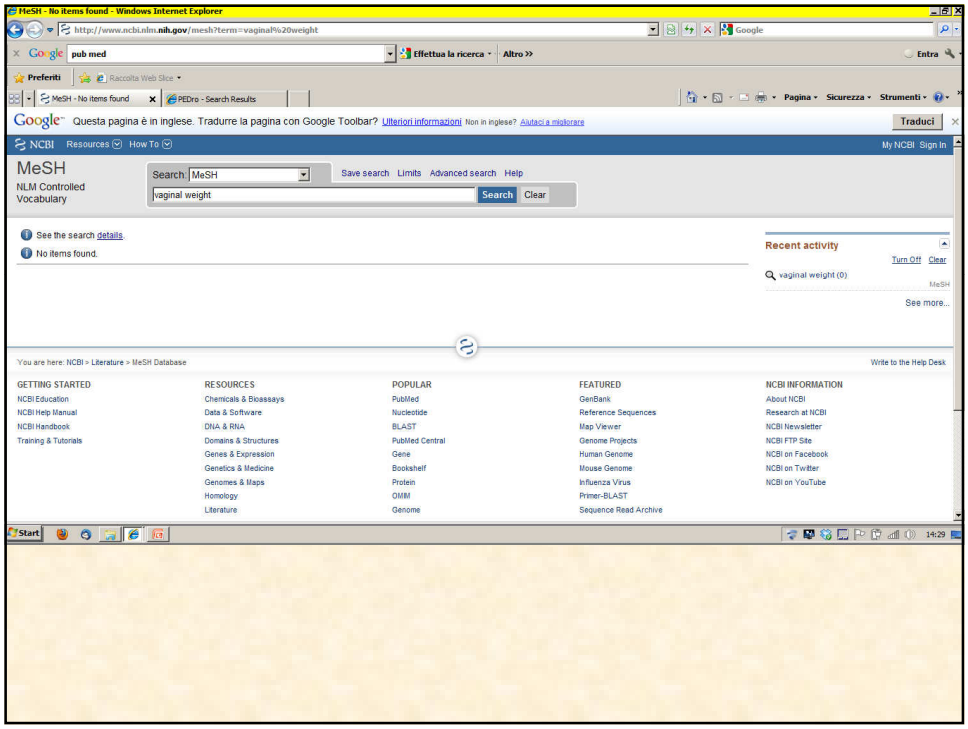
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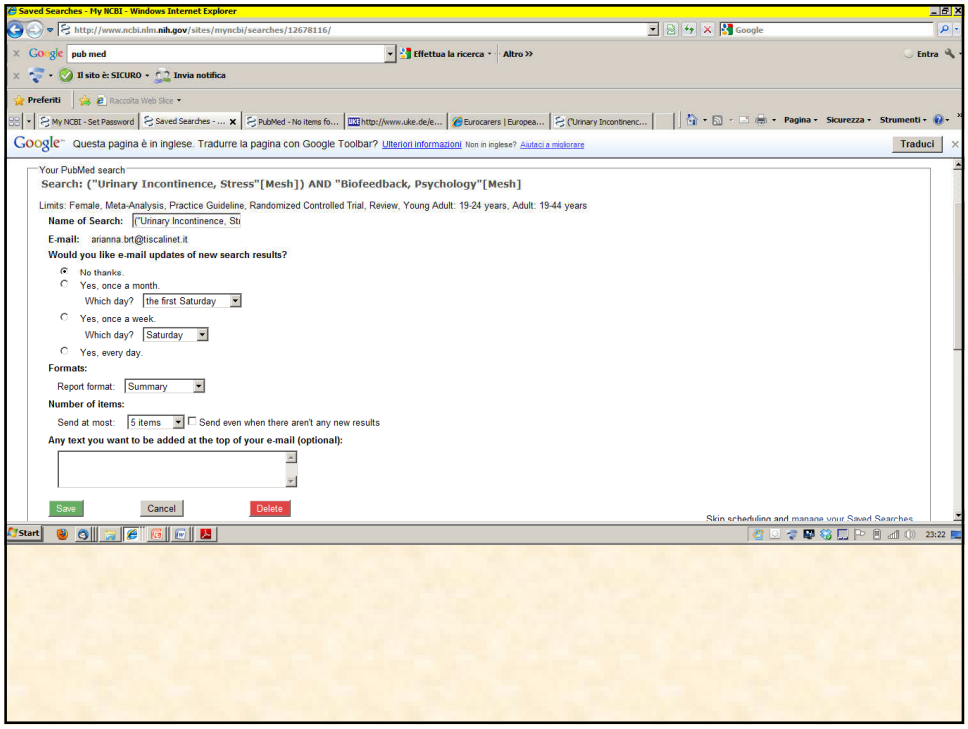
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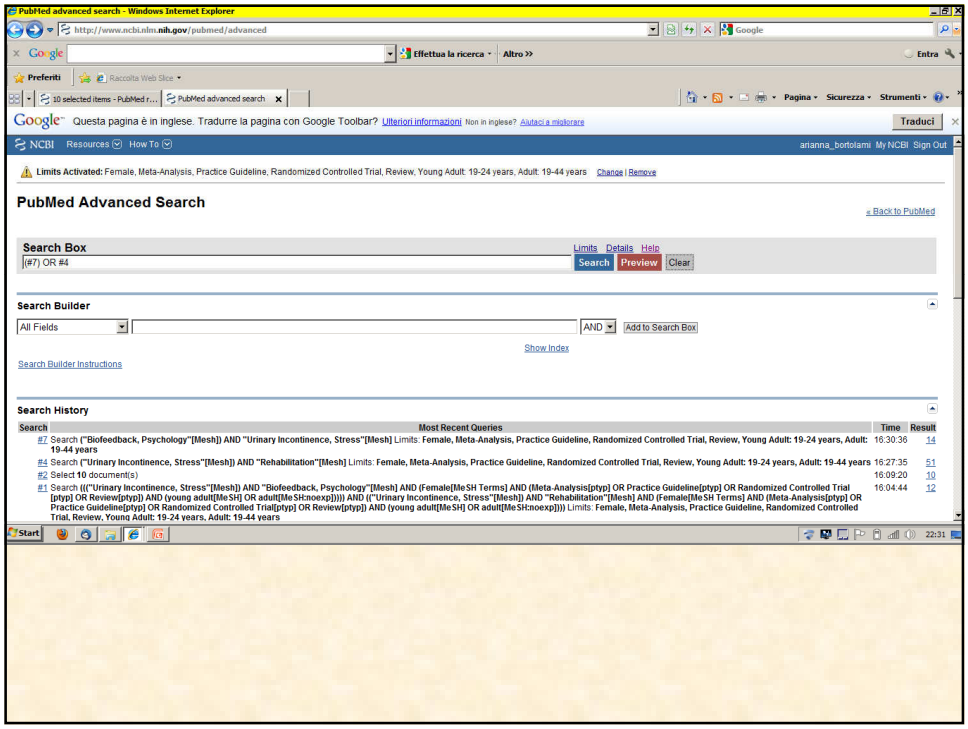
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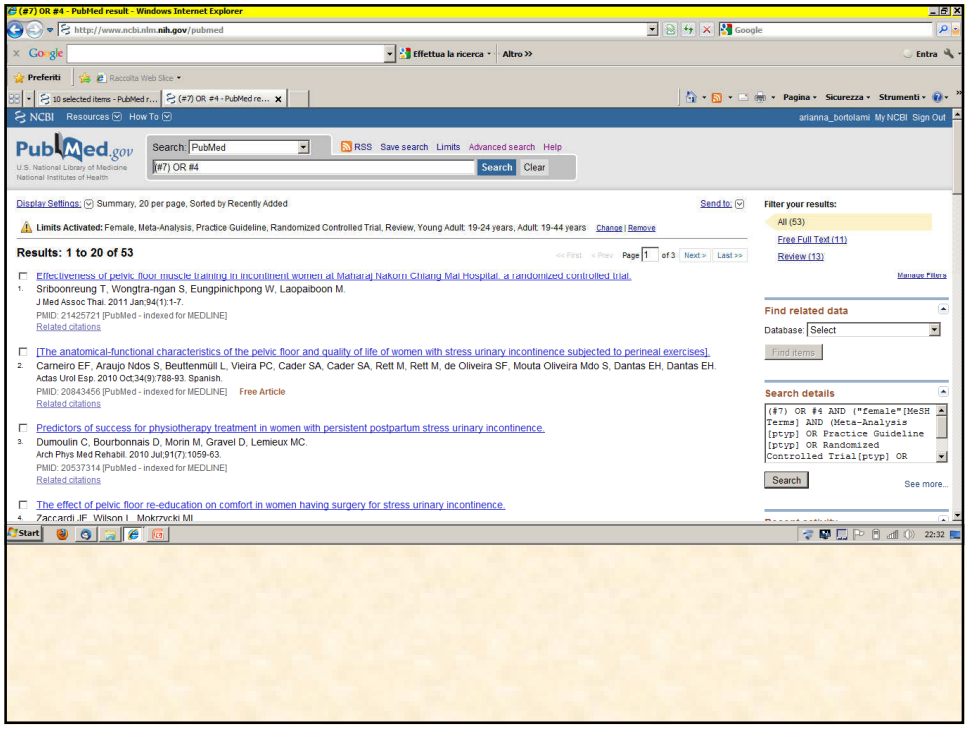
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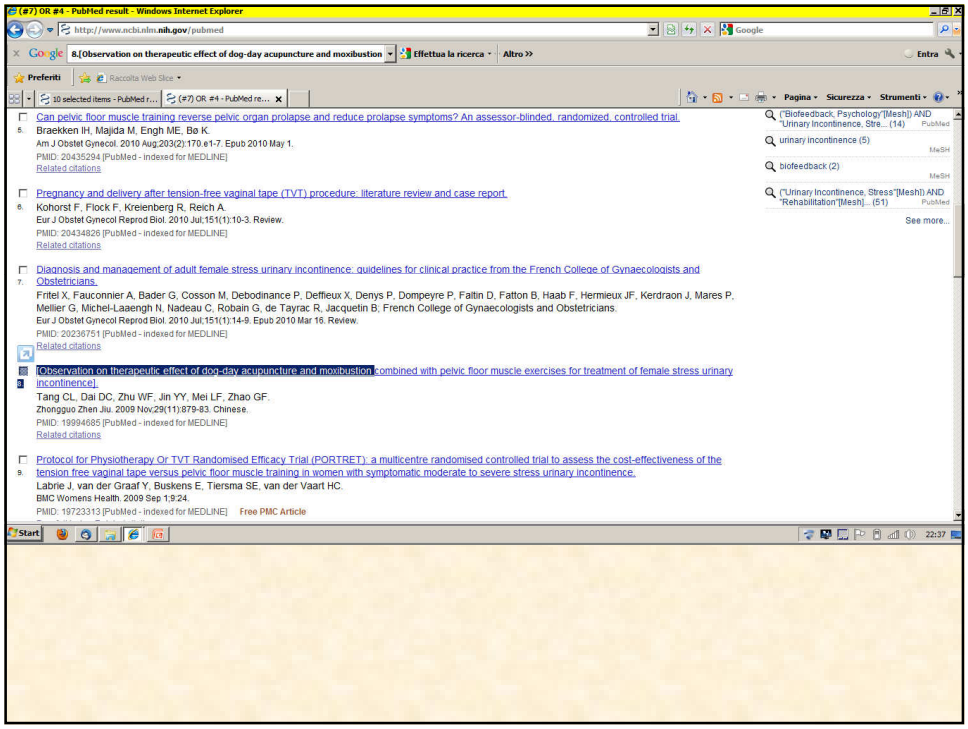
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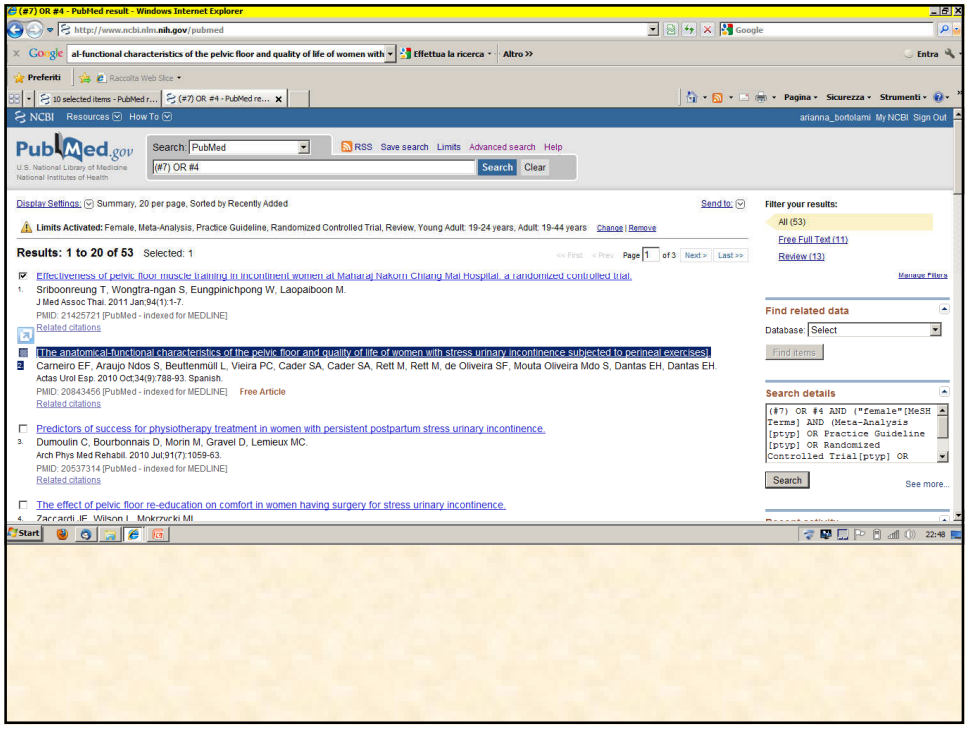
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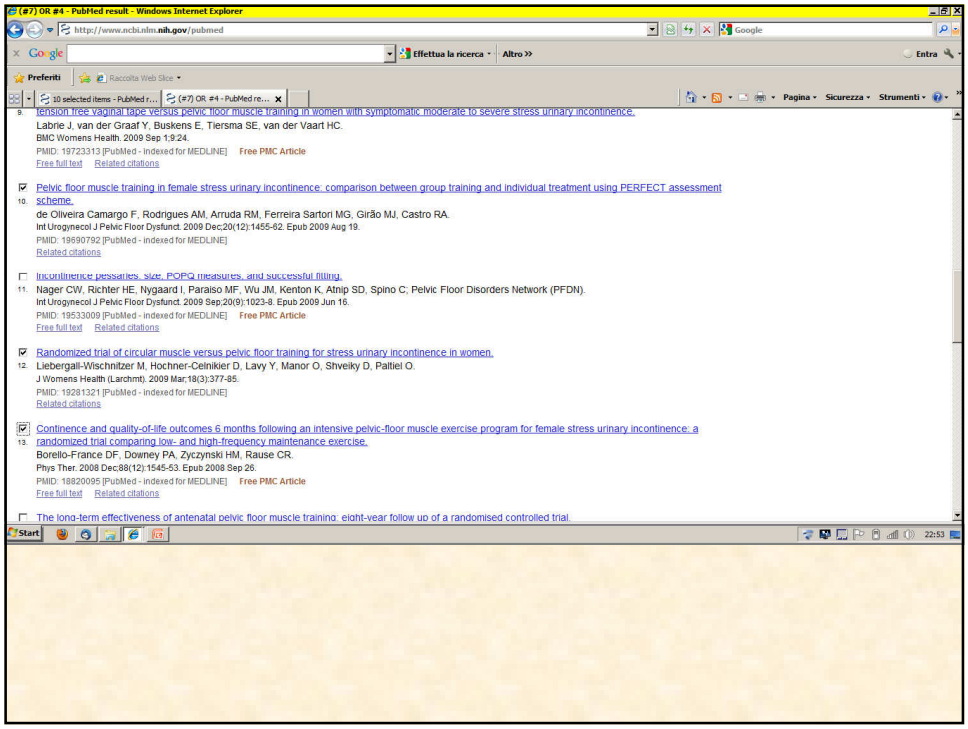
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J Womens Health (Larchmt). 2009 Mar;18(3):377-85.
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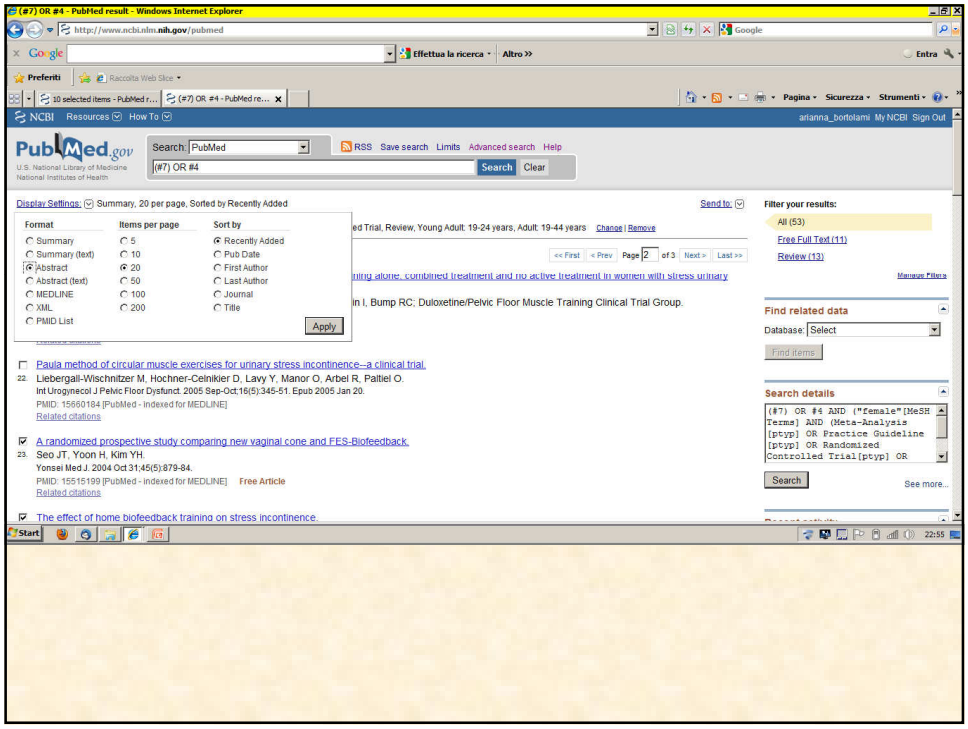
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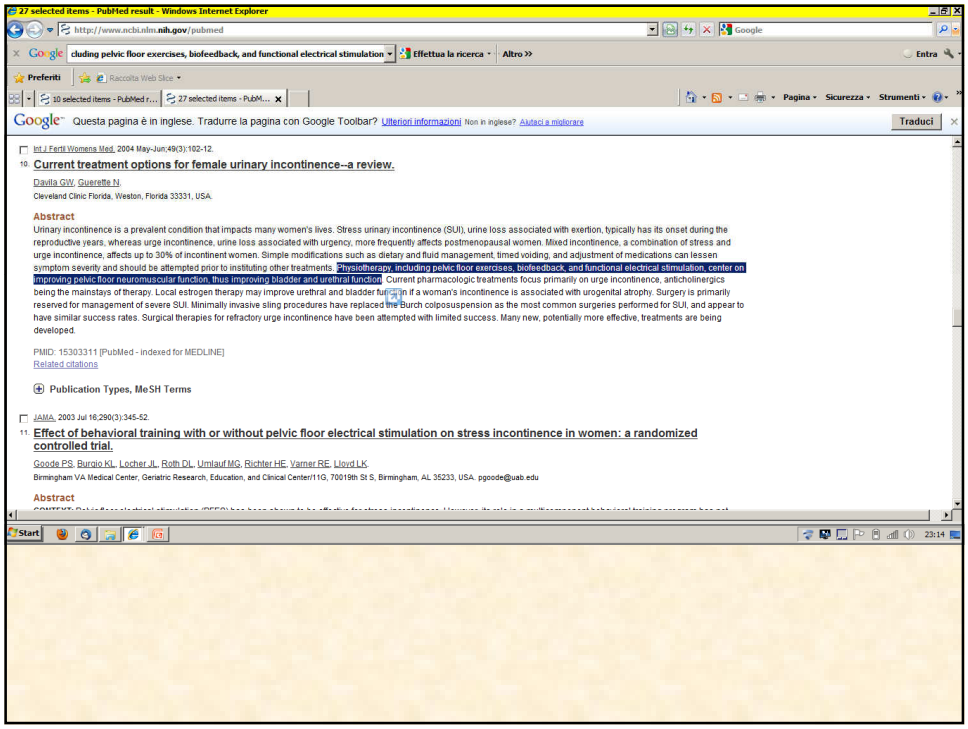
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cluding pelvic floor exercises, biofeedback, and functional electrical stimulation
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Int J Fertil Womens Med. 2004 May-Jun;49(3):102-12.
