phn NORTH WESTERN MELBOURNE

An Australian Government Initiative

Endometriosis: the hidden pain

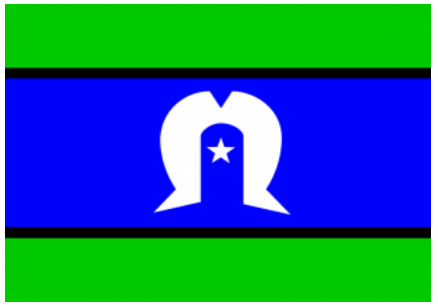
Tuesday 26 August 2025

The content in this session is valid at date of presentation

Acknowledgement of Country

North Western Melbourne Primary Health Network would like to acknowledge the Traditional Custodians of the land on which our work takes place, The Wurundjeri Woi Wurrung People, The Boon Wurrung People and The Wathaurong People.

We pay respects to Elders past, present and emerging as well as pay respects to any Aboriginal and Torres Strait Islander people in the session with us today.



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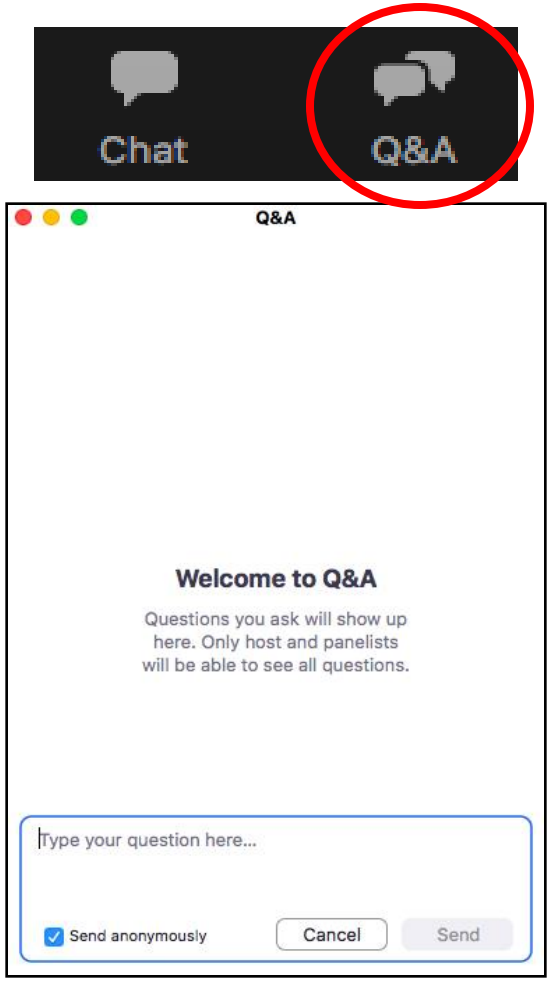

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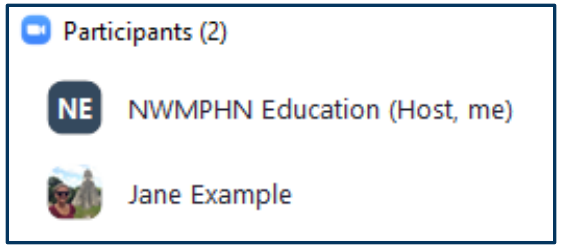

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HealthPathways Melbourne

Endometriosis: The Hidden Pain

26 August 2025

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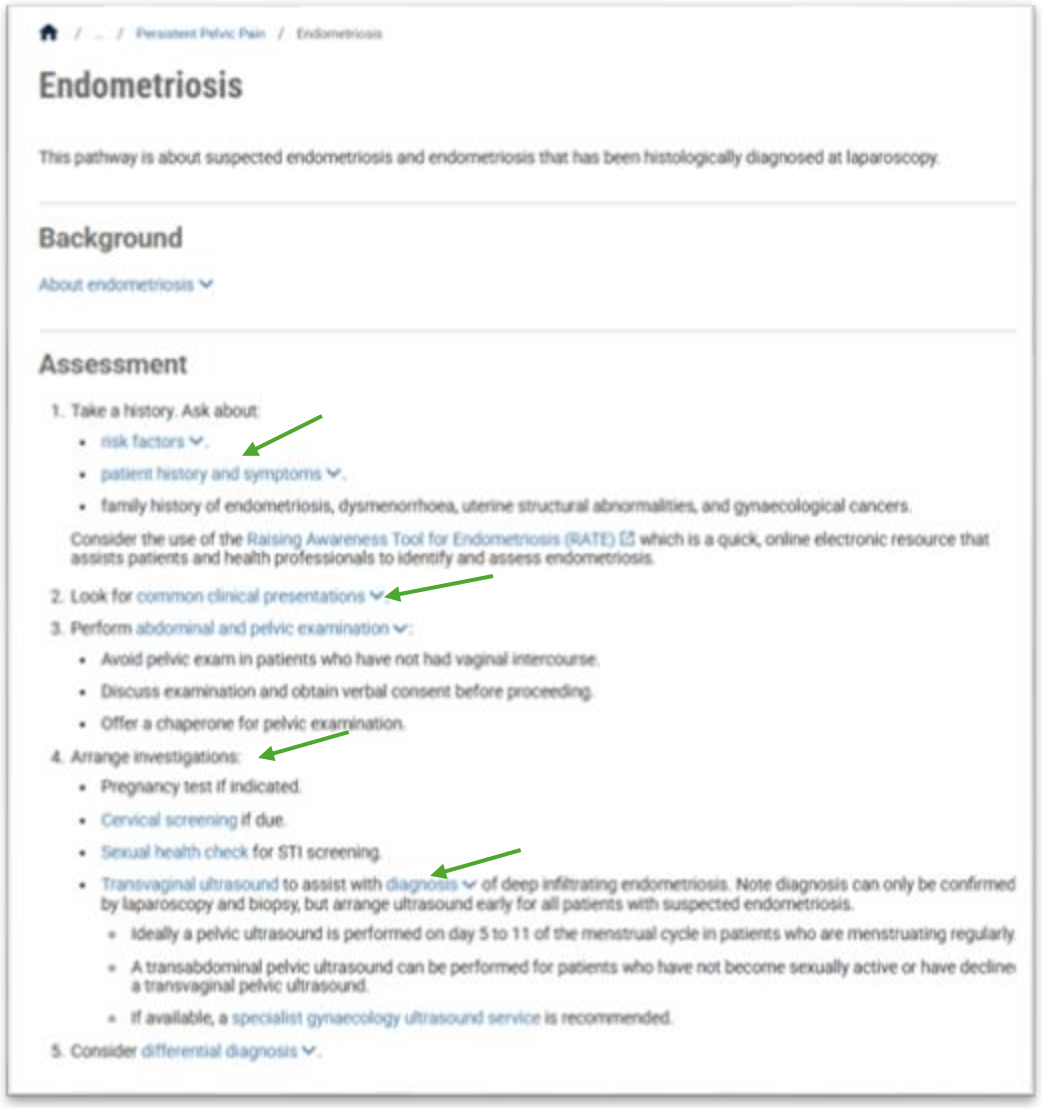
Pathways are written by GP clinical editors with support from local GPs, hospital-based specialists and other subject matter experts

- clear and concise, evidence-based medical advice
- Reduce variation in care
- how to refer to the most appropriate hospital, community health service or allied health provider.
- what services are available to my patients

HealthPathways – Endometriosis: The Hidden Pain

Click 'Send Feedback' to add comments and questions about this pathway.

HealthPathways – Endometriosis: The Hidden Pain



Persistent Pelvic Pain / Endometriosis

Endometriosis

This pathway is about suspected endometriosis and endometriosis that has been histologically diagnosed at laparoscopy.

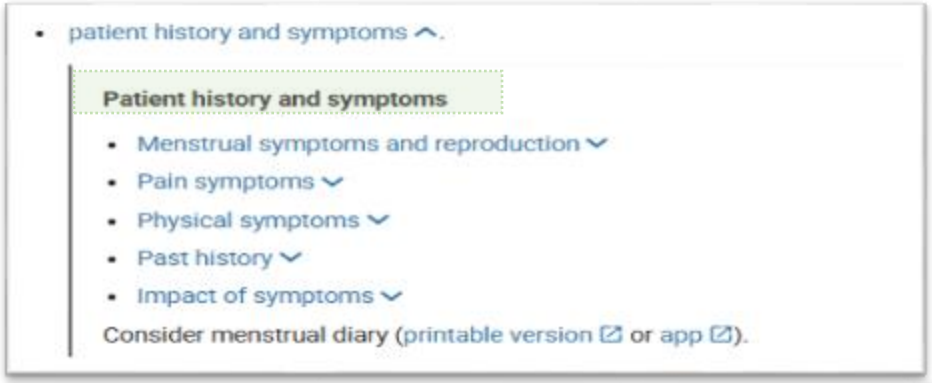
Background

About endometriosis

Assessment

1. Take a history. Ask about:
   - risk factors
   - patient history and symptoms
   - family history of endometriosis, dysmenorrhoea, uterine structural abnormalities, and gynaecological cancers.

   Consider the use of the Raising Awareness Tool for Endometriosis (RATE) which is a quick, online electronic resource that assists patients and health professionals to identify and assess endometriosis.
2. Look for common clinical presentations
3. Perform abdominal and pelvic examination:
   - Avoid pelvic exam in patients who have not had vaginal intercourse.
   - Discuss examination and obtain verbal consent before proceeding.
   - Offer a chaperone for pelvic examination.
4. Arrange investigations:
   - Pregnancy test if indicated.
   - Cervical screening if due.
   - Sexual health check for STI screening.
   - Transvaginal ultrasound to assist with diagnosis of deep infiltrating endometriosis. Note diagnosis can only be confirmed by laparoscopy and biopsy, but arrange ultrasound early for all patients with suspected endometriosis.
     - Ideally a pelvic ultrasound is performed on day 5 to 11 of the menstrual cycle in patients who are menstruating regularly.
     - A transabdominal pelvic ultrasound can be performed for patients who have not become sexually active or have declined a transvaginal pelvic ultrasound.
     - If available, a specialist gynaecology ultrasound service is recommended.
5. Consider differential diagnosis.

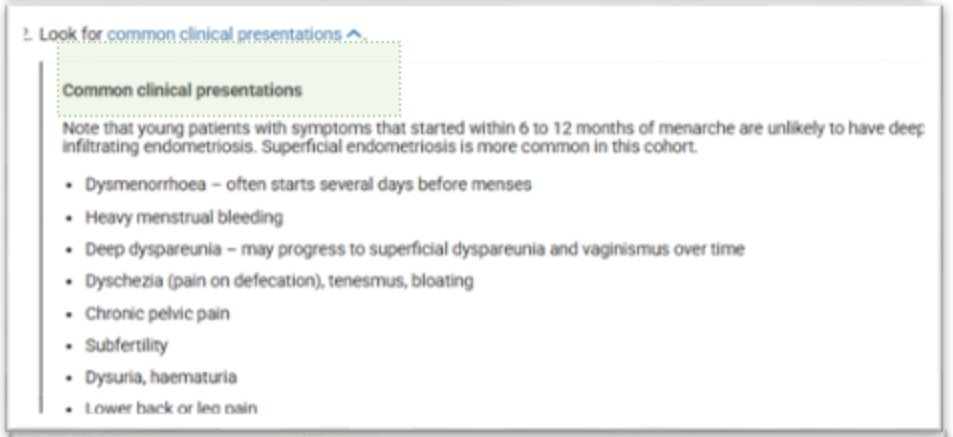


- patient history and symptoms.

Patient history and symptoms

- Menstrual symptoms and reproduction
- Pain symptoms
- Physical symptoms
- Past history
- Impact of symptoms

Consider menstrual diary (printable version or app).

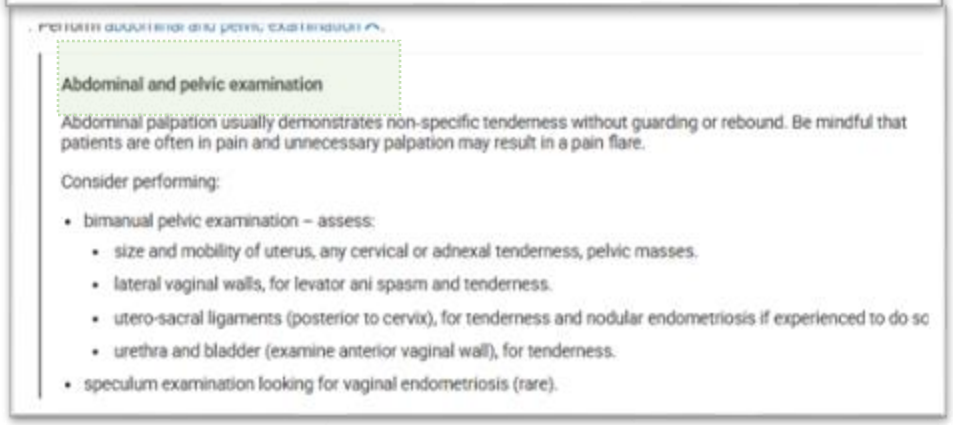


2. Look for common clinical presentations.

Common clinical presentations

Note that young patients with symptoms that started within 6 to 12 months of menarche are unlikely to have deep infiltrating endometriosis. Superficial endometriosis is more common in this cohort.

