Beyond the Kegel: Understanding Pelvic Organ Prolapse Transcript

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Introduction to Pelvic Floor Basics

A lot of times what I'm doing when I work with someone is teaching them A, what their pelvic floor is, B, how to turn it on. And then there, and sometimes people are like, well, that's not what I was doing.

A lot of times people think that they're doing a Kegel, but they're really like squeezing their glute or they're turning on their AD doctor muscles, the muscles in between their legs.

So learning the part of what we do in or I do in physical therapy is teaching people like what their pelvic floor actually is and how to know that it's turning on.

This is Dr. Talks. Hello and welcome. I'm delighted today to have two experts on the subject of pelvic organ prolapse. Firstly, I will introduce Dr. Ellie Allen.

She is a doctorate in orthopedic physical therapy and she specializes in pelvic health. She will tell us about how she approaches the workup and treatment of a woman who comes to her with pelvic organ prolapse problems.

Dr. Rochelle Bernstein is a physician gynecologist who, after many years of delivering babies and dealing with general gynecology, has now moved over to the specialty of menopause per se.

And she has a marvelous website that I will reference in the show notes below called Purely Menopause, where she covers a number of very, very interesting topics.

So welcome to both of you. I'm so glad we could get together today. Thank you for having us. Thank you. The first question I have is kind of how would you define pelvic organ prolapse?

And I'll start with you Rochelle, because I suspect that most of the women with this problem first see their gynecologist or maybe their primary care doc and then later get referred over to the practice of Dr.

Allen. So what kinds of symptoms are we talking about here?

Defining Pelvic Organ Prolapse

Sure. So I will go ahead, if it's okay with you, I'll just go ahead and describe to you how I tell my patients what the pelvic floor looks like and then we can talk a little bit about symptoms and I think that the opportunity to describe that with a physical therapist is a great opportunity because it's not just anatomy, it's muscles and it's not just the pelvic floor, it's the abdominal muscles and so having the two perspectives together I think is actually really helpful.

The bony pelvis has a hole, right? So if you just put the bones together, there's nothing holding it together. And what holds it together is a muscle or the levator anii, which has lots of different components to it.

But it's a muscle that acts as a hammock to hold everything inside. So the uterus sits on the pelvic floor. the bladder sits on the pelvic floor and the pelvic floor attaches to all the parts of the bony pelvis all the way around.

So when you have damage to that muscle, you actually get what is sort of like a hernia or there's pressure where that damage is and then things can push on or fall through the pelvic floor.

And so symptoms vary based on the individual. Sometimes women just have a bulge that they can feel or is uncomfortable. Sometimes they feel pressure. It can change your urinary habits, your bowel habits.

and it can actually disrupt sexual intercourse. So depending on the type of abnormality that you see, that will justify

the symptoms that patients have when they come into the office.

Thank you. And what kinds of other conditions might need to be ruled out before concluding that a woman's symptoms are from her pelvic organ prolapse?

Sure, so anything that is going to put pressure on the pelvic floor is going to give you potentially similar symptoms. So if you had a large ovarian cyst, for example, you might have pressure, abdominal pain.

I mean, even a urinary tract infection might, because the bladder is right there, the urethra is right there. It's important for patients to know that To do a good exam of the vagina and the pelvic floor, it's a detailed exam.

So it takes a physician a reasonable period of time to do a speculum exam that evaluates all the components of the pelvic floor and the vagina to determine what the cause is.

So I encourage patients to really go in and don't just connect these symptoms to an annual exam and just really quickly, can you just tell me what's going on with my bladder?

It does take a lot of time. It's complicated to figure out exactly what the approach should be and you want that time from your physician. So I encourage patients to go in and give them the time.

And that's in part why you went into the purely menopause space with your practice beat. So you would have that kind of time instead of running off to do deliveries and so on.

One thing I found interesting in some of the reading that I did was the symptoms of pelvic organ prolapse are not just from aging and that they are often severely disruptive to people's lives.