10. Current treatment options for female urinary incontinence--a review.
Davila GW, Guerette N.
Cleveland Clinic Florida, Weston, Florida 33331, USA.
Abstract
Urinary incontinence is a prevalent condition that impacts many women's lives. Stress urinary incontinence (SUI), urine loss associated with exertion, typically has its onset during the reproductive years, whereas urge incontinence, urine loss associated with urgency, more frequently affects postmenopausal women. Mixed incontinence, a combination of stress and urge incontinence, affects up to 30% of incontinent women. Simple modifications such as dietary and fluid management, timed voiding, and adjustment of medications can lessen symptom severity and should be attempted prior to instituting other treatments. Physiotherapy, including pelvic floor exercises, biofeedback, and functional electrical stimulation, center on improving pelvic floor neuromuscular function, thus improving bladder and urethral function. Current pharmacologic treatments focus primarily on urge incontinence, anticholinergics being the mainstays of therapy. Local estrogen therapy may improve urethral and bladder function in a woman's incontinence is associated with urogenital atrophy. Surgery is primarily reserved for management of severe SUI. Minimally invasive sling procedures have replaced the Burch colposuspension as the most common surgeries performed for SUI, and appear to have similar success rates. Surgical therapies for refractory urge incontinence have been attempted with limited success. Many new, potentially more effective, treatments are being developed.
PMID: 15303311 [PubMed - indexed for MEDLINE]
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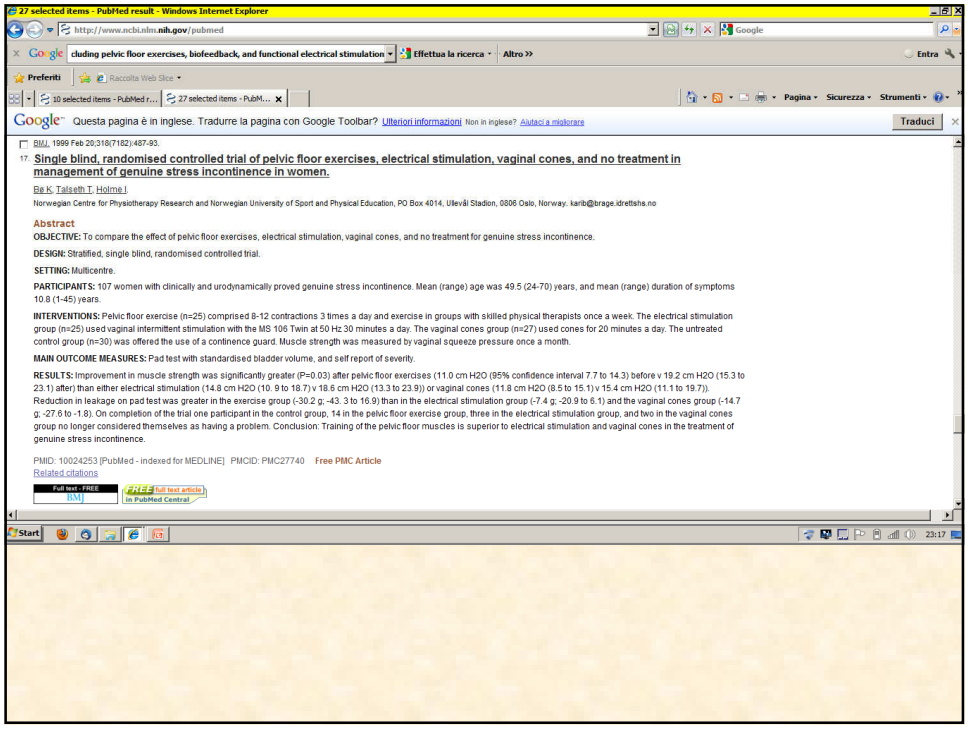
JAMA. 2003 Jul 16;290(3):345-52.
11. Effect of behavioral training with or without pelvic floor electrical stimulation on stress incontinence in women: a randomized controlled trial.
Goode PS, Burgio KL, Locher JL, Roth DL, Umlauf MG, Richter HE, Varner RE, Lloyd LK.
Birmingham VA Medical Center, Geriatric Research, Education, and Clinical Center/11G, 700 19th St S, Birmingham, AL 35233, USA. pgoode@uab.edu
Abstract