- Dysmenorrhoea – often starts several days before menses
- Heavy menstrual bleeding
- Deep dyspareunia – may progress to superficial dyspareunia and vaginismus over time
- Dyschezia (pain on defecation), tenesmus, bloating
- Chronic pelvic pain
- Subfertility
- Dysuria, haematuria
- Lower back or leg pain



3. Perform abdominal and pelvic examination.

Abdominal and pelvic examination

Abdominal palpation usually demonstrates non-specific tenderness without guarding or rebound. Be mindful that patients are often in pain and unnecessary palpation may result in a pain flare.

Consider performing:

- bimanual pelvic examination – assess:
  - size and mobility of uterus, any cervical or adnexal tenderness, pelvic masses.
  - lateral vaginal walls, for levator ani spasm and tenderness.
  - utero-sacral ligaments (posterior to cervix), for tenderness and nodular endometriosis if experienced to do so
  - urethra and bladder (examine anterior vaginal wall), for tenderness.
- speculum examination looking for vaginal endometriosis (rare).

The Endometriosis pathway will soon reflect the May 2025 Australian Living Evidence Guideline: Endometriosis, with updates currently in progress.

HealthPathways – Endometriosis: The Hidden Pain

Management

1. Refer to emergency department or for acute gynaecology assessment if:
   - new onset, severe, uncontrolled pelvic pain.
   - known endometriosis with hydronephrosis or bowel obstruction.
2. Refer for non-acute gynaecology assessment if:
   - significant deep dyspareunia.
   - dyschezia (pain on defecation).
   - suspected endometrioma.
   - persistent pain flares despite a consistent management strategy.
3. For patients with suspected or confirmed endometriosis, encourage active participation in self-care and management:
   - Provide support and education, including written resources early in the process.
   - Review patient regularly, and work with patient on shared decision-making, formulating goals and a management plan, and ongoing education.
4. If suspected mild endometriosis, consider:
   - non-pharmacological management.
   - medical management using analgesia and/or hormonal therapies. Consider a trial of each treatment option for ≥ 3 months.
5. Offer all patients with chronic endometriosis or suspected endometriosis referral for multidisciplinary care including:
   - psychological therapy and counselling.
   - pelvic floor physiotherapy for help with pain education, pelvic floor relaxation exercises, management of vaginismus, dyspareunia, and pelvic floor hypertonicity. [3]
   - Endometriosis and Pelvic Pain Clinic for multidisciplinary support.
6. If symptoms fail to respond to adequate medical management, refer for non-acute gynaecology assessment for laparoscopy and consideration of surgical management.
7. If appropriate, discuss pregnancy planning. Presence of endometriosis is a risk factor for infertility – advise the patient to take this into account when making decisions around family planning, as fertility also decreases with age. See also Preconception Assessment.
8. If a patient with known endometriosis presents with reproductive issues, refer for non-acute gynaecology assessment.
9. If the patient has difficulty managing persistent pain, despite maximal medical and gynaecological interventions:
   - aim for multidisciplinary management and create a GP Chronic Condition Management Plan (GPCCMP) and/or a GP Mental Health Treatment Plan.
   - follow the Persistent Pelvic Pain pathway.

Referral

- Refer to emergency department or for acute gynaecology assessment if:
  - severe uncontrolled pelvic pain.
  - known endometriosis with hydronephrosis or bowel obstruction.
- Refer for non-acute gynaecology assessment if:
  - significant deep dyspareunia.
  - dyschezia (pain on defecation).
  - suspected endometrioma.
  - known endometriosis with associated reproductive issues.
  - suspected endometriosis that has not responded to adequate medical management.
- Offer all patients with chronic endometriosis or suspected endometriosis referral for multidisciplinary care including:
  - psychological therapy and counselling.
  - pelvic floor physiotherapy for help with pain education, pelvic floor relaxation exercises, management of vaginismus, dyspareunia, and pelvic floor hypertonicity. [3]
  - Endometriosis and Pelvic Pain Clinic for multidisciplinary support.

Information

For health professionals

Further information

- Jean Hailes for Women's Health – Endometriosis: A Discussion About Diagnosis and Treatment
- National Institute for Health and Care Excellence (NICE) – Endometriosis: Diagnosis and Management
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) – Endometriosis Clinical Practice Guideline

For patients

HealthPathways- Relevant and Related pathways

Relevant Pathways

Endometriosis

Persistent Pelvic Pain

Pelvic Inflammatory Disease (PID)

Dysmenorrhoea

Heavy Menstrual Bleeding

Premenstrual Syndrome (PMS)

Polycystic Ovarian Syndrome (PCOS)

Vulvodynia

Pelvic Floor Dysfunction and Prolapse

Menopause

Menopause Hormone Therapy (MHT)

Intermenstrual Bleeding

Referral Pathways

Acute Gynaecology Referral (Same-day)

Non-acute Gynaecology Referral (> 24 hours)

Colposcopy Referral

Fertility Specialised Referral

Related Pathways

Cervical Cancer

Cervical Polyps

Cervical Screening

Ovarian Cancer - Established

Ovarian Cancer Follow-up

Ovarian Cyst (Pelvic Mass)

Sub-fertility

Termination of Pregnancy (TOP)

Vaginal Pessaries

Progestogen-only Pills (POPs)

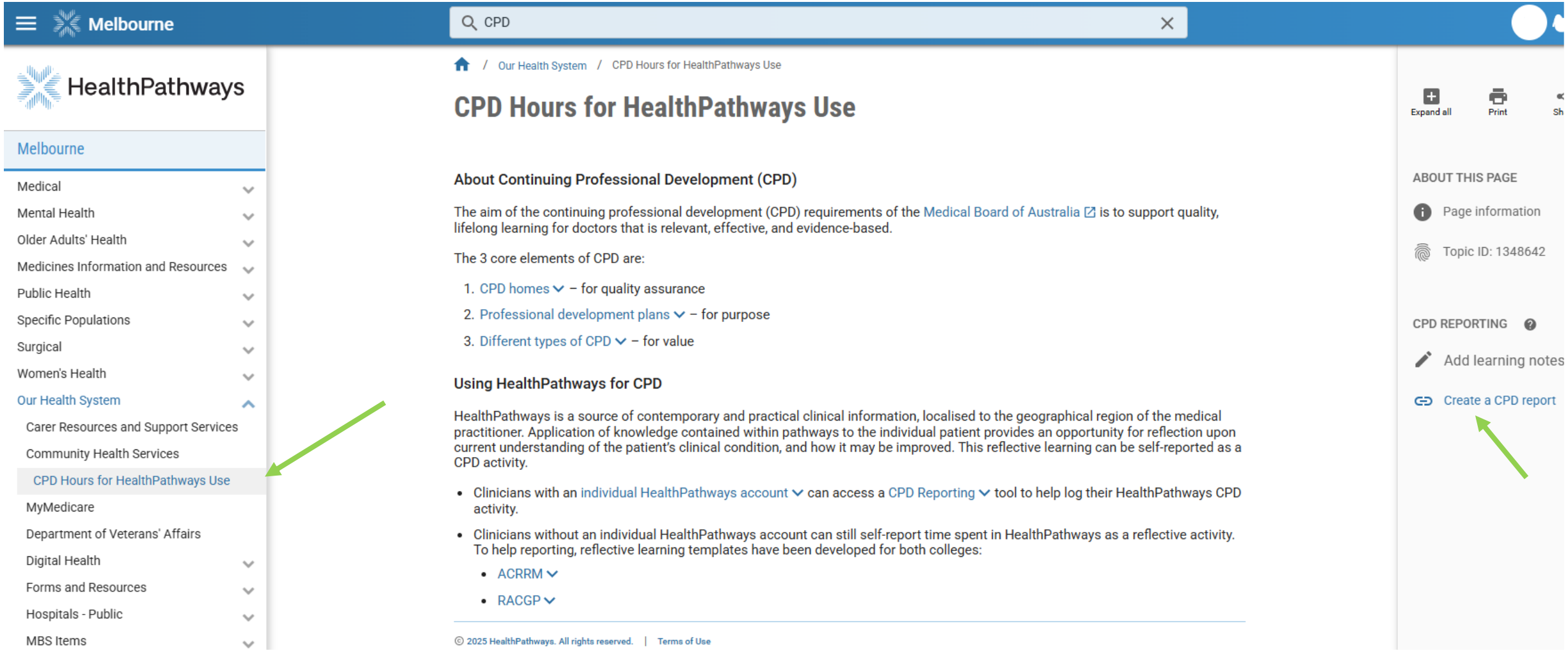
Combined Hormonal Contraceptives (CHCs)

Termination of Pregnancy Follow-up

Medical Termination of Pregnancy (MTOP) in General Practice

CPD hours for HealthPathways use

HealthPathways – CPD Hours for HealthPathways Use



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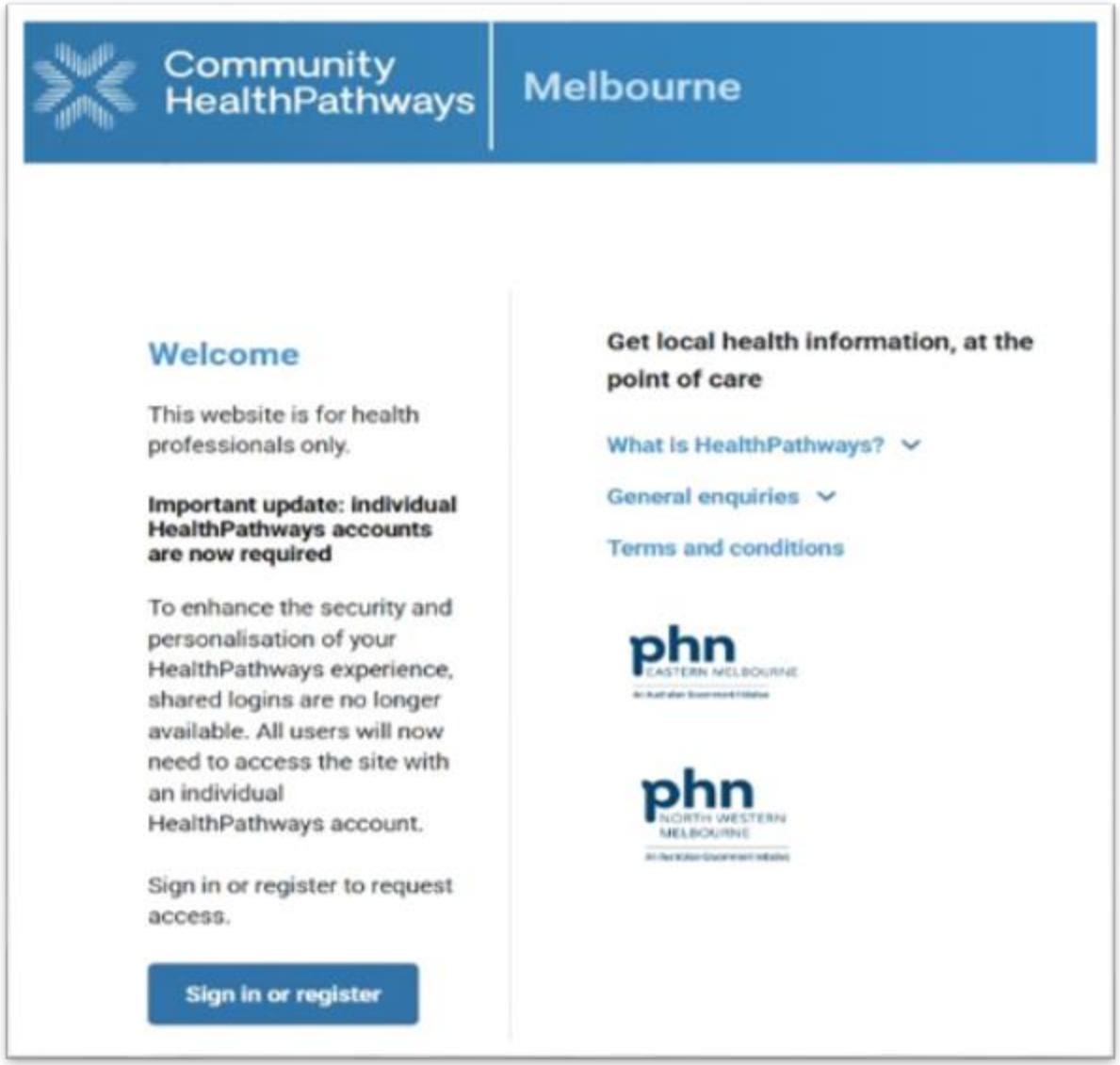
If you have any questions, please email the team info@healthpathwaysmelbourne.org.au



Speakers

Dr. Samina Ahmed

MBBS, FCPS, FRANZCOG, Masters in Rep Med

Western Health

Samina Ahmed has specialty appointments as a specialist obstetrician and gynaecologist at the Joan Kirner Women's and Children's Hospital, Northpark Private Hospital and St Vincent's Private Hospital.