A real disability constrains people's social lives quite significantly and something that people shouldn't ignore and just, as you say, throw it on to the end of an annual exam.

Now Nell, is there anything you would add to what Dr. Bernstein has said so far? Like you mentioned earlier and what Dr. Bernstein was talking about.

Diagnosis, Symptoms, and Differential Causes

Most of the time when someone comes to my office, right, they've already been diagnosed with a pelvic organ prolapse and I give it air quotes because I think sometimes they do end up having that sort of quick exam, not the full exam that Dr.

Bernstein is talking about because that does take a lot of time and a lot of times people will be referred to me with just this information that they have a cystoseal which is another common phrase that's used to describe what's happening.

And so sometimes what I do is try to more clearly diagnose where the tissue problem is because it can be more anterior or more posterior and then I try to also help people understand like what are the symptoms that they're having that are related to the prolapse and what could be maybe related to some other issues that are going on with their pelvis and their pelvic floor because sometimes they can overlap a little bit with other things.

That's good information. Rochelle, when you see someone, let's say, and you have the time, you believe that their symptoms are probably due to some of the loss of that good pelvic sling, you would probably rule out a urinary tract infection if it were a recent onset problem, and then often refer people to see Ellie Allen in her office initially if that's the kind of physical situation that you have diagnosed.

Is that correct? Yeah, so it is correct. I am a huge proponent of pelvic floor physical therapy. So I just want to define what Ellie was talking about as far as the cystocele is a prolapse of the bladder.

So what that means is that when I was doing my exam, when I looked in the vagina, I can see the bladder coming down. Now some women have significant symptoms related to that.

You can have incontinence, you can have urinary retention, which would put you an increase for urinary tract infection, and you can of course have pain and you can have sexual intercourse issues, etc.

But the extent of the prolapse is significant based on the extent of symptoms. So by referring someone to pelvic organ or pelvic floor physical therapy, if they can strengthen that pelvic floor, they can get enough relief of that prolapse of the bladder where they don't need any other intervention.

So that's why I think that, you know, for me, it's rare that you will jump into surgery. I mean, there are times that you will, but For the most part, there's a whole spectrum of prolapse that you can see, and even some pretty severe prolapse that can improve with pelvic floor physical therapy alone.

Perfect. Thank you. Maybe, Ellie, you can tell us what happens after the initial assessment that you do and how you approach the pelvic floor therapy with patients.

And then what does success look like, if that is a successful approach? Okay, that was a few questions. I'm going to start, I'd comment on something that Dr.

Bernstein just mentioned. So she was saying that there's sometimes a grade, right? Or a gradient of someone who has a pelvic organ prolapse, right? And the way that I look at it, and I'll explain this with my model to patients, right?

When they come in, what the grade of what I think their prolapse is, right? So there's a, it goes all the way from one to grade four, right? And so What I usually, the way that the research is going is that with physical therapy, we can help manage a lot of the symptoms that Dr.

Bernstein was mentioning. So urinary incontinence, not so much the urinary retention piece, that's harder to manage.

Physical Therapy Assessment and Grading

from a PT perspective, but urinary incontinence, feelings of pressure or heaviness and the perineum, any difficulty with going to the bathroom, right?

Some of the sexual dysfunction, right? We can have pretty good results with women who have anywhere between a grade one and a grade three. Sometimes when they have a grade four, it's hard to make a whole lot of change because When someone has a grade 4, what that means is that their pelvic organs are outside of the pelvic ring, which sounds really scary.

And for some people it is kind of scary. But a lot of times there's less chance that we're going to make a big difference with physical therapy alone for someone who has a grade 4. So a lot of times I'll explain like what the grades are and then what I saw in their exam and then what we could expect to see.

So someone who starts with a grade three, a lot of times we can get all the way up to a grade one depending on some of the other factors like the physiologic factors, the pressure management factors that we see, right?