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BMJ. 1999 Feb 20;318(7182):487-93.

17. **Single blind, randomised controlled trial of pelvic floor exercises, electrical stimulation, vaginal cones, and no treatment in management of genuine stress incontinence in women.**

Bø K, Talseth T, Holme I.

Norwegian Centre for Physiotherapy Research and Norwegian University of Sport and Physical Education, PO Box 4014, Ullevål Stadion, 0806 Oslo, Norway. karib@brage.idrettshs.no

Abstract

OBJECTIVE: To compare the effect of pelvic floor exercises, electrical stimulation, vaginal cones, and no treatment for genuine stress incontinence.

DESIGN: Stratified, single blind, randomised controlled trial.

SETTING: Multicentre.

PARTICIPANTS: 107 women with clinically and urodynamically proved genuine stress incontinence. Mean (range) age was 49.5 (24-70) years, and mean (range) duration of symptoms 10.8 (1-45) years.

INTERVENTIONS: Pelvic floor exercise (n=25) comprised 8-12 contractions 3 times a day and exercise in groups with skilled physical therapists once a week. The electrical stimulation group (n=25) used vaginal intermittent stimulation with the MS 106 Twin at 50 Hz 30 minutes a day. The vaginal cones group (n=27) used cones for 20 minutes a day. The untreated control group (n=30) was offered the use of a continence guard. Muscle strength was measured by vaginal squeeze pressure once a month.

MAIN OUTCOME MEASURES: Pad test with standardised bladder volume, and self report of severity.

RESULTS: Improvement in muscle strength was significantly greater (P=0.03) after pelvic floor exercises (11.0 cm H2O (95% confidence interval 7.7 to 14.3) before v 19.2 cm H2O (15.3 to 23.1) after) than either electrical stimulation (14.8 cm H2O (10. 9 to 18.7) v 18.6 cm H2O (13.3 to 23.9)) or vaginal cones (11.8 cm H2O (8.5 to 15.1) v 15.4 cm H2O (11.1 to 19.7)). Reduction in leakage on pad test was greater in the exercise group (-30.2 g; -43. 3 to 16.9) than in the electrical stimulation group (-7.4 g; -20.9 to 6.1) and the vaginal cones group (-14.7 g; -27.6 to -1.8). On completion of the trial one participant in the control group, 14 in the pelvic floor exercise group, three in the electrical stimulation group, and two in the vaginal cones group no longer considered themselves as having a problem. Conclusion: Training of the pelvic floor muscles is superior to electrical stimulation and vaginal cones in the treatment of genuine stress incontinence.

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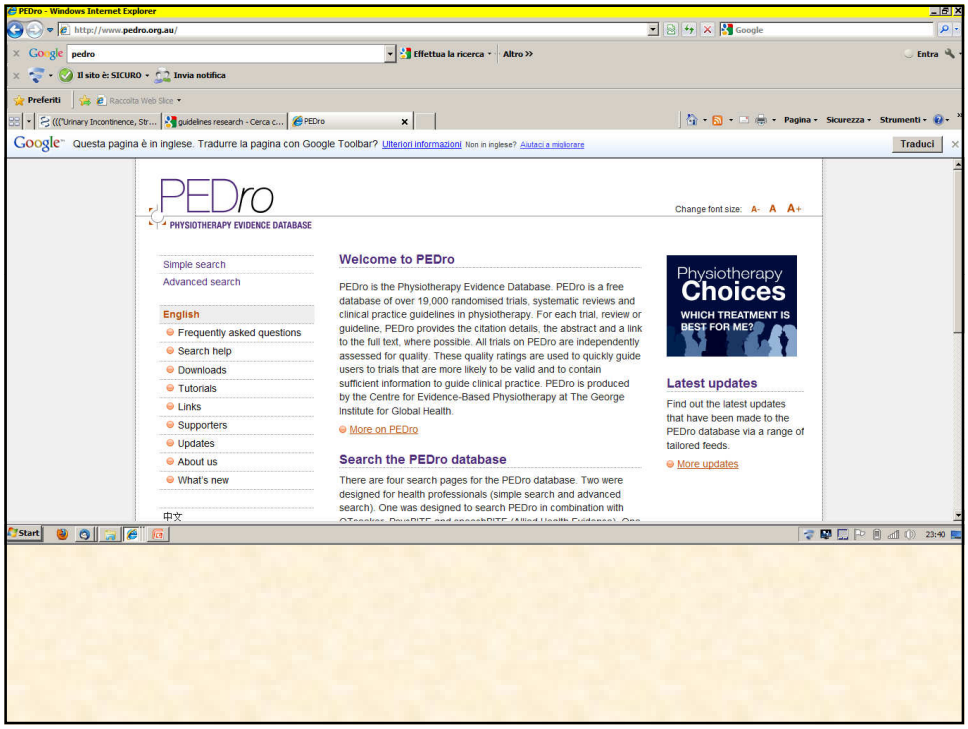