She also held a fertility sub-specialist appointment at the Joan Kirner Women's and Children's Hospital. In this role, she assisted couples to produce offspring through assisted reproductive techniques (ART/IVF). As an active member of Fertility Society of Australia and New Zealand, Australasian Gynaecological Endoscopy and Surgery Society, and the Australian Society For Colposcopy And Cervical Pathology, she actively engages in ongoing activities to provide evidence-based advanced care to her patients.

In addition, Samina holds senior academic appointments at Deakin University and the University of Melbourne. She is also a training supervisor at Royal College of Obstetricians and Gynaecologist.

Ranjana Rahman

Women's Health Physiotherapist | Western Specialist Centre, Werribee, Victoria

Ranjana Rahman is a passionate Women's Health Physiotherapist at Western Specialist Centre in Werribee, Victoria.

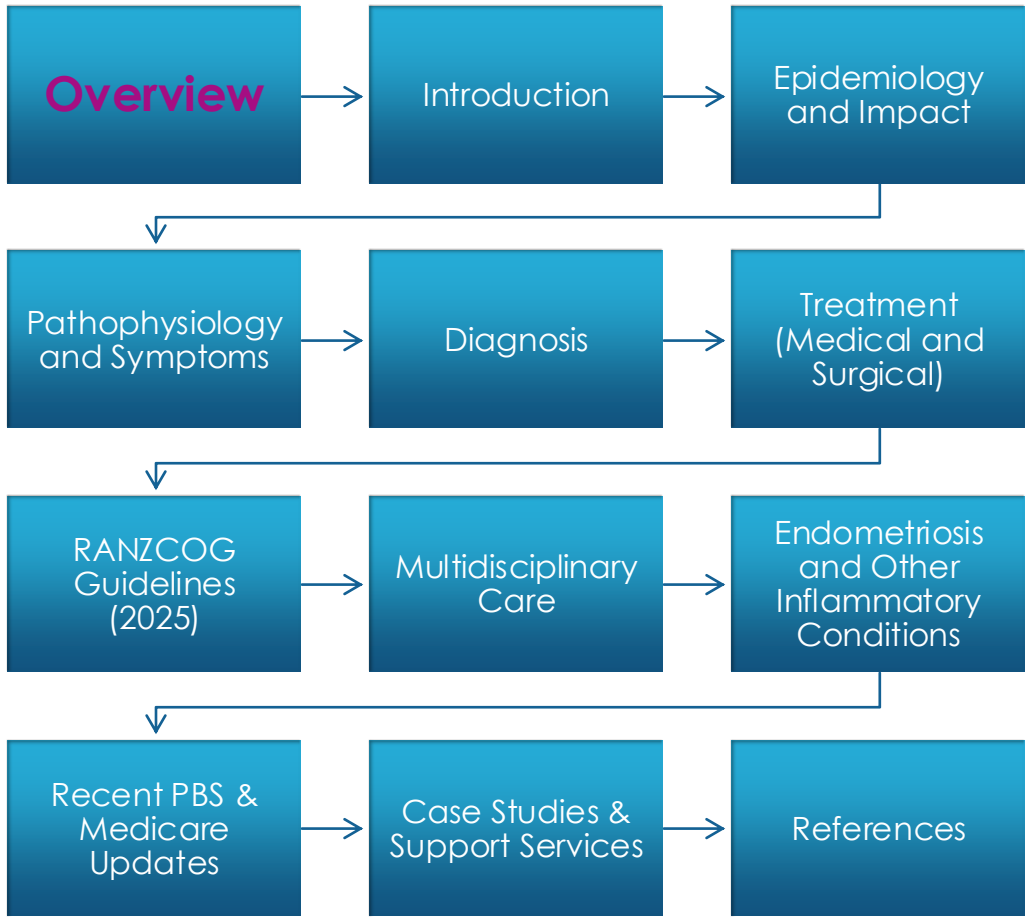
With expertise in pelvic floor therapy, birth trauma recovery, and managing conditions like endometriosis, PCOS, and bowel health, Ranjana is dedicated to empowering women—especially from multicultural and migrant backgrounds—through education and compassionate care.

Her community outreach includes workshops and speaking engagements with organizations such as the Australian Multicultural Women's Association and the Australian Islamic Medical Association.

Ranjana's mission is to break down health stigmas and improve access to women's health services for all.

TITLE: ENDOMETRIOSIS: THE HIDDEN PAIN
SUBTITLE: UNVEILING THE CHALLENGES AND ADVANCEMENTS IN MANAGEMENT

Presenter: Dr Samina Ahmed, Gynaecologist and Fertility Doctor
Qualifications: MBBS, FCPS, FRANZCOG, Masters in Reproductive Medicine


Overview
Introduction
Epidemiology and Impact
Pathophysiology and Symptoms
Diagnosis
Treatment (Medical and Surgical)
RANZCOG Guidelines (2025)
Multidisciplinary Care
Endometriosis and Other Inflammatory Conditions
Recent PBS & Medicare Updates
Case Studies & Support Services
References

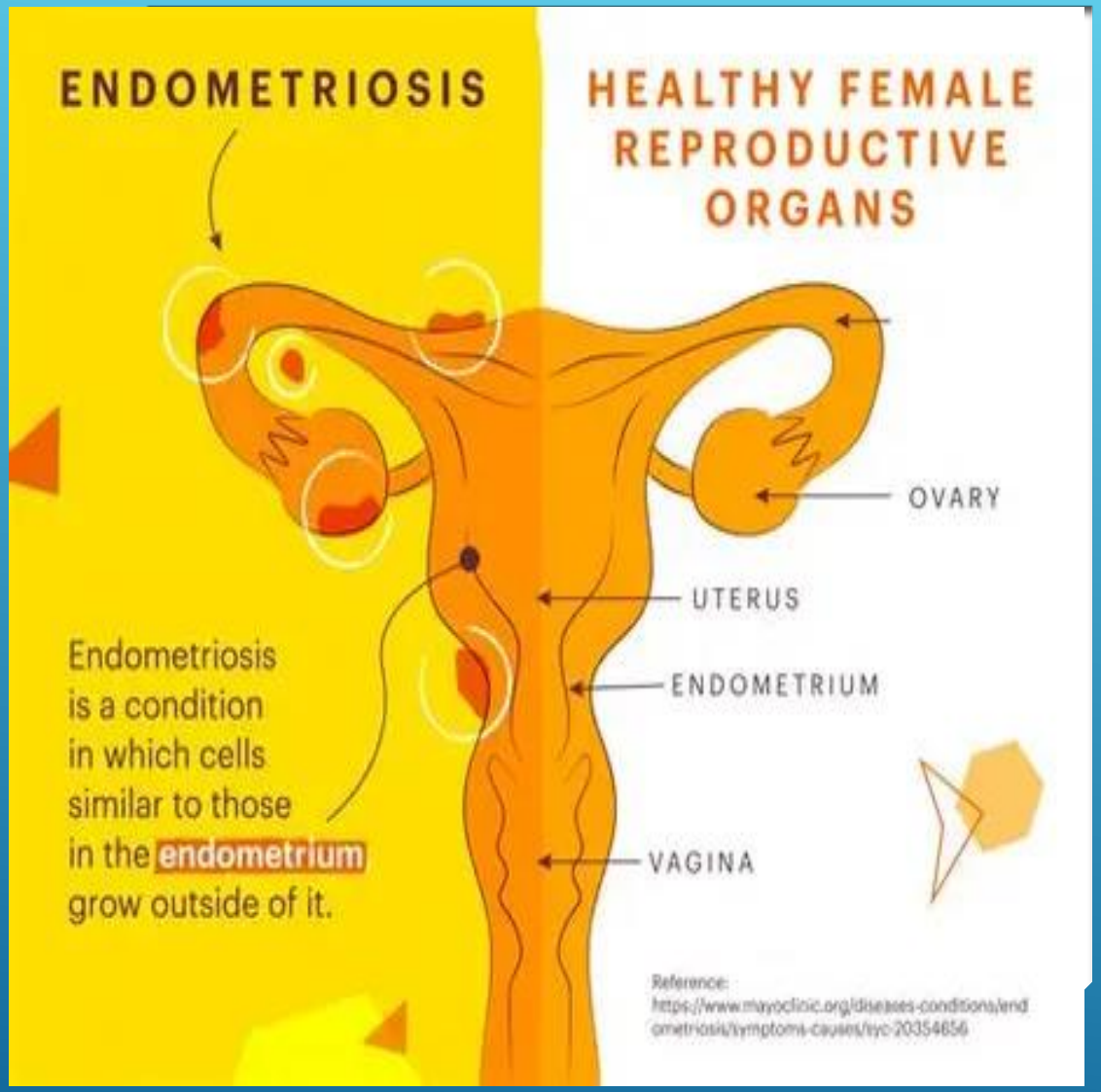
Endometriosis is a chronic inflammatory condition where tissue similar to the endometrium grows outside the uterus, leading to pain, infertility, and other complications. It affects approximately 1 in 9 individuals assigned female at birth in Australia before menopause.

RANZCOG 2025; Endometriosis Australia.

Epidemiology and Societal Impact

- Prevalence: ~10% of reproductive-age women
- Economic burden: >$9.7 billion annually in Australia (includes healthcare, loss of productivity)
- Average diagnosis delay: 6–8 years