I just wanted to kind of dive into that a little bit more what Dr. Bernstein was talking about that sometimes having an understanding of the grading both like globally and then for that person is really helpful for them to understand where we're going to go next, like what the prognosis might look like.

So when I assess someone who is sent to me who has a pelvic organ prolapse, I'll do my own vaginal exam. Some physical therapists do use a speculum. I don't have that level of training.

And at this point, it doesn't with the community that I see, I don't think that it's a necessary skill for me. But if I do

think that someone has a more complex situation going on, I'll refer them to someone who has that skill set.

And I'll look at both how their what their body is doing in different positions and with different activities. I can learn a lot about that person's symptoms by watching them move and then just telling me how they feel, right?

So particularly one of the biggest symptoms is like pressure in your perineum, right? And a lot of tennis women will know like when they notice it and how extreme it is.

So that's a lot of what we do talking about like what do you feel when you squat? What do you feel when you're in a hands and knees position, when you feel when you're on your back.

What about when you're going to the bathroom, do you feel like there's pressure releasing down, right? So kind of making the differentiating between different positions because every person is different in that situation.

That's a lot of what we'll do in the first few sessions is figuring out when and where the people, when that person is having their symptoms, right? A lot of people with pelvic organ prolapse have difficulty with high impact activities, so jumping, running, and the toilet, right?

So we'll kind of try to differentiate between those things in terms of the severity of their symptoms. Okay, so that was the conversation about grading.

And then we talked about what do we do in the first day, right? The other thing, like you mentioned, Pat, I'm more trained as an orthopedic physical therapist, so I look at how the whole body is moving, and I think a lot of the world of PT is moving in this direction also.

Traditionally, a pelvic floor physical therapist looked just at the pelvic floor and nothing else, but like Dr. Bernstein mentioned, Our pelvic floor functions in concert with our abdominal stabilizers, our back stabilizers, our diaphragm.

And so a lot of times I'll actually work more on those things with people than just directly on their pelvic floor because a lot of times it's not just a problem in terms of how their pelvic floor is working.

It has to do also with the tissue. that's in their pelvic floor that kind of helps to support that sling that Dr. Bergstein was explaining. And then also how you use those neighboring muscles to help either improve stability and coordination, right, or make it worse.

In PT we call it pressure management. So someone who has A hard time managing pressure in their abdominal cavity will often make the prolapse quote unquote worse, right?

They will bear down or make the pressure increase solely by how they're using the other muscles in the region. So if I can teach them how to use their muscle, other muscles a little bit more effectively and more as a team, then the pelvic floor isn't the thing that is then responsible for managing the pressure by itself.

Does that kind of make sense? It has a lot of steps to it, right? But that's kind of our goal, right? Helping people learn how to manage pressure. The other piece that I work a lot with people on is maximizing their strength in their glute muscles, in the muscles around their hip, because there are a lot of muscles in the hip and that, how do I want to say this, that are both hip muscles and pelvic floor muscles, right?

And so more often than not I'll find some weakness or some deficiency in people's hip muscles and when those are more balanced then the pelvic floor is essentially unloaded.

It can do a better job at its job of helping to support the organs than having to you know take up the slack when hip muscles are weaker. So that's another piece that I work on a lot with people.

And the last piece is a lot of times PTs are part of the conversation around wearing a pessary. So if someone is having a lot of heaviness or they have like uncontrolled incontinence, what we can do is place a ring inside the

vaginal wall and it helps to lend pressure so that the muscles can do their job a little bit better so that people don't leak urine or the prolapse will not get worse over time.

Thank you. Do you have anything to add to that Dr. Bernstein about a passeree when that might be appropriate for certain people? What you see on exam, you know, as far as the thing that you would say, okay, this is not going to get better is, you know, someone will put their legs up in the stirrups and you can actually see the bladder coming up to the opening or the introitus of the vagina.