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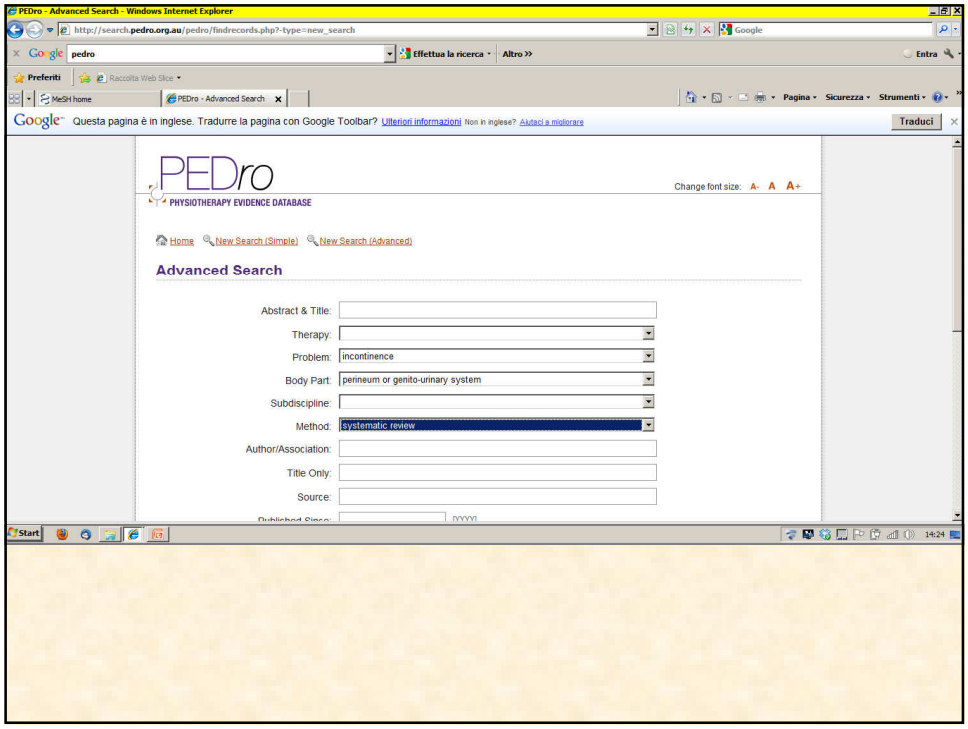
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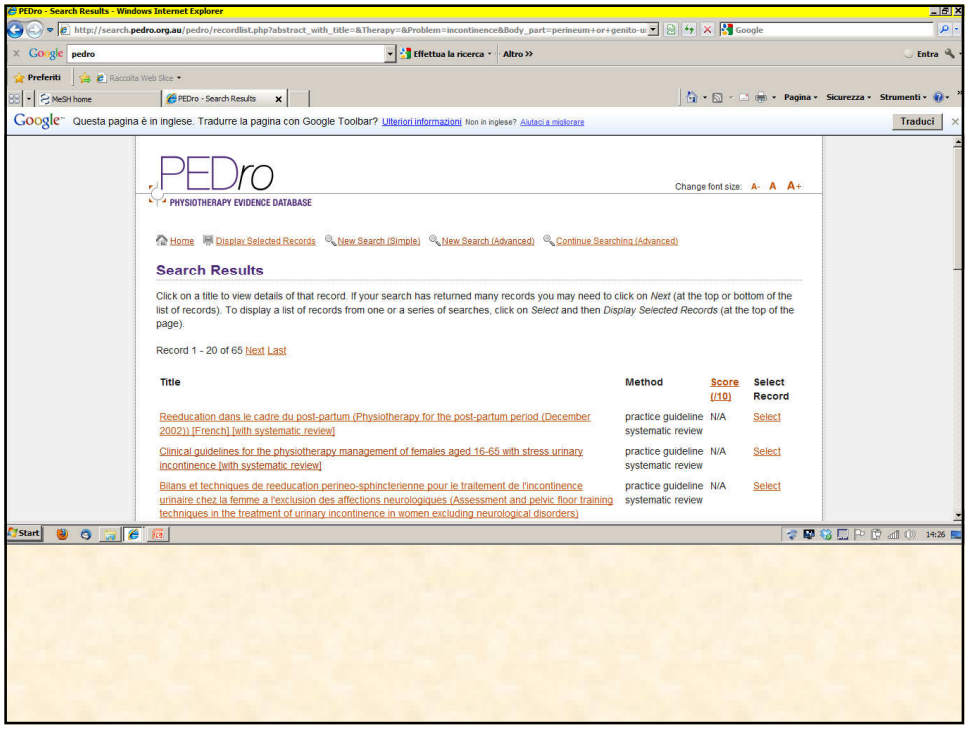
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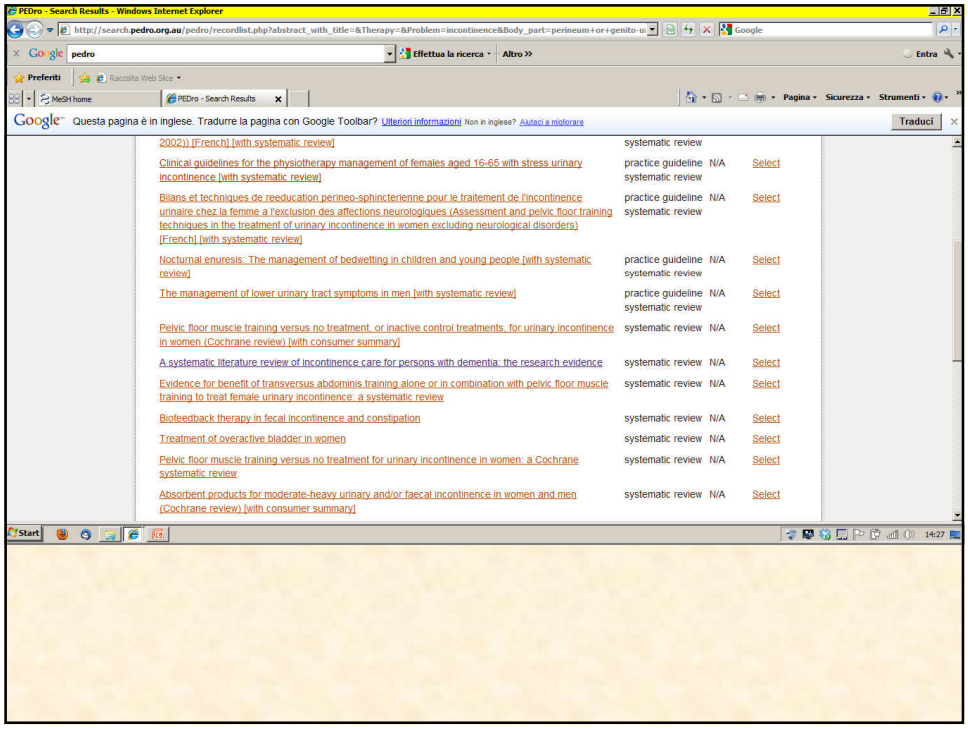
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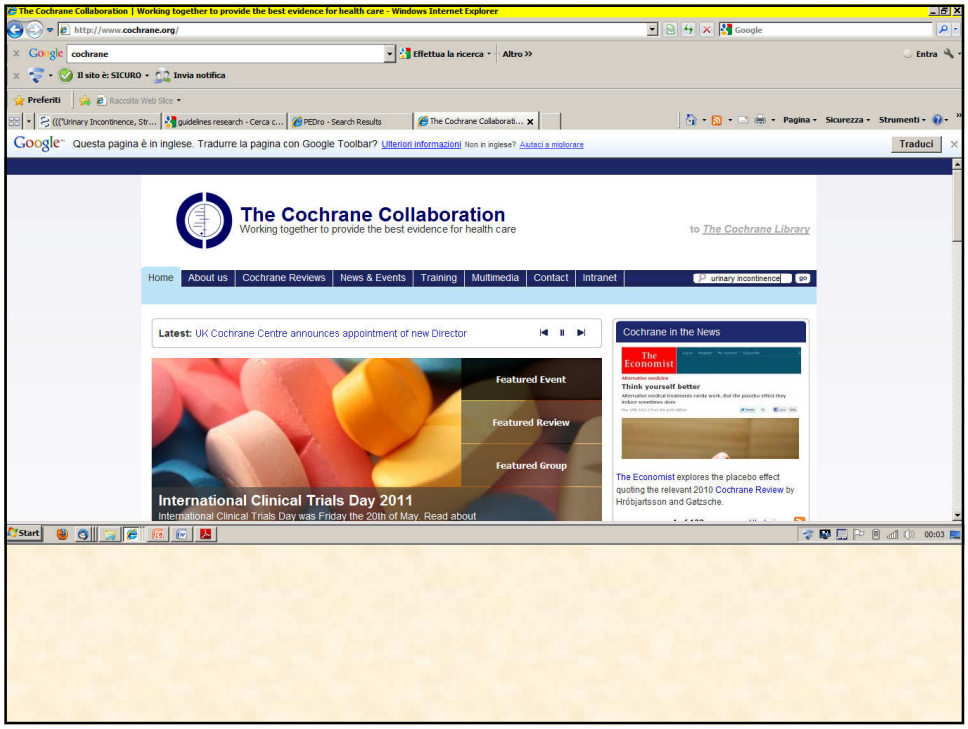
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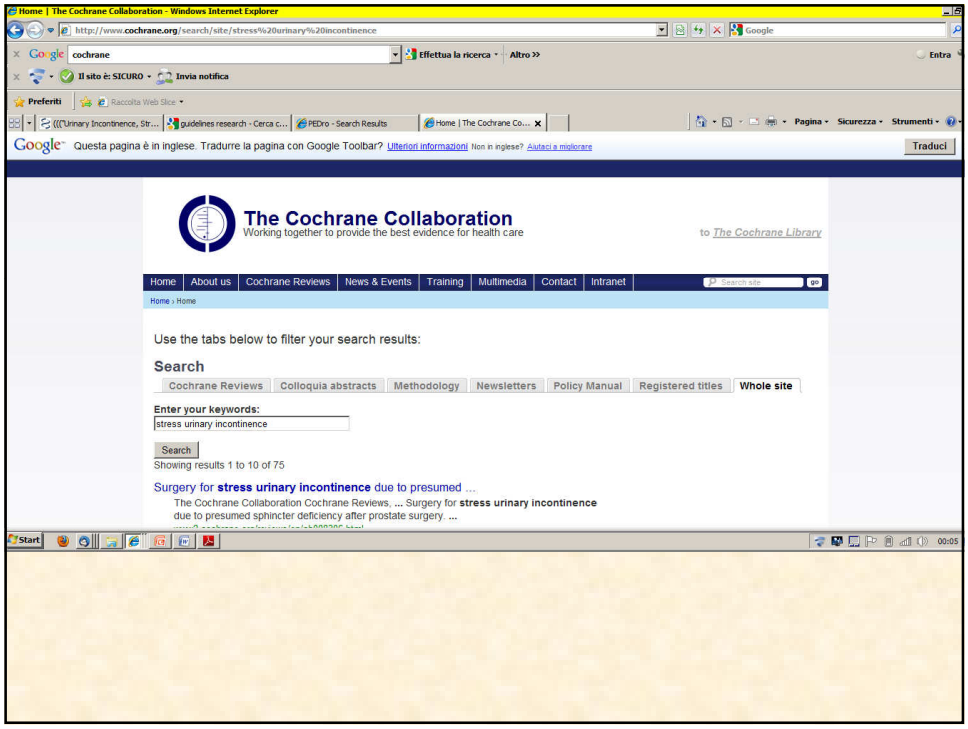
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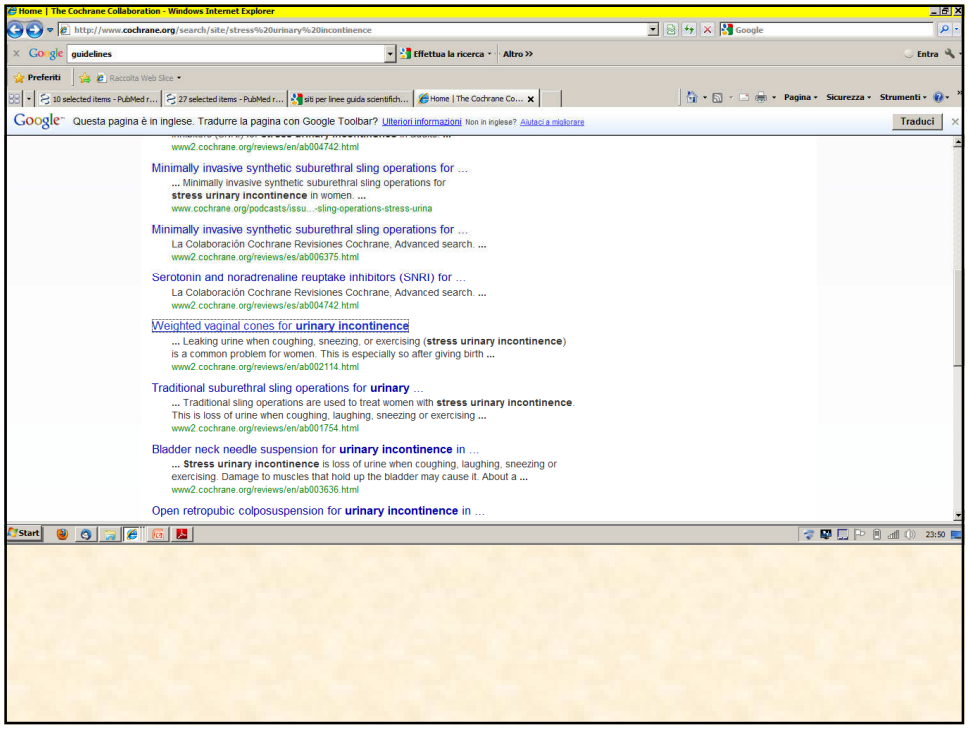
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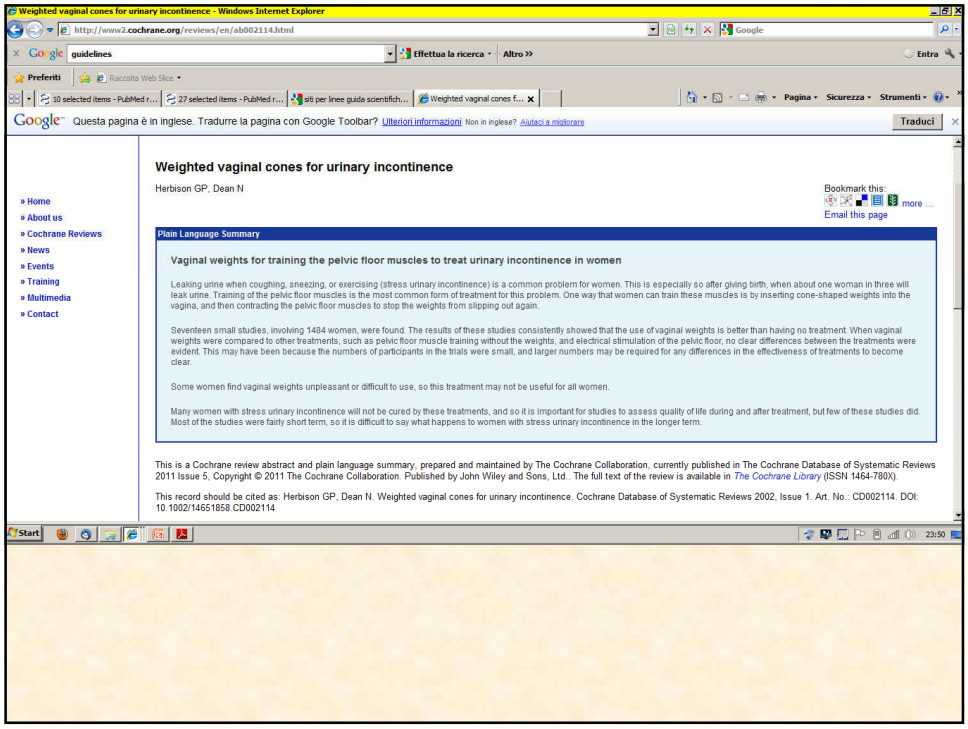
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Plain Language Summary
Vaginal weights for training the pelvic floor muscles to treat urinary incontinence in women
Leaking urine when coughing, sneezing, or exercising (stress urinary incontinence) is a common problem for women. This is especially so after giving birth, when about one woman in three will leak urine. Training of the pelvic floor muscles is the most common form of treatment for this problem. One way that women can train these muscles is by inserting cone-shaped weights into the vagina, and then contracting the pelvic floor muscles to stop the weights from slipping out again.
Seventeen small studies, involving 1484 women, were found. The results of these studies consistently showed that the use of vaginal weights is better than having no treatment. When vaginal weights were compared to other treatments, such as pelvic floor muscle training without the weights, and electrical stimulation of the pelvic floor, no clear differences between the treatments were evident. This may have been because the numbers of participants in the trials were small, and larger numbers may be required for any differences in the effectiveness of treatments to become clear.
Some women find vaginal weights unpleasant or difficult to use, so this treatment may not be useful for all women.
Many women with stress urinary incontinence will not be cured by these treatments, and so it is important for studies to assess quality of life during and after treatment, but few of these studies did. Most of the studies were fairly short term, so it is difficult to say what happens to women with stress urinary incontinence in the longer term.