Endometriosis Australia 2024; Zondervan et al., Lancet 2020

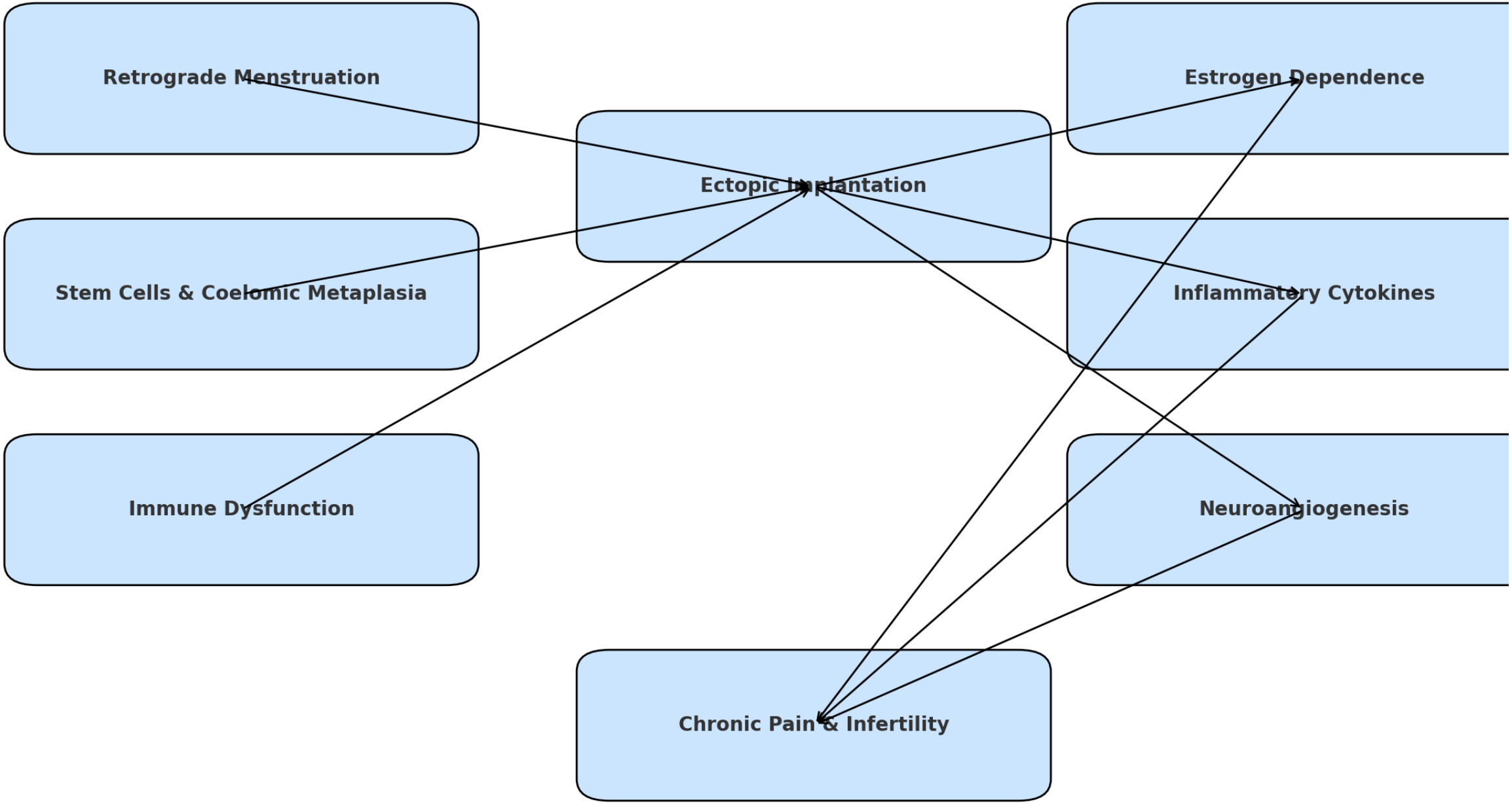


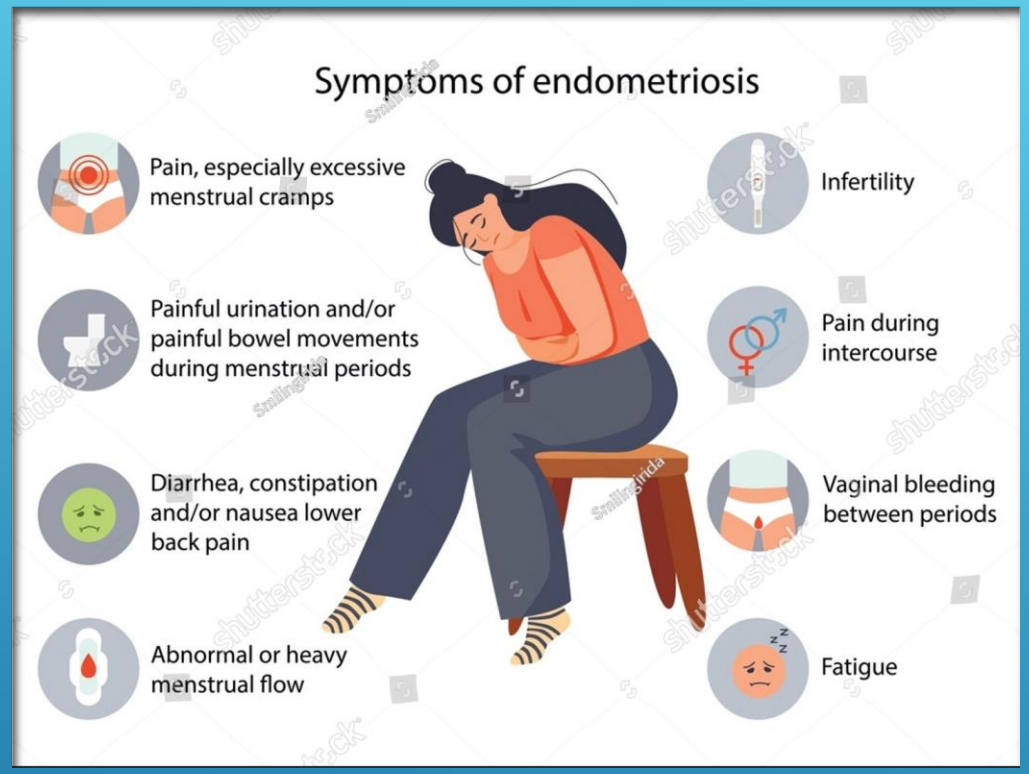
Pathophysiology of Endometriosis

Theories:

Retrograde menstruation, coelomic metaplasia, immune dysfunction

Chronic inflammation, estrogen dependence, and neuroangiogenesis involved

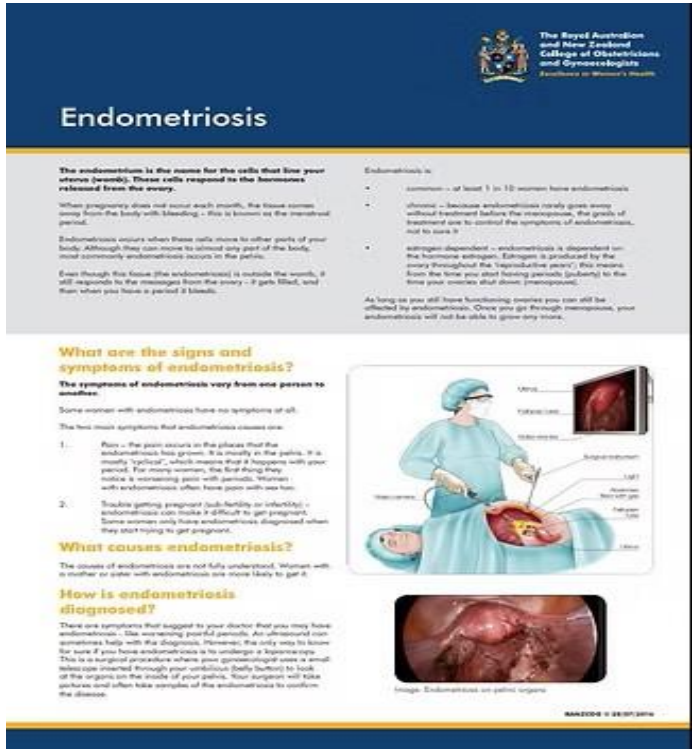

Retrograde Menstruation
Stem Cells & Coelomic Metaplasia
Immune Dysfunction
Ectopic Implantation
Estrogen Dependence
Inflammatory Cytokines
Neuroangiogenesis
Chronic Pain & Infertility



Symptoms of Endometriosis

- Dysmenorrhea
- Chronic pelvic pain
- Dyspareunia
- Infertility
- Bowel/bladder symptoms

NICE 2023 & JEAN HAILES FOUNDATION



Diagnosis of Endometriosis

The Visual flowchart walks through the diagnostic process:

- **Symptom presentation**
- **Clinical history/symptom scoring**
- **Imaging (TVUS/MRI)**
- **Assessment of findings**
- **Laparoscopy if necessary**

RANZCOG 2025 & ESHRE 2022

Early Intervention

Reduces risk of progression

Improves quality of life

Minimises impact on fertility

Visual: Timeline of early vs delayed intervention

RANZCOG 2025

Stage I, or "minimal" endometriosis:

- Endometrial implants are few in number
- Minimal or no scar tissue

Stage II:

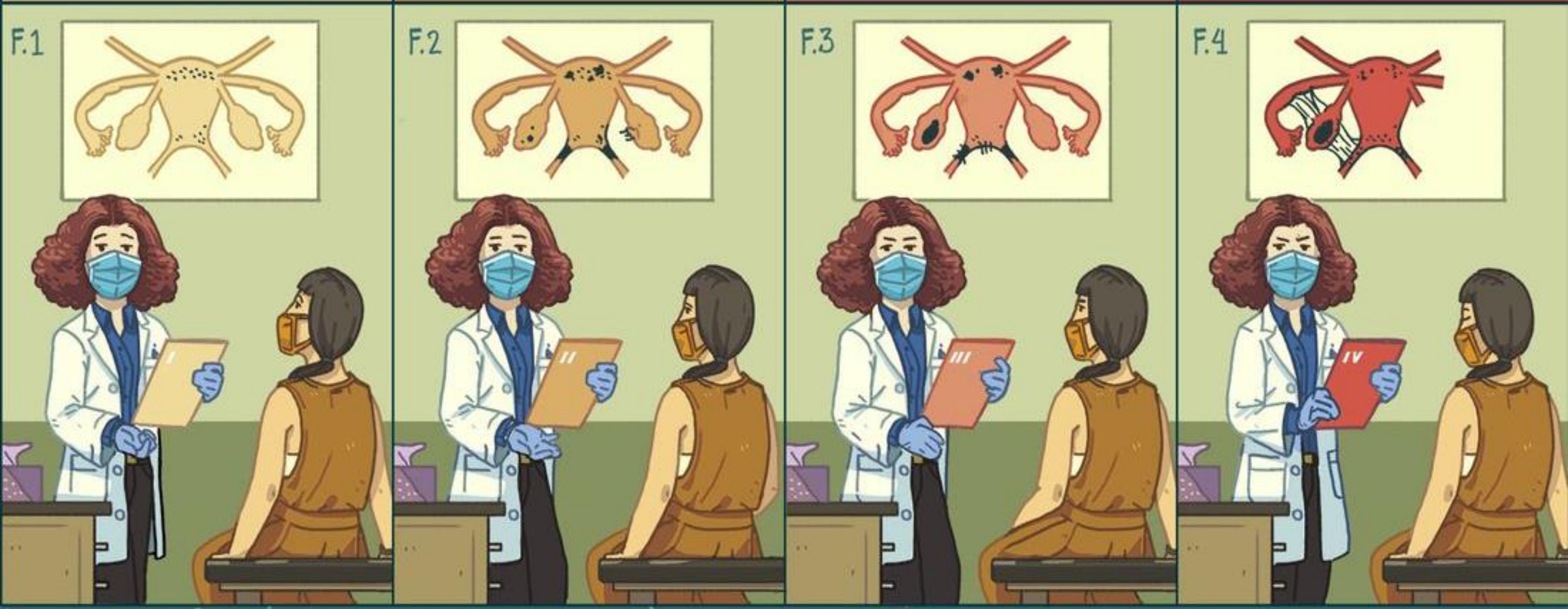
- More and deeper scar tissue
- Scar tissue, but usually no inflammation

Stage III:

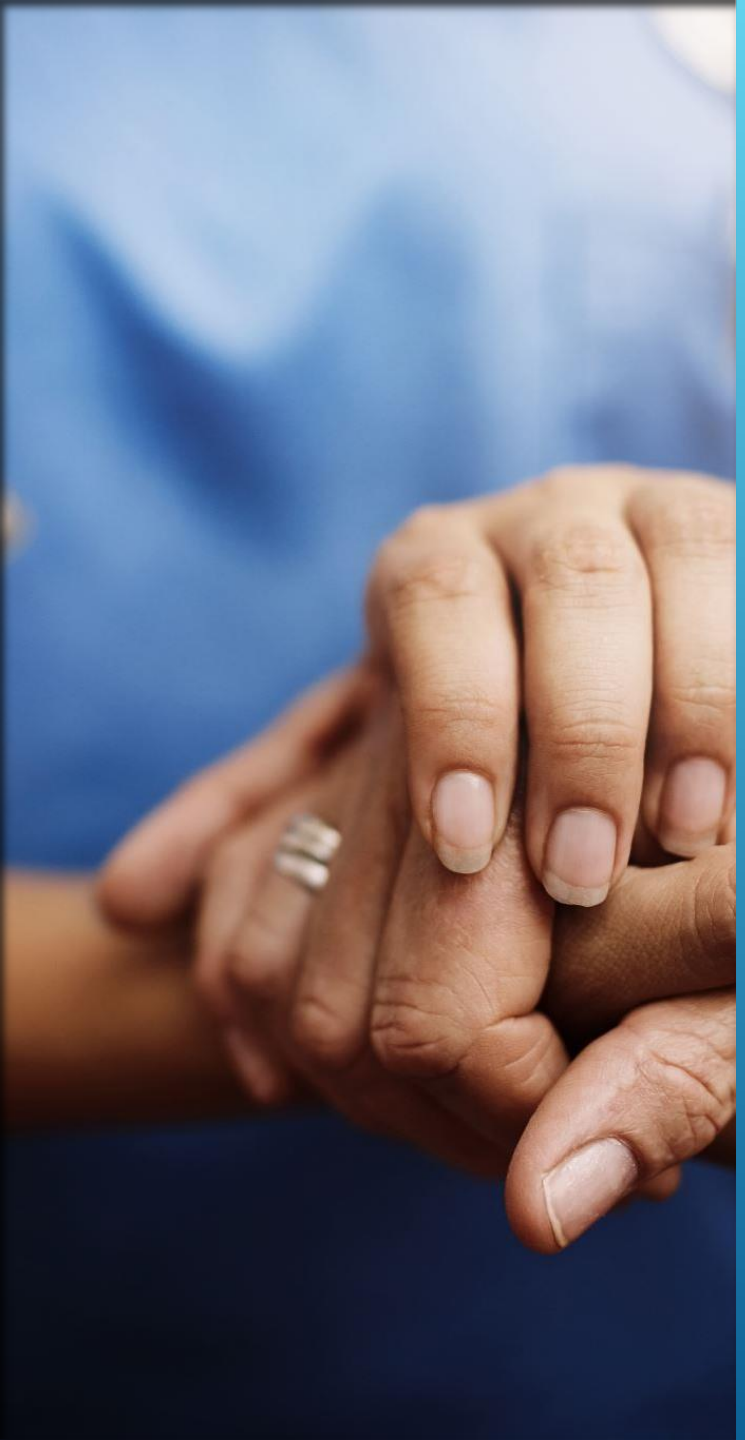
- Many deep endometrial implants and cysts in at least one ovary
- Filmy adhesions may be present