And so you actually see it protruding. Same thing for the uterus. You can sometimes people come in and they just like feel like they feel something hard in the vagina.

that's hanging down and it turns out that it's their cervix, which of course is connected to the uterus and that's prolapsing down completely. It's called proscedentia.

So those would be the times that Ellie's describing as far as can you're looking at surgical intervention at that point in time because the tissues are are not good.

And another thing I did want to add was that oftentimes an ultrasound is an important part of the workout because fibroids or uterine abnormalities also can cause the uterus to come down into the pelvis and put more pressure on the pelvic floor and prolapse worse, et cetera.

So if you just imagine that the problem is that you have this sling and you have something putting pressure and falling through the sling, I actually brought a pessary.

So this is a pessary. This is a pessary. There are a bunch of different kinds of pessaries. What you do is you, as the gynecologist, and I don't know whether or not this is something a physical therapist would do, but the gynecologist would actually feel the pelvis.

There's, you know, ones for incontinence. This one has a little piece that can put pressure on the urethra. and you actually fit this into the vagina and it supports those pelvic organs so that they stay within the bony pelvis and then if you can actually strengthen those muscles around you know with that pessary holding up those pelvic organs you can potentially achieve symptom relief.

So, and pessaries are great.

Pessaries and When Surgery Is Considered

I've got lots of patients who do really well with pessaries. They can stay in for up to three months and then just need to be taken out and cleaned and can be replaced.

So between both of you, what would you say is the success rate, if you will, for someone who doesn't have the extreme kinds of protrusions into the outside world or the lower vagina with the pelvic floor therapy approach as compared to the pessary or certainly surgery?

I think that's a really good question. That's kind of a hard question to answer, Pat, because it's really person-dependent, right? Because there are a lot of contextual factors that can affect how successful someone is with doing physical therapy for their pelvic floor.

But in general, I would say that most people who come to work on that do get better. And again, that there are also depends on a little bit what their problem is, like what their biggest symptom is and how much that symptom is affecting their life.

I'll give you an example. I had a woman who came to me about I don't know, maybe two years ago. And she was diagnosed with a level three pelvic organ prolapse.

She was, you know, I'm pretty sure post-menopausal, you know, like in her early 60s, very active, right? And her main concern was that she leaked urine sometimes and that she could feel that heaviness, right, in her pelvis.

And she was pretty skeptical. She was like, I have no idea if this is going to work. And You know, I reassured her and I told her like what we basically did everything that we've been talking about today.

And she, I helped her get to a place where she could get a pessary to answer what you were saying, Rochelle. I don't think that there are very many physical therapists who fit pessaries.

Some of them do, but a lot, my rule, the way that I do it is I say, why don't you talk to your gynecologist about this? option because a lot of times they just get sent right to me and I'm like okay great we'll do these these things and then and I think a pessary could be really helpful for you because I will find after six weeks of treatment that they're not really improving in in there or they're not improving enough right in terms of the grade of the severity of the prolapse so then I'll say let's try a pessary and see if you like it right and see if you can do exercise and it helps to improve some of your symptoms even more and then And that's kind of how I use, how I refer people back and forth to be fit for a pessary.

Anyway, so she definitely improved in her ability to control her urination, right? She definitely improved in her ability to tolerate like high load activities, jumping.

She doesn't really run, but like HIIT type workouts, like she didn't have any leakage after that. She could understand how to turn her pelvic floor on when she wanted to, her bowel movements more, more regular.

So I think she's a good example of someone who had no idea what it was going to be like to go into physical therapy and came out with definitely some improvements.

Now, did I, did we really change the grade of her prolapse? No, like I think she went from a three to a two, which is not a terrible result, right? But it's not like the physical therapy makes it go away.

from a tissue perspective. So I think if we just use, do you have a pelvic organ prolapse, yes or no? If we only use that one metric, then I don't always think that physical therapy alone is enough to change.