This is a Cochrane review abstract and plain language summary, prepared and maintained by The Cochrane Collaboration, currently published in The Cochrane Database of Systematic Reviews 2011 Issue 5, Copyright © 2011 The Cochrane Collaboration. Published by John Wiley and Sons, Ltd.. The full text of the review is available in The Cochrane Library (ISSN 1464-780X).
This record should be cited as: Herbison GP, Dean N. Weighted vaginal cones for urinary incontinence. Cochrane Database of Systematic Reviews 2002, Issue 1. Art. No.: CD002114. DOI: 10.1002/14651858.CD002114
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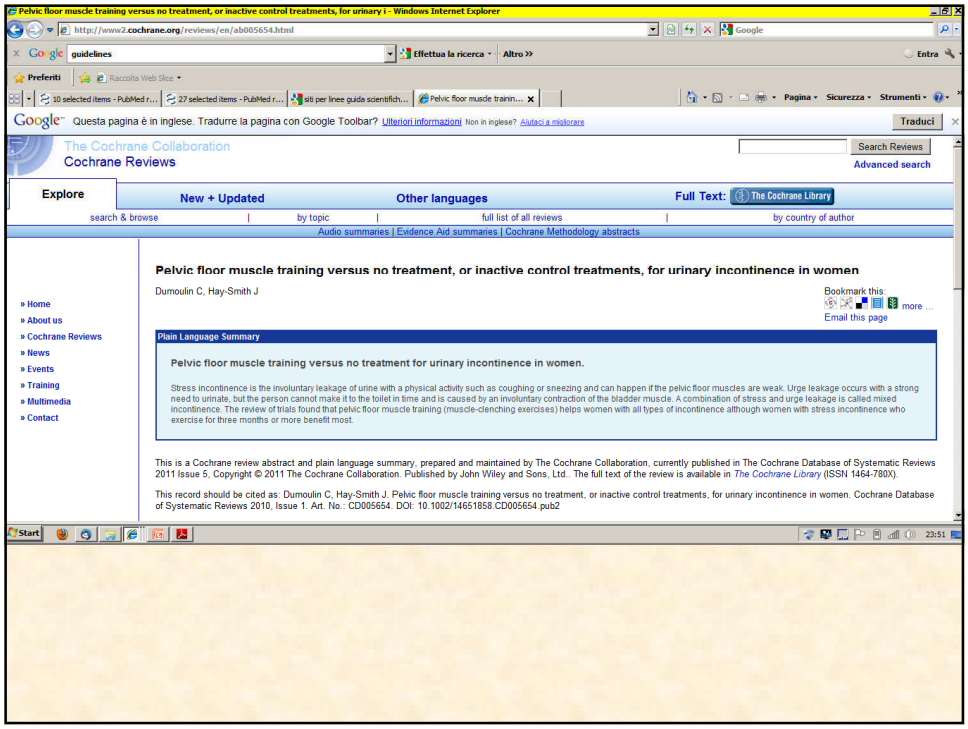
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Plain Language Summary
Pelvic floor muscle training versus no treatment for urinary incontinence in women.
Stress incontinence is the involuntary leakage of urine with a physical activity such as coughing or sneezing and can happen if the pelvic floor muscles are weak. Urge leakage occurs with a strong need to urinate, but the person cannot make it to the toilet in time and is caused by an involuntary contraction of the bladder muscle. A combination of stress and urge leakage is called mixed incontinence. The review of trials found that pelvic floor muscle training (muscle-clenching exercises) helps women with all types of incontinence although women with stress incontinence who exercise for three months or more benefit most.
This is a Cochrane review abstract and plain language summary, prepared and maintained by The Cochrane Collaboration, currently published in The Cochrane Database of Systematic Reviews 2011 Issue 5, Copyright © 2011 The Cochrane Collaboration. Published by John Wiley and Sons, Ltd.. The full text of the review is available in The Cochrane Library (ISSN 1464-780X).
This record should be cited as: Dumoulin C, Hay-Smith J. Pelvic floor muscle training versus no treatment, or inactive control treatments, for urinary incontinence in women. Cochrane Database of Systematic Reviews 2010, Issue 1. Art. No.: CD005654. DOI: 10.1002/14651858.CD005654.pub2
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P.I.C.O.:

Paziente o popolazione: *pazienti di sesso femminile in età fertile affette da incontinenza urinaria da sforzo*

Intervento: esercizio terapeutico (pelvic floor muscle training) biofeedback (bfb), stimolaizone elettrica funzionale (sef), coni vaginali (vaginal weight)

Comparazione: all

Outcome: *qualità di vita, misurata con indicatore*

L'esercizio terapeutico (pelvic floor muscle training) risulta essere la tecnica/strumento più efficace nella fisioterapia del pavimento pelvico per l'incontinenza urinaria da sforzo nelle pazienti di sesso femminile in età fertile.

3.QUESITO CLINICO

P.I.C.O.:

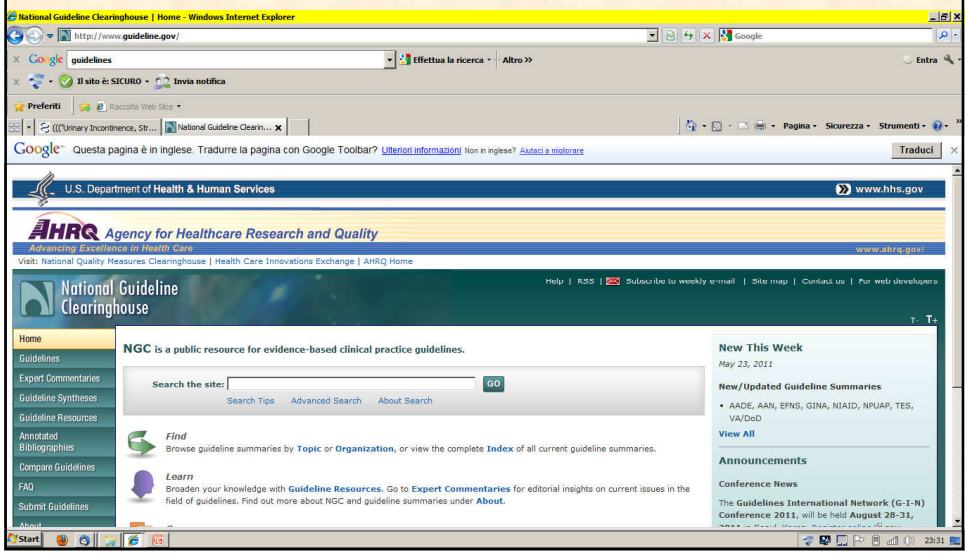
Paziente o popolazione: *pazienti di sesso femminile in età fertile affette da incontinenza urinaria da sforzo*