Stage IV:

- The most severe stage
- Many cysts and large adhesions
- May require more than one kind of treatment, and multiple surgeries



RATE	RATE Tool for Assessment
Recognise	Recognise symptoms
Assess	Assess pain & impact
Track over	Track over time
Evaluate	Evaluate treatment needs



Patient-Centred Care

- Shared decision-making
- Respect for values, needs, and preferences
- Education and engagement

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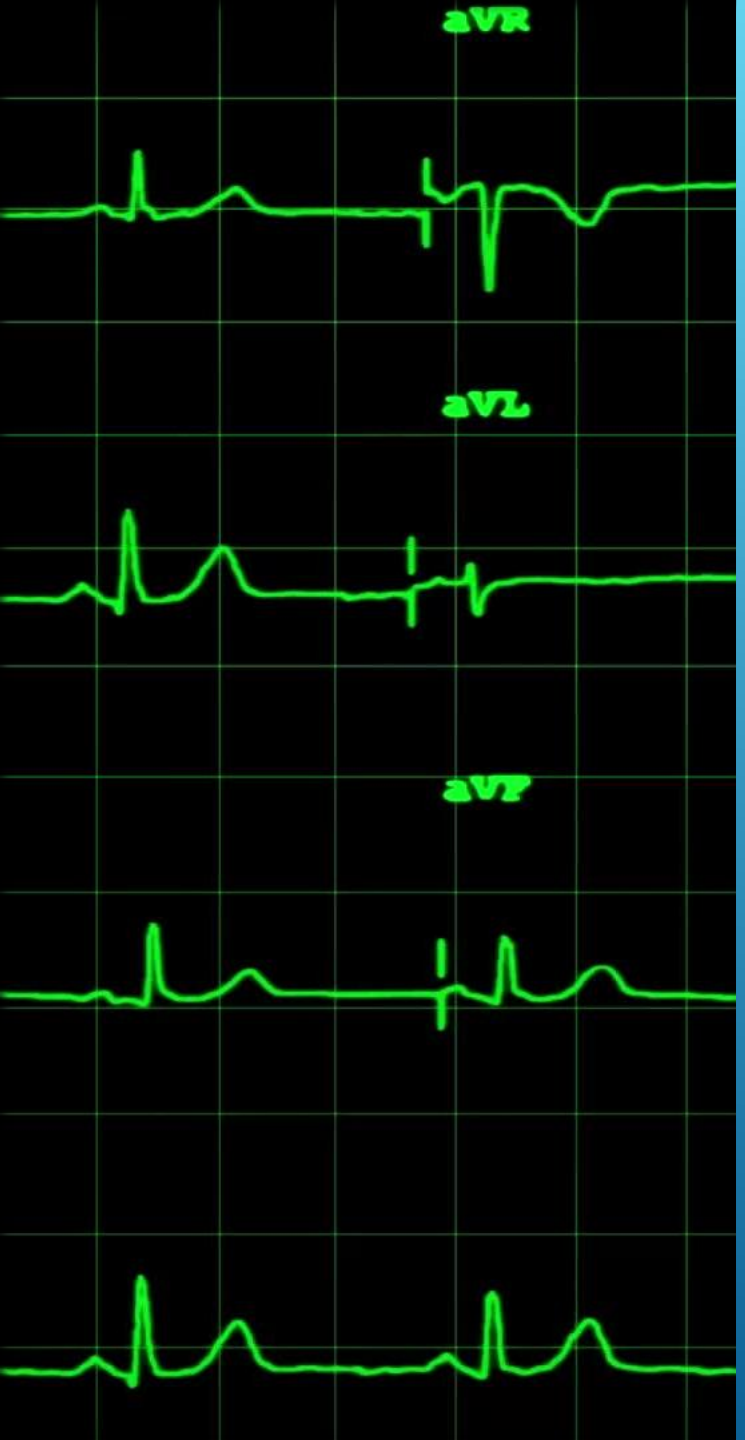


- **Medical Management Options**
- 1st Line: NSAIDs, combined OCPs
- 2nd Line: Progestins (oral, IUD, implant)
- 3rd Line: GnRH analogues, SPRMs
- New agents: Ryeqo, Visanne, Slinda

PBS 2025; ESHRE 2022; NICE 2023

SPRM MEDICATIONS **SELECTIVELY BIND** TO PROGESTERONE RECEPTORS AND ACT AS:

-**AGONISTS** (STIMULATING PROGESTERONE ACTIVITY) IN SOME TISSUES
-**ANTAGONISTS** (BLOCKING PROGESTERONE ACTIVITY) IN OTHERS

This **dual action** gives them therapeutic potential with fewer side effects than full antagonists.

Medication	Primary Use	Relevance to Endometriosis
Ulipristal Acetate	Uterine fibroids (e.g. Esmya®)	Under research for endometriosis; anti-proliferative effects
Mifepristone	Medical abortion; fibroids	Investigational use for endometriosis symptom control
Asoprisnil	Research only	Studied for fibroids and endometriosis
Telapristone Acetate	Experimental	Limited studies in endometrial and gynecologic disorders
Vilaprisan	Research (fibroids)	May have future applications in endometriosis

IN PRACTICE:
RYEQO® (PBS LISTED IN AUSTRALIA) IS A **COMBINATION THERAPY**:
CONTAINS **RELUGOLIX** (A GNRH ANTAGONIST), **ESTRADIOL**, AND **NORETHISTERONE ACETATE**.
WHILE NOT A PURE SPRM, IT PROVIDES **SPRM-LIKE CLINICAL EFFECTS**—MAKING IT A PREFERRED **NEW-GENERATION** OPTION.

Progesterone Therapies

LNG-IUD (Mirena)

Etonogestrel Implant (Implanon)

Slinda (drospirenone-only pill)

Mode of Action: Endometrial suppression

PBS Australia 2025

SPRMs & GnRH Analogues

Visanne (Dienogest): Oral SPRM

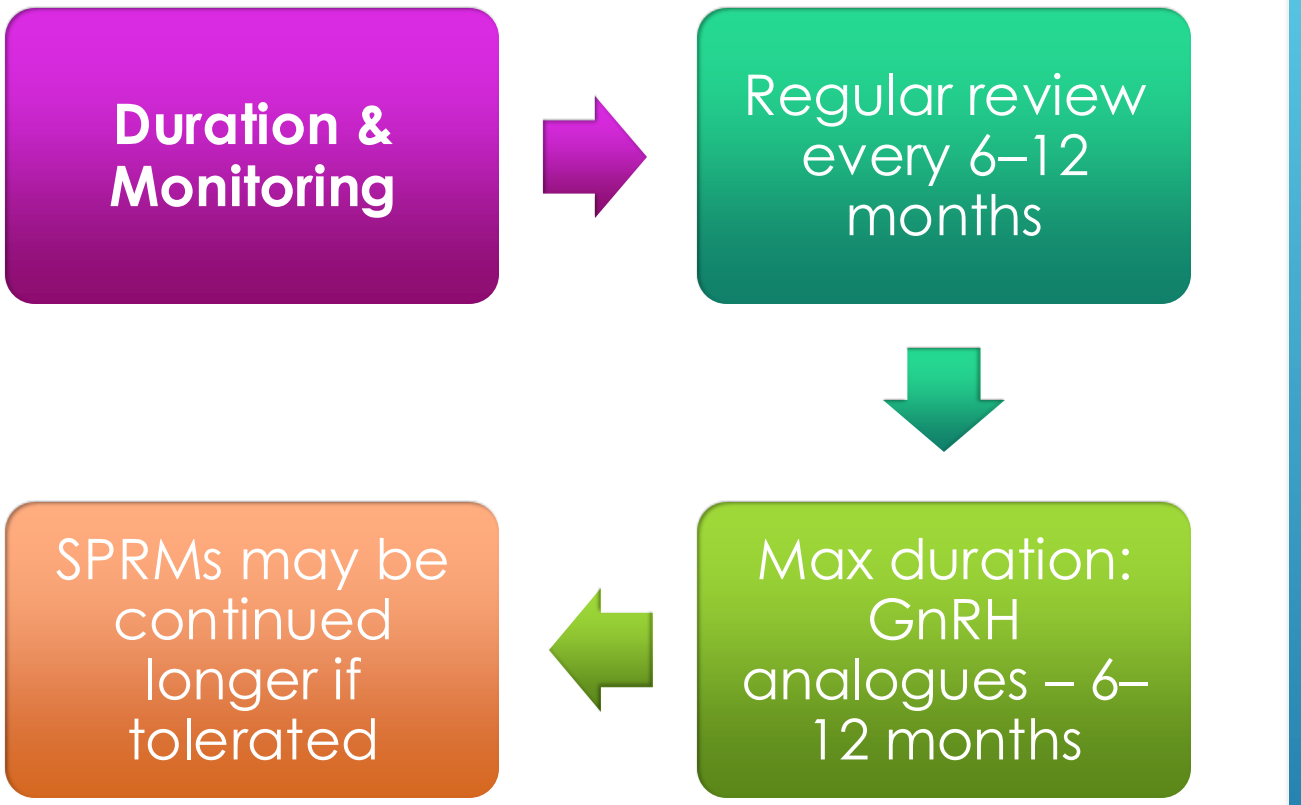
GnRH analogues: Downregulate estrogen production