But I also don't think that asking the question, do you have a pelvic organ prolapse is the right question to ask because there are so many women who either have had children or not had children or had pelvic surgery or whatever who have a pelvic organ prolapse and have some problems associated with them that I think that it's worth trying physical therapy for a prolonged period of time.

I would even say up to about six months before deciding if you need to have any sort of further intervention. I guess that answers the question as well as I can.

Rochelle, do you have anything to add to, you know, it's not the prolapse itself, it's the functionality for the woman and how long you would try something before concluding that it didn't make a difference?

Yeah, I absolutely agree with her that it's very individual. People can have a one woman and can have significant prolapse and really not mind it. And another woman can have mild prolapse and it's really disrupts her life.

And so if they're doing activities where they're jumping, you know, jumping a lot, it might be, you know, being hard. And there are definitely some tricks to the trade that you can do to help.

If someone only has incontinence when they run and that's their primary symptom, they can place a tampon or there's some other things they can place in the vagina just to give them some stability of the pelvic floor over the urethra so that manages their incontinence and then they don't have issues any other time.

I mean, there's no question that it's very individual. The amount of time I really, I let the physical therapist make the determination of the patient.

And you know, some patients are more compliant than others. And then obviously some physical therapists are better than others, you know, like there's.

Fortunately, now there's training that really focuses on the pelvic floor.

Kegels, Biofeedback, and Proper Muscle Activation

There's just so many, it's just like Ellie is explaining, understanding that there's so many other muscles that are involved that can be trained. And now that I'm in menopause and focusing on menopause and the importance of strength training for osteoporosis prevention and the importance of plyometrics and lifting heavy weights and that kind of thing, there's sort of a different impact on your pelvic floor.

So having a consciousness about how your pelvic floor integrates into all of your exercise. Really, I just, every patient is going to manage that and comprehend it differently.

And so I really do work with the physical therapist to help me make those determinations. I might have mentioned for our viewers that both of our experts today are athletes in their own right and have different but complementary activities that they like to do.

So they're coming from a basis of personal experience. Maybe I'll give you the, well, I have a question which is about kegels. If you look at, let's say urinary incontinence on Google, the first thing that it will tell you is do kegel exercises.

And as I'm hearing both of you speak, I'm thinking we should call this episode Beyond the Kegel. or something like that, because I haven't heard either of you mentioning that.

And I'm sure it's individual, depends on the particular woman you're dealing with. But if you'd care to comment, I'm sure there are many people who are out there saying, but I've been doing kegels for 15 years, and this is what happened or didn't happen.

Well, I'll just say very quickly that there are a lot of women who do gables, but they have no idea where their pelvic floor is. And so again, that's where Ellie comes in and biofeedback comes in.

And really, there are devices that you can use, there are weights that you can use. There are ways to understand where your pelvic floor is so that you can actually strengthen the appropriate muscles.

So I'll let Ellie talk about that and I think the other important thing is that you know we shy away from the pelvic floor after childbirth and there will there is beginning to be and soon will be more of an active role for physical therapy after in the postpartum period and I think that that will have some long-term help as far as pelvic floor strength in the future as well.

My daughter-in-law was recommended for physical therapy, pelvic therapy after childbirth, and I was like, really? Wow. And I'm a gynecologist also, so you'd think I've heard of this, but no.

Yeah. Um, so I think to answer your first question, Pat, about a Kegel, right, or I call it a Kegel, is think that that is a bit of unfortunate information that people get from Dr.

Google and it definitely needs some context because just turning on your pelvic floor muscles, like Rochelle was saying, doesn't necessarily, or doing what you think is turning on your pelvic floor muscles doesn't necessarily mean that that's what you're doing.

So that's the first thing a lot of Sometimes what I'm doing when I work with someone is teaching them, A, what their pelvic floor is, B, how to turn it on.