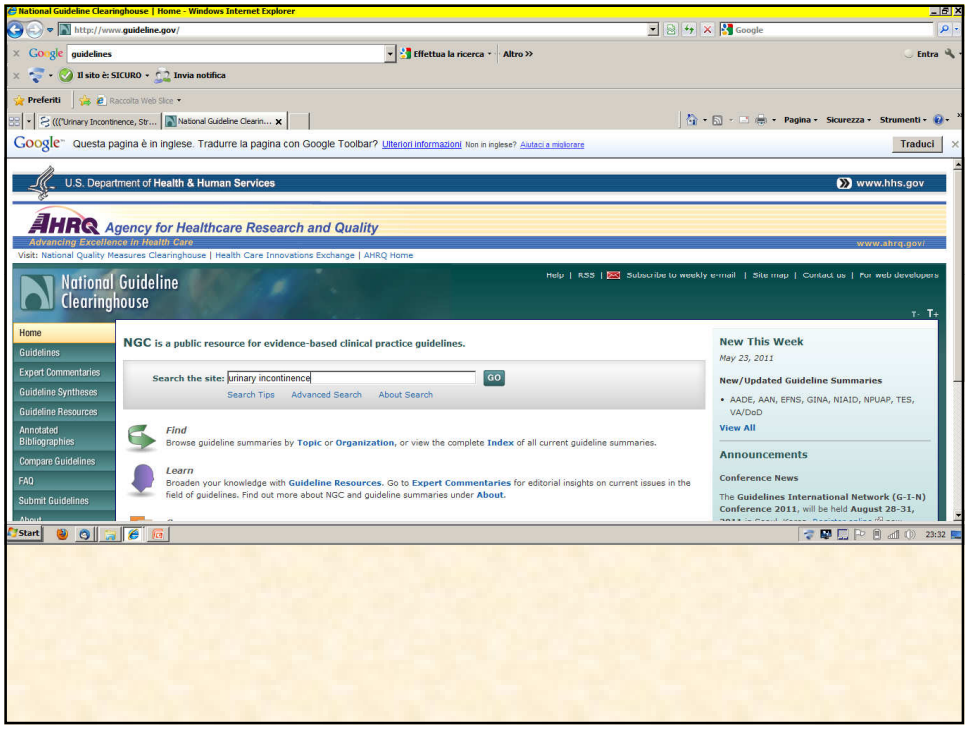
Intervento: primo intervento

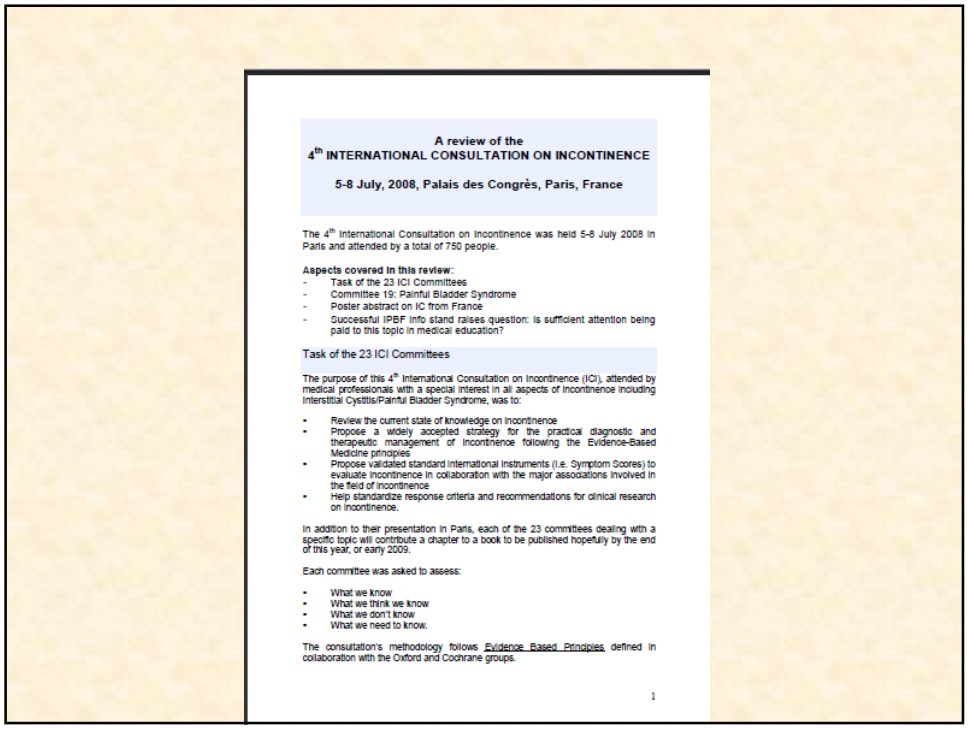
Comparazione: all

Outcome: qualità di vita

4. UTILIZZO DELLE BANCHE DATI







A review of the
4th INTERNATIONAL CONSULTATION ON INCONTINENCE

5-8 July, 2008, Palais des Congrès, Paris, France

The 4th International Consultation on Incontinence was held 5-8 July 2008 in Paris and attended by a total of 750 people.

Aspects covered in this review:

- Task of the 23 ICI Committees
- Committee 19: Painful Bladder Syndrome
- Poster abstract on IC from France
- Successful IPBF info stand raises question: Is sufficient attention being paid to this topic in medical education?

Task of the 23 ICI Committees

The purpose of this 4th International Consultation on Incontinence (ICI), attended by medical professionals with a special interest in all aspects of incontinence including Interstitial Cystitis/Painful Bladder Syndrome, was to:

- Review the current state of knowledge on incontinence
- Propose a widely accepted strategy for the practical diagnostic and therapeutic management of incontinence following the Evidence-Based Medicine principles
- Propose validated standard international instruments (i.e. Symptom Scores) to evaluate incontinence in collaboration with the major associations involved in the field of incontinence
- Help standardize response criteria and recommendations for clinical research on incontinence.

In addition to their presentation in Paris, each of the 23 committees dealing with a specific topic will contribute a chapter to a book to be published hopefully by the end of this year, or early 2009.

Each committee was asked to assess:

- What we know
- What we think we know
- What we don't know
- What we need to know.

The consultation's methodology follows Evidence Based Principles, defined in collaboration with the Oxford and Cochrane groups.

1

Neurourology and Urodynamics 29:213–240 (2010)

REVIEW ARTICLE

Fourth International Consultation on Incontinence Recommendations of the International Scientific Committee: Evaluation and Treatment of Urinary Incontinence, Pelvic Organ Prolapse, and Fecal Incontinence

P. Abrams , K.E. Andersson, L. Birder, L. Brubaker, L. Cardozo, C. Chapple, A. Cottenden, W. Davila, D. de Ridder, R. Dmochowski, M. Drake, C. DuBeau, C. Fry, P. Hanno, J. Hay Smith, S. Herschorn, G. Hosker, C. Kelleher, H. Koelbl, S. Khoury,* R. Madoff, I. Milsom, K. Moore, D. Newman, V. Nitti, C. Norton, I. Nygaard, C. Payne, A. Smith, D. Staskin, S. Tekgul, J. Thuroff, A. Tubaro, D. Vodusek, A. Wein, and J.J. Wyndaele and the Members of the Committees

3. QUESITO CLINICO

P.I.C.O.:

Paziente o popolazione: *pazienti di sesso femminile in età fertile affette da incontinenza urinaria da sforzo*

Intervento: primo intervento

Comparazione: all

Outcome: qualità di vita

L'esercizio terapeutico (pelvic floor muscle training) risulta essere, insieme al *lifestyle intervetion* e al *bladder training* il primo intervento consigliato in caso di incontinenza urinaria da sforzo nelle pazienti di sesso femminile.