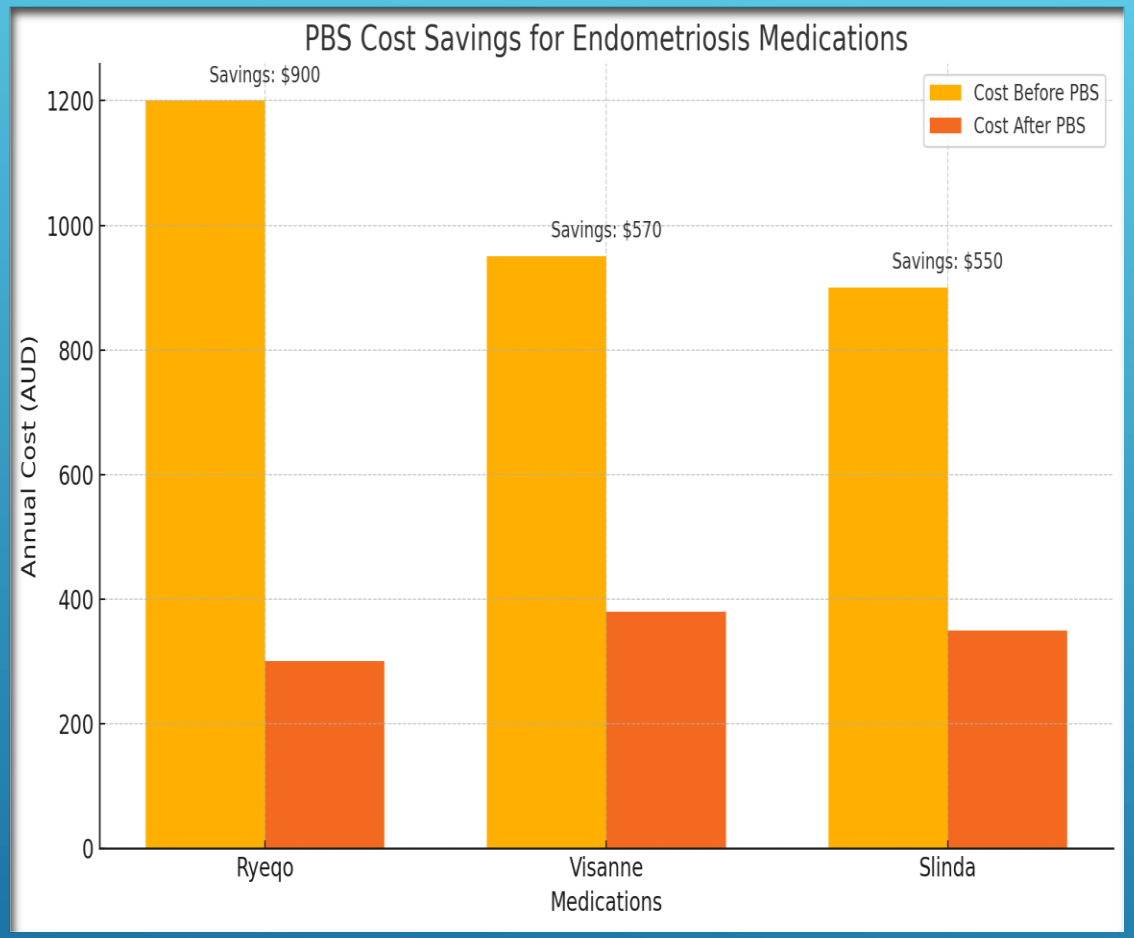
Side effects: Hypoestrogenic symptoms

RANZCOG 2025

COMPARISON OF NEW MEDICATIONS

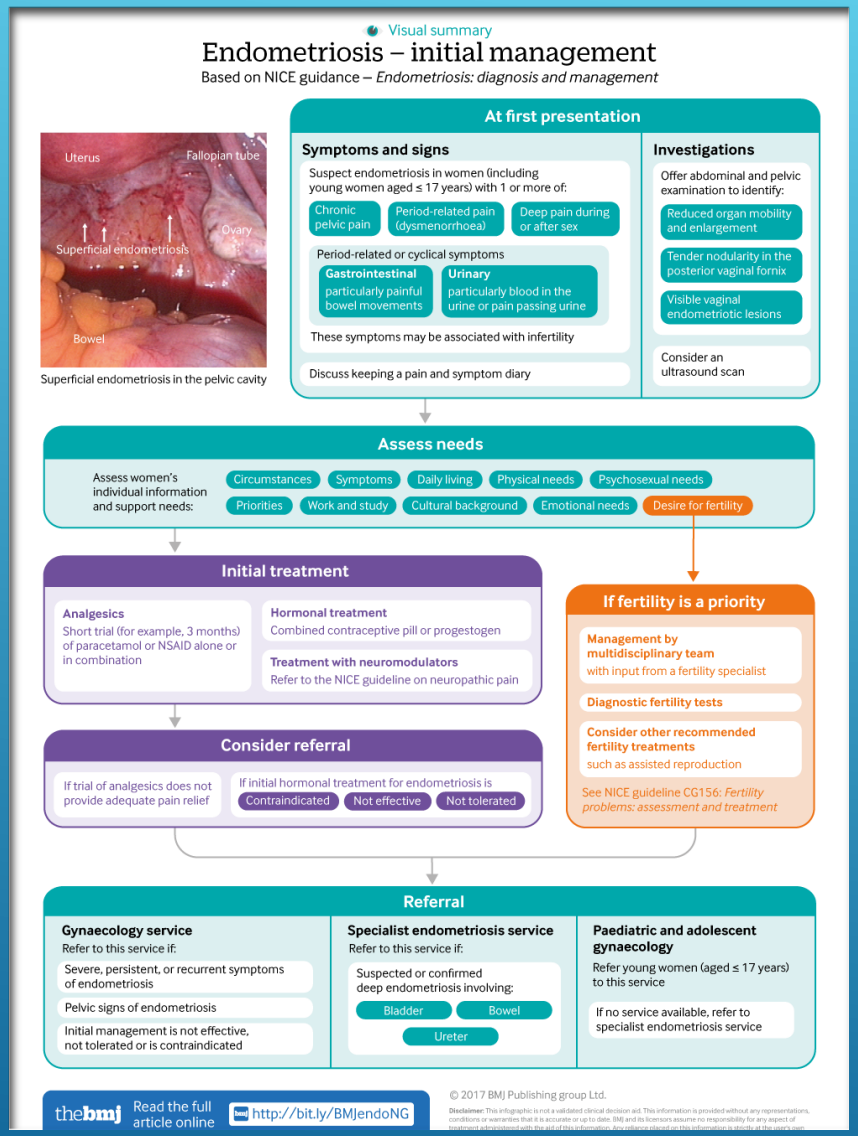
Agent	Type	Cost Saving (PBS)	Effectiveness	Side Effects
Ryeqo	Combo SPRM	High	High	Nausea, headache
Visanne	Progestin	Moderate	High	Mood changes
Slinda	Progestin	Moderate	Moderate	Minimal


Duration & Monitoring
Regular review every 6–12 months
Max duration: GnRH analogues – 6–12 months
SPRMs may be continued longer if tolerated



Recent PBS & Medicare Changes

- PBS listing for Ryeqo, Slinda, Visanne
- MBS items for long consults: 92707 (GP), 92711 (Specialist)
- Cost savings for patients up to $400/year
- *Visual*: Medicare rebate chart
- PBS.gov.au 2025.



Surgical Management

Laparoscopy: Diagnostic & therapeutic

Excision/ablation

Improves pain & fertility

Multidisciplinary surgical care improves outcomes

gynaecologists, colorectal and urological surgeons,

RANZCOG 2025; ESHRE 2022

The **2025 RANZCOG and 2022 ESHRE guidelines** recommend surgery be offered to patients who:

- Have not responded to medical therapy
- Have endometriomas >3cm
- Have bowel/bladder involvement
- Are trying to conceive but face barriers

RECURRENCE AND FOLLOW-UP

UNFORTUNATELY, RECURRENCE OCCURS IN **UP TO 40–50%** WITHIN FIVE YEARS IF HORMONAL SUPPRESSION IS NOT CONTINUED POST-SURGERY. THEREFORE, **SURGICAL TREATMENT SHOULD BE INTEGRATED WITH MEDICAL MANAGEMENT**, ESPECIALLY FOR LONG-TERM SYMPTOM CONTROL.

Role in Fertility Preservation

- Early surgical referral for moderate-severe endo
- ART + Surgery = best outcomes
- ***ESHRE 2022***

RANZCOG™

Excellence in Women's Health

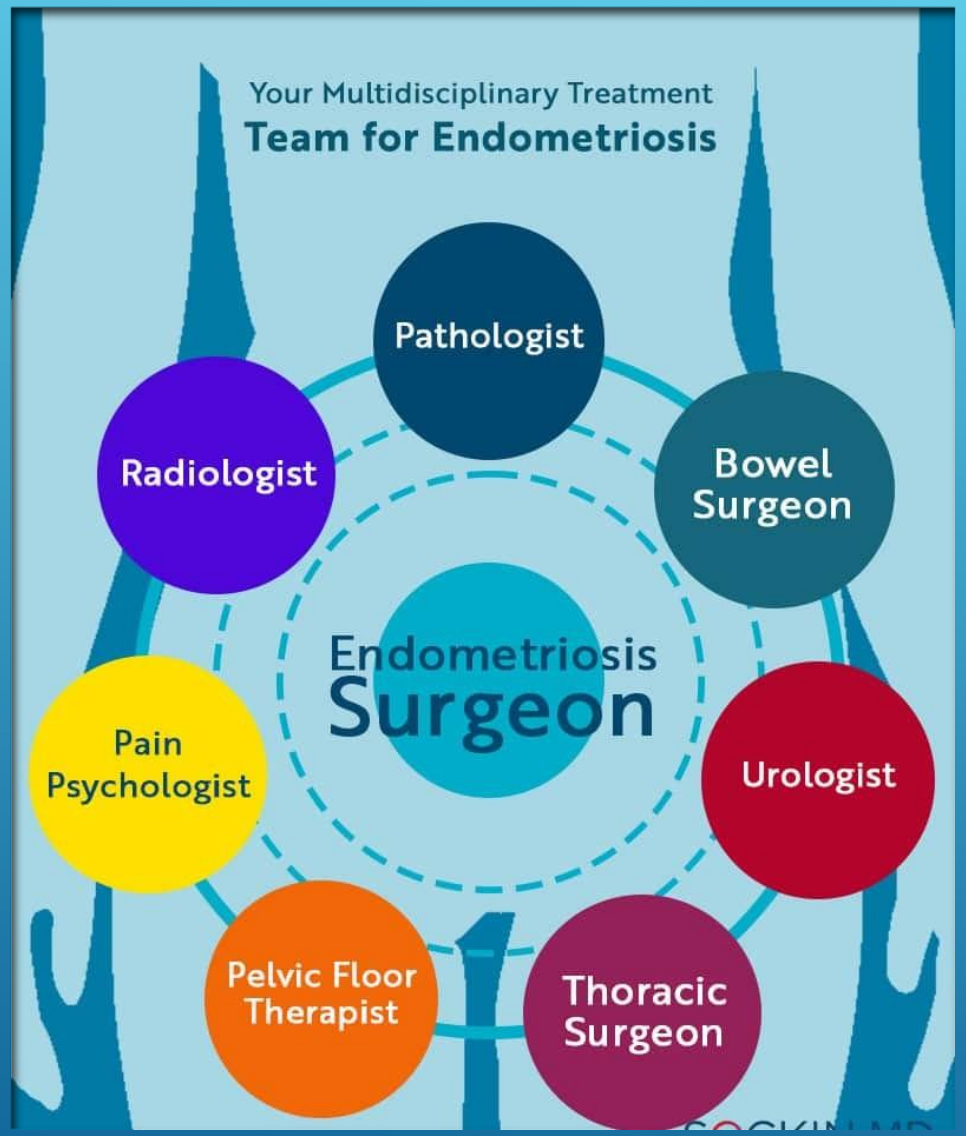
RANZCOG Endometriosis Guidelines (2025)

Non-invasive diagnostics

Earlier medical management

Recognition of extra-pelvic symptoms

Emphasis on holistic, lifelong management



Multidisciplinary Team Approach

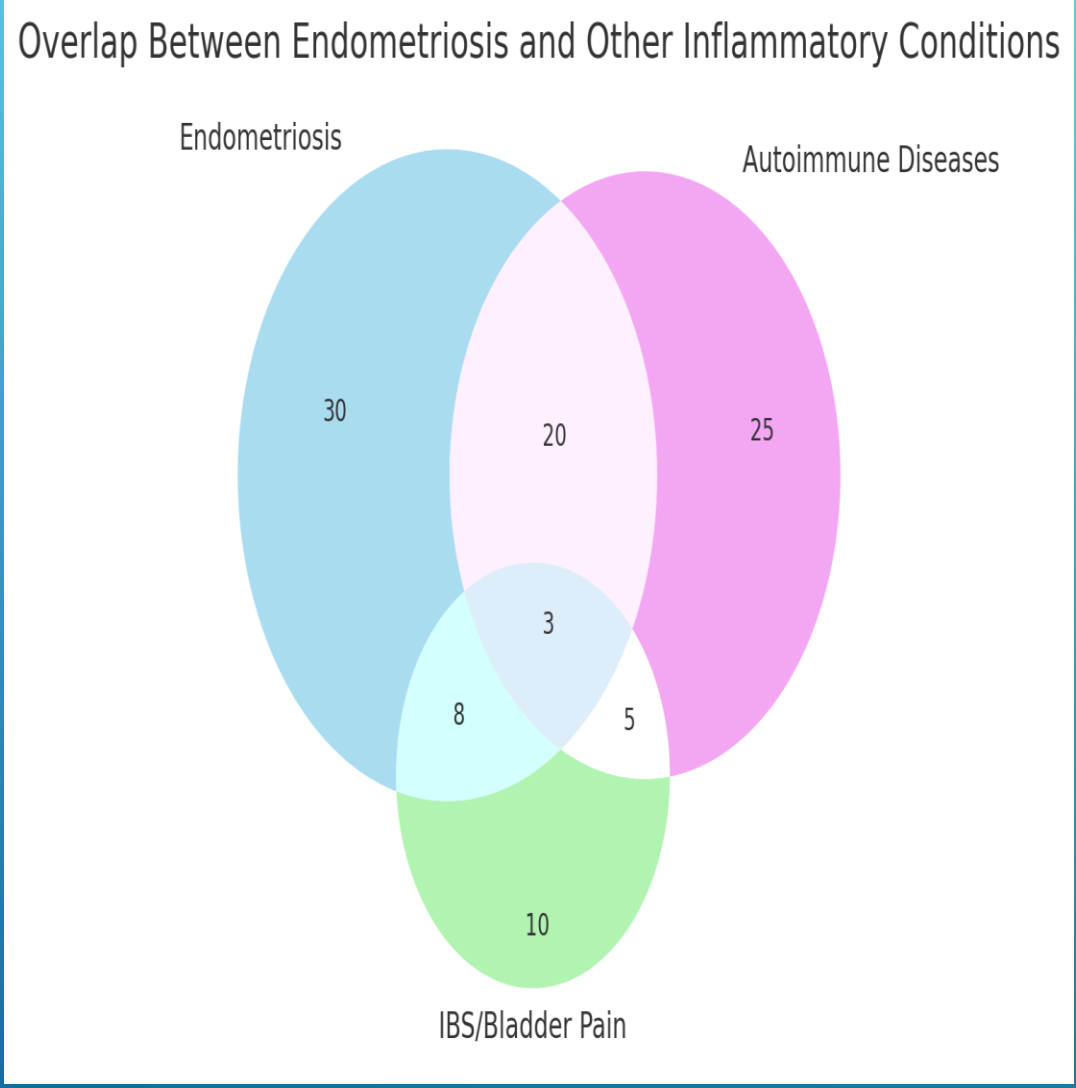
GPs, gynaecologists, fertility specialists, pelvic physios, dietitians, psychologists