And then there, and sometimes people are like, well, that's not what I was doing. I was like, I know. You were using

some other accessory muscles, right?

A lot of times people think that they're doing a Kegel, but they're really like squeezing their glute. Or they're turning on their AD doctor muscles, the muscles in between their legs, right?

So learning the part of what we do in or I do in physical therapy is teaching people like what their pelvic floor actually is and how to know that it's turning on.

And this is like sometimes hard, right? But then also, so sometimes I'll do it internally, right? Teach people how to turn their muscles on. But sometimes you can do it externally.

And most of the time, if someone's not having really, hasn't had surgery, hasn't recently had a baby, has people who have had the radiation on their pelvis, right?

They really need to learn, like Rochelle was saying, with biofeedback or someone else's assistance, like my hands, right? To learn how to turn their muscles on again properly.

But a lot of times people can do a whole lot, just learning a little bit more about what it should feel like. versus what they're doing. So I think there's kind of a difference between those things.

Thank you. Thanks, both of you. And maybe our last word here, what does surgery look like in the current era? Which will be very brief because either we need surgery or we don't need surgery.

And maybe just give us a word so people, again, don't stay disabled by whatever symptoms they have. So if all else fails, what's the next step? So I think surgery is not a benign process, right?

And first of all, there are definitely some surgeons that are a little more aggressive and don't have an understanding of physical therapy and how many ways it can help.

But you're really reconstructing the muscles, right? And so whether they'll come back together and work as well as they did before is just, you're just never certain.

You're creating a defect that then you sew back together. So people can have pain after surgery. They can have recurrence of the prolapse. They can have spasm of the pelvic floor.

They can have pain with intercourse. I mean, there's all sorts of things that can happen. So it's important not to take it lightly when you go into that space.

Surgery, Recovery, and Postpartum Perspective

However, when it is the only thing that's left, then we do the best we can to oftentimes you will remove, you know, the uterus because the uterus is putting all that pressure and then you, you sort of close that hammock because, you know, if there's this defect and something's falling through, you have to push it back up and then recreate that hammock and then Again, doing, I really encourage patients to see a physical therapist after surgery as well, so that they're working through those next steps as far as either strengthening or whatever else needs to be done.

And sometimes, you know, the urinary incontinence is hard there. Some people just do not have very good tissue. And so that's when you have these mesh that are being used and They can also have some issues, but sometimes they really are the option that you need in order to hold things where they need to be or to maintain continents.

So when you do get to that point, surgery is a very good option. I just think it's important to realize that that nothing is in isolation, you know, you don't just go in and just cut something and fix it and it works.

So you need to consider the whole picture and the whole patient. That's good to hear. I have one other thing to say based on what Rochelle was just saying.

I think there's a lot of more information in the postpartum space about pelvic floor physical therapy. A lot of women are being diagnosed with a pelvic organ prolapse within several months after giving birth.

And if anybody is watching who talks to women of childbearing age, most of the time that prolapse that you have after childbirth will resolve on its own or will resolve to a certain degree after a year or several years.

doesn't necessarily mean that you shouldn't seek care if you're having problems, right? Bits of information I hope to spread is that in a lot of people having a pelvic organ prolapse is pretty normal, right?

It's a pretty common occurrence to start having these conversations where we talk about it like that there's nothing wrong with you, right? And it's not going to be that way necessarily forever or it's not going to be a debilitating experience because I think there are sort of a scary topic.

So the more that we can talk about what it is, right? That it is very common, either early postpartum phase or later in life, right? And that there's things you can do about it kind of helps to normalize it a little bit.

So it's not as scary. Thank you. That's a great message. All right. This has been a very comprehensive and marvelous discussion. I hope our viewers are learning some things here.

I certainly learned some things here today. And if this is the kind of information that you like and you would like more of it, please subscribe and like this video.

And if not, I want to thank each of you guys so much for coming in today and being with us and giving us such marvelous information. Thank you so much.

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