Coordinated care enhances QoL and outcomes

Visual: Team diagram

RANZCOG 2025

NICE 2023



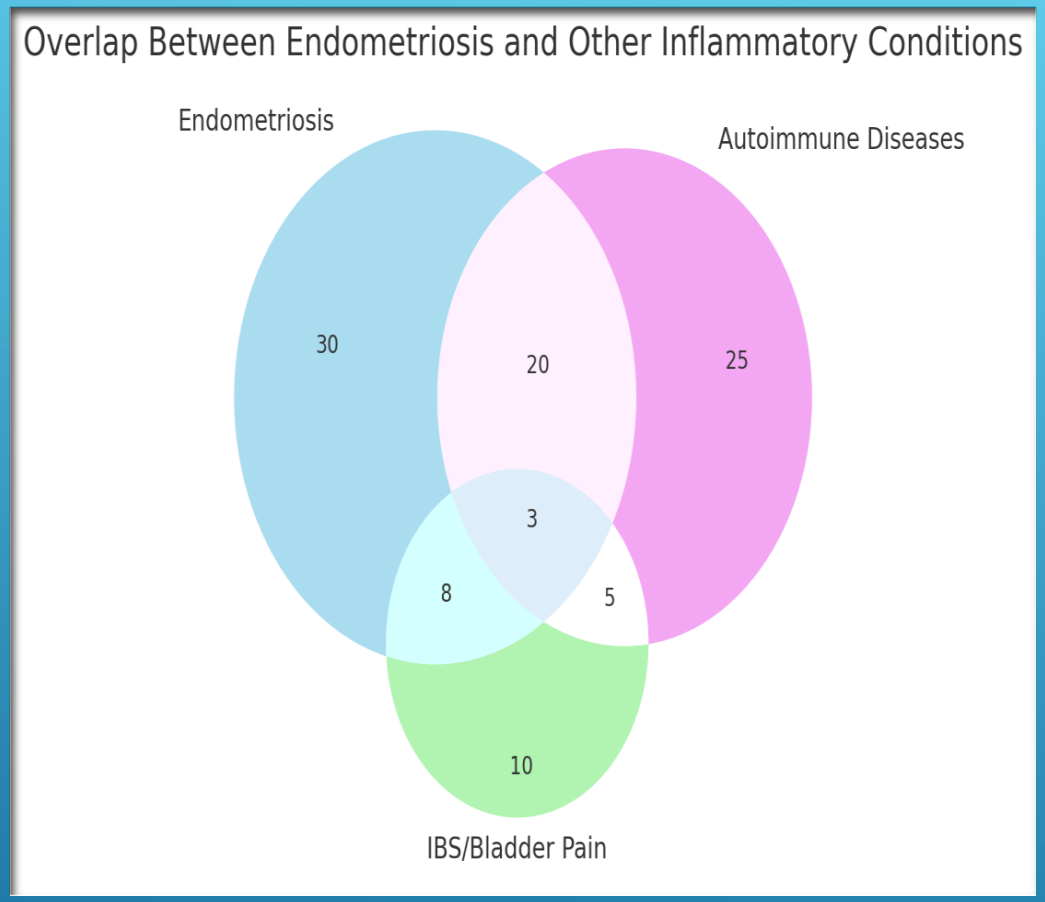
Endometriosis and Inflammatory Conditions

- "Emerging research increasingly supports the idea that **endometriosis is not just a gynaecological condition**, but a **systemic, inflammatory disease** with **broad immunologic and metabolic implications**.

Shared Inflammatory Pathways

Endometriosis shares **chronic inflammatory pathways** with several other conditions:

- Elevated **pro-inflammatory cytokines** (e.g., IL-6, TNF-α)
- Altered **macrophage and T-cell function**
- Increased **oxidative stress and angiogenesis**
- This systemic inflammation helps explain why many patients report **widespread pain and fatigue**, not just pelvic symptoms.



Associated Conditions
Studies have identified significantly higher rates of the following in women with endometriosis:

- **Irritable Bowel Syndrome (IBS)**
- **Interstitial Cystitis / Bladder Pain Syndrome**
- **Autoimmune disorders** such as:
  - Hashimoto's thyroiditis
  - Rheumatoid arthritis
  - Systemic lupus erythematosus
- **Chronic Fatigue Syndrome**
- **Fibromyalgia**

Clinical Relevance

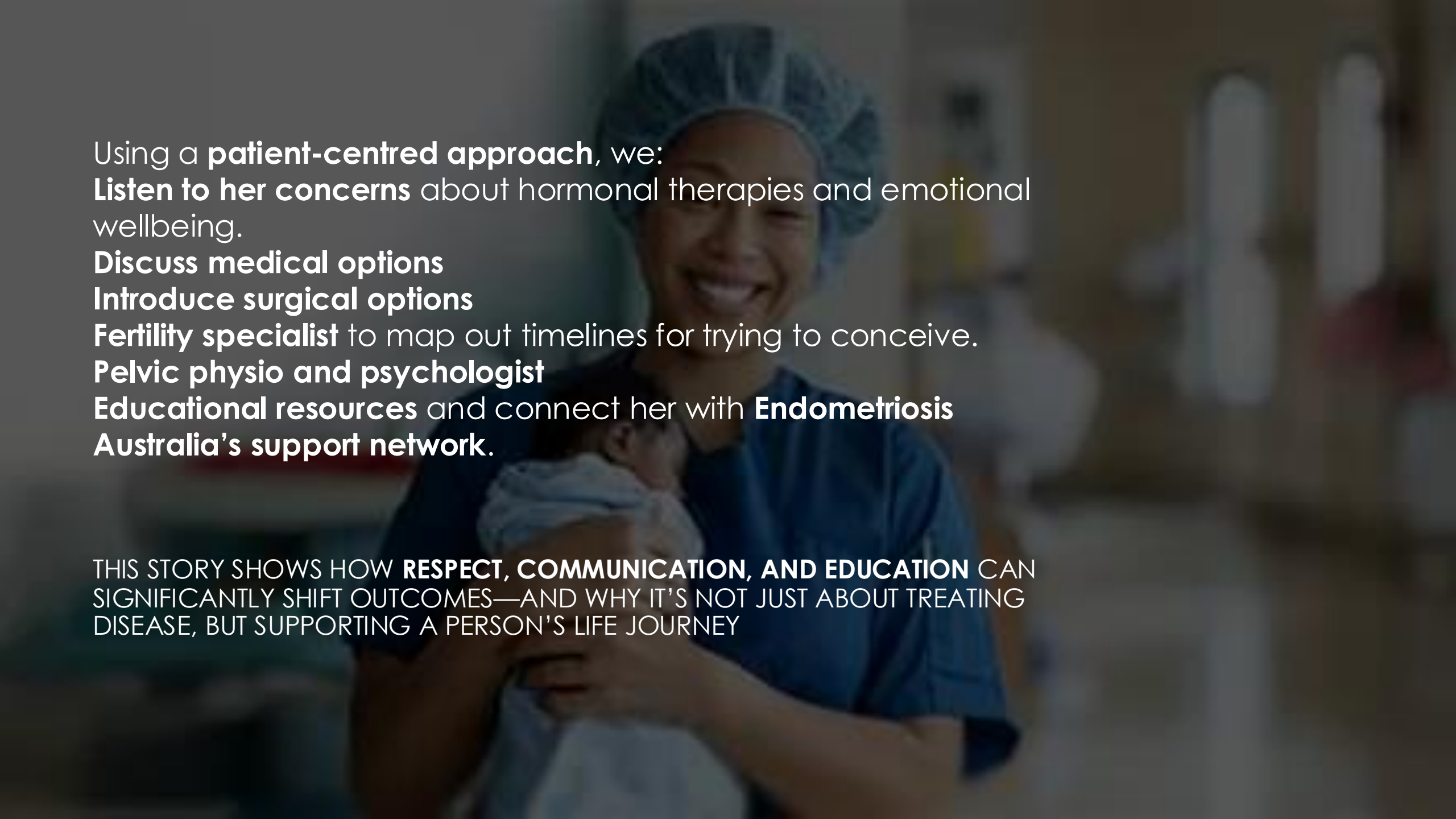
The overlap of these conditions can:

- Delay diagnosis (due to misattribution of symptoms)
- Complicate treatment (e.g., standard endo therapies may not help IBS-related pain)
- Increase mental health burden (anxiety, depression)
- That's why a **multidisciplinary care team**—including gastroenterologists, immunologists, pain specialists, and psychologists—is crucial.

2020 *LANCET* REVIEW BY ZONDERVAN ET AL

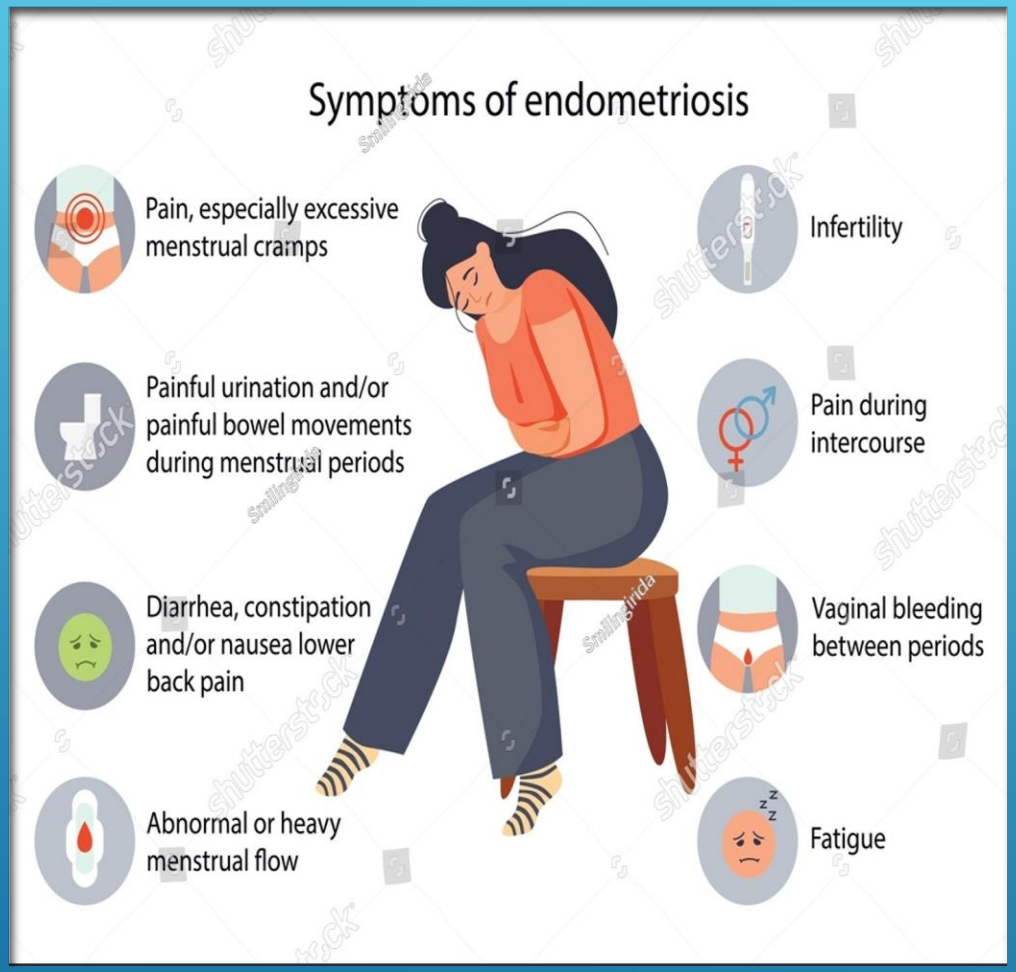
Real-Life Example – Patient-Centred Care

- "Let's consider a **28-year-old woman**, Sarah, who presents with severe dysmenorrhea, chronic pelvic pain, and difficulty conceiving. She's seen multiple GPs over the years and was initially prescribed the oral contraceptive pill. However, she discontinued it due to mood-related side effects.
- After being referred to a specialist, Sarah is diagnosed with **stage 3 endometriosis** via laparoscopy. She expresses concern about starting another hormonal treatment due to her past experience but also feels anxious about her fertility window narrowing.



Using a **patient-centred approach**, we:
Listen to her concerns about hormonal therapies and emotional wellbeing.
Discuss medical options
Introduce surgical options
Fertility specialist to map out timelines for trying to conceive.
Pelvic physio and psychologist
Educational resources and connect her with **Endometriosis Australia's support network**.

THIS STORY SHOWS HOW **RESPECT, COMMUNICATION, AND EDUCATION** CAN SIGNIFICANTLY SHIFT OUTCOMES—AND WHY IT'S NOT JUST ABOUT TREATING DISEASE, BUT SUPPORTING A PERSON'S LIFE JOURNEY



Case Study – Complex Pelvic Pain

32 y/o with 8 years of symptoms

Multiple GP visits, misdiagnosed as IBS

Finally diagnosed via laparoscopy

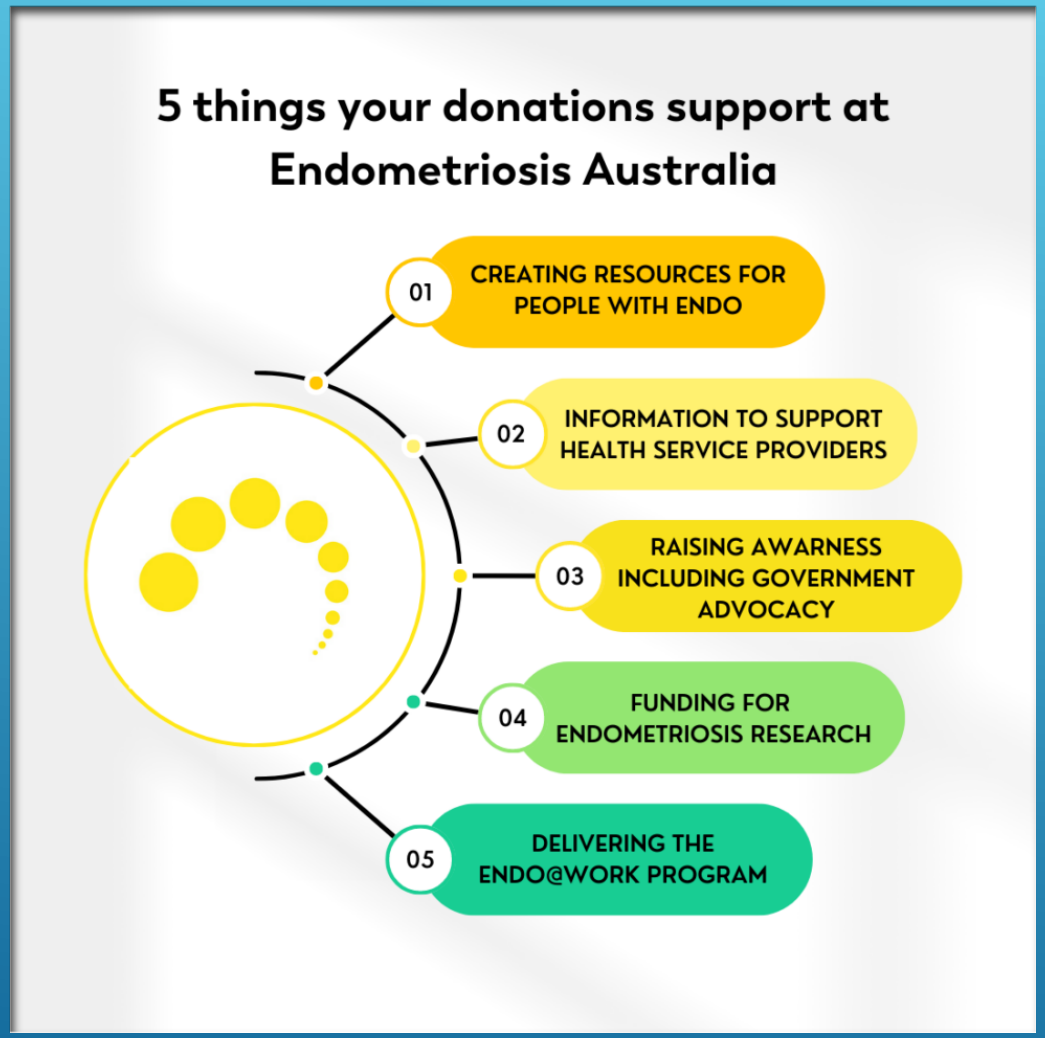
Managed with Visanne + physio + diet changes

Case Study – Fertility Journey

28 y/o with stage 3 endometriosis

Underwent excision surgery

Conceived via IVF 12 months later



Support Services in Australia

Endometriosis Australia: education & advocacy

Jean Hailes Foundation: clinical resources

Pelvic Pain Foundation: RATE tool, support

EndoActive, QENDO, local hospital endo centres

Visual: Support service logos and contact lines

Conclusion:

Endometriosis remains one of the most underdiagnosed and misunderstood chronic conditions affecting reproductive-age individuals.

Clinicians must prioritise early intervention, advocate for patient-centred and multidisciplinary care, and remain informed on the latest evidence and resources available.

Continued education and collaboration are critical in reshaping the endometriosis care landscape.

Chronic, often misdiagnosed condition with high burden

New guidelines + PBS/MBS changes = better access

Importance of early diagnosis and holistic care

While the burden is immense, evolving guidelines and healthcare reforms offer hope for earlier diagnosis, improved access to treatment, and a better quality of life.

Role of education, collaboration, and advocacy

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WOMEN'S Pelvic HEALTH

The Role of Physiotherapy in the Management of Women's Pelvic Health – Pelvic Pain

Introduction

- Pelvic pain, particularly chronic pelvic pain (CPP), is a significant health issue that affects approximately one in five women in Australia. It is defined as pain that lasts for six months or more, occurring on most days.

- This presentation will explore the nature of pelvic pain, its causes, and how physiotherapy plays a pivotal role in managing, treating, and supporting women experiencing persistent pelvic pain.

What is Pelvic Pain?

Definition: Persistent pelvic pain (also referred to as chronic pelvic pain) is discomfort or pain in the pelvic region that persists for at least six months.

Prevalence: Around 20% of women in Australia will experience chronic pelvic pain in their lifetime.

Common Causes:

- **Digestive Issues:** Irritable bowel syndrome, constipation, and inflammatory bowel disease.
- **Reproductive System Conditions:** Endometriosis, pelvic inflammatory disease, and ovarian cysts.
- **Urinary System Issues:** Interstitial cystitis and bladder pain syndrome.
- **Musculoskeletal Causes**: Pelvic floor dysfunction, strained muscles, and myofascial pelvic pain.

Nerve-related Pain: Irritation or damage to the pelvic nerves.

Understanding & Pelvic Pain Impact

Physical and Emotional Effects:

- Pain Interference: Pelvic pain can disrupt daily life, causing difficulty with mobility, work, and social activities.
- Mental Health Impact: Persistent pelvic pain often leads to depression, anxiety, and low quality of life.
- Relationship Strain: Sexual pain can affect intimate relationships.

Multifactorial Nature: Pelvic pain can arise from various interconnected systems and requires a comprehensive approach to treatment.

The Role of Physiotherapy in Pelvic Pain Management

Physiotherapy Overview:

- Physiotherapy is essential for managing pelvic pain by addressing musculoskeletal dysfunction, improving mobility, reducing pain, and enhancing quality of life.

- The primary goals of physiotherapy include:
  - Reducing pain and inflammation.
  - Improving pelvic floor function.
  - Enhancing strength, flexibility, and coordination.
  - Managing stress and providing coping strategies.

Pelvic Floor Muscle Training (PFMT)

PFMT in Pelvic Pain: Pelvic floor muscle (PFM) dysfunction is a key contributor to chronic pelvic pain.

- **Muscle Dysfunction:** Tightness, weakness, or poor coordination of the pelvic floor muscles can exacerbate pain.
- **PFM Disorder and Chronic Pelvic Pain (CPP):** Dysfunctional pelvic floor muscles can lead to myofascial pelvic pain, urinary issues, and sexual pain.

Physiotherapy Approach:

- **Down Training Coordination:** Involves relaxing and releasing tight pelvic muscles (Anderson, 2019)
- **Strengthening and Relaxation Techniques:** Targeting the pelvic floor muscles to improve coordination and reduce - (Mardon, 2022).

Myofascial Pelvic Pain (MFPP)

What is MFPP?

- MFPP is a significant component of chronic pelvic pain, characterized by myofascial trigger points within the pelvic floor musculature.
- These trigger points can refer pain to surrounding areas such as the lower abdomen, lower back, and hips.

- **Physiotherapy Treatment for MFPP:**
  - **Myofascial Trigger Point Release:** A hands-on technique to release tightness and pain within the pelvic muscles.
  - **Biofeedback:** Helps patients become aware of muscle tension and guides them to relax the pelvic floor muscles.
  - **Electrical Stimulation:** Used to reduce muscle tightness and improve function (Pastore, 2012).

Exercise and Movement in Pelvic Pain Management

01 The Importance of Exercise:

- Exercise is widely recognized for its benefits in managing chronic pain conditions.
- **Cardiovascular Exercise and Stretching:** Can reduce pain and improve overall health.

02 Specific Exercises for Pelvic Pain:

- **Yoga and Pilates:** Gentle exercises like yoga have been shown to help alleviate pain, particularly in conditions like endometriosis (Goncalves, 2017).
- **Pelvic Floor Exercises:** These exercises help strengthen and relax pelvic floor muscles, which can reduce symptoms of pelvic pain.

Stress Reduction and Mindfulness

Mental Health and Pelvic Pain: Stress and anxiety can exacerbate pelvic pain, so managing mental wellbeing is crucial in treatment.

Physiotherapy Techniques:

- **Mindfulness and Breathing Exercises:** Techniques such as deep breathing and meditation help manage stress and reduce pain (Williams, 2020).
- **Coping Strategies:** Learning how to cope with flare-ups of pain and manage symptoms day-to-day is key for long-term success.
- **Sleep and Rest:** Ensuring adequate rest and good sleep hygiene is vital for healing and managing persistent pain (Sivertsen, 2015).

Innovative Therapies In Pelvic Pain Management

Transcutaneous Electrical Nerve Stimulation (TENS):

- TENS is an effective therapy for conditions like dysmenorrhea (painful menstruation) and chronic pelvic pain.
- It works by sending electrical impulses to the skin to help block pain signals to the brain.

Physical Activity and Chronic Pain:

- Regular physical activity has been shown to reduce the severity of chronic pelvic pain and improve overall physical function.
- Exercise can reduce the impact of dysmenorrhea and other pelvic-related pain (Geneen et al., 2015).

Flare Management & Pain Relief

Pain Flare-ups: It's common for individuals with chronic pelvic pain to experience flare-ups, where symptoms intensify.

Pain Management Strategies: Heat therapy, gentle stretches, and mindful breathing can help manage flare-ups.

Education on managing pain at home is essential for empowering patients (Locke, 2023)

Multidisciplinary Approach to Pelvic Pain

Collaboration with Other Healthcare Professionals:

- Physiotherapists often work as part of a multidisciplinary team, which may include gynecologists, urologists, psychologists, and pain specialists.

- A collaborative approach ensures comprehensive treatment and improves the quality of care for patients with pelvic pain.

Case Study

CONCLUSION

Key Takeaways:

- Chronic pelvic pain is a common issue with many potential causes, including musculoskeletal, nerve-related, and organ-specific factors.
- Physiotherapy plays a critical role in managing pelvic pain through techniques like pelvic floor muscle training, myofascial release, exercise, and stress management.
- A multidisciplinary approach is essential to providing holistic care and improving patient outcomes.

Final Thoughts:

Physiotherapists are essential in helping women understand their condition, reduce pain, and support them in leading active, fulfilling lives despite persistent pelvic pain

Questions and Discussion

THANK YOU

so much!

Session Conclusion

We value your feedback, let us know your thoughts.

Scan this QR code

You will receive a post session email within a week which will include slides and resources discussed during this session.

Attendance certificate will be received within 4-6 weeks.

RACGP CPD hours will be uploaded within 30 days.

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