Physical therapy in women's health: reeducation in coloproctology

Fisioterapia na saúde da mulher: reeducação coloproctológica

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Physical therapy in women's health is one of the areas of physical therapy that has grown most in the recent years in Brazil and in the world; This advance is due to the association of scientific evidence with professional ethics. Its performance in the field of coloproctology has been increasing and this is due to the effectiveness that physical therapy approaches have demonstrated over time, associated with a better understanding of the physiological mechanisms of continence and defecation.

Furthermore, it is noteworthy that this also results from a clinical diagnosis by physicians and a well-prepared and precise functional kinetic diagnosis by physical therapists. In this sense, it can be said that due to the progress of techniques for exploring the intestinal and anorectal physiology, associated with the recordings of anorectal pressures, rectal compliance study, defecography and electromyography of the pelvic floor muscles (PFMs), a more accurate medical diagnosis and more effective physical therapy treatment became possible.[1]

Reeducation in coloproctological physical therapy comprises a group of procedures that are used to help regain control of the neuromuscular function of the perineal lumbar-pelvic complex and sphincteric muscles, integrating them to the functional activities of daily life. We cannot fail to mention that this re-education must include treatment from a biopsychosocial point of view and be based on the International Classification of Functioning, Disability and Health (ICF). For a better understanding of the goals and effects of therapeutic resources used in the reeducation of the bowel and anorectal complex, we must, in addition to have knowledge of anatomy, anorectal physiology and PFMs, as well as a deep learning of the biophysical and biological properties of the resources used in the therapeutical approaches.[2]

The pelvic floor is composed of a muscle complex that is housed within the pelvic bones and has three main functions; defecation, urination and sexual function. Most dysfunctions consist of anal incontinence, and dyssynergic defecation, which can occur in isolation or associated with structural problems, such as rectal prolapse, rectal mucosa intussusception, solitary rectal ulcer syndrome, rectocele, enterocele, which are promoters of obstructed defecation. As well as other disorders such as descending perineum syndrome and anorectal pains, since they all contribute to evacuation impairment and promote a significant impact on quality of life.[3,4]

Among all procedures used in the treatment of anorectal dysfunctions, it is important to mention behavioral therapy that is described as a group of specific interventions with low cost whose objective is to modify

the relationship between the signs and symptoms presented by the patient and his environment. This can be obtained by means of behavior and/or environment changes in which the individual is found. Emphasizing that biofeedback is considered a behavioral therapy, and presents levels of evidence in anal incontinence (Level II, Grade B) and dyssynergic defecation (Level I, Grade A).[5] The behavioral techniques help the patient to learn ways to control his bladder, bowel, and pelvic floor muscles and sphincters. These techniques are considered safe and do not have side effects.

According to the International Continence Society[6] an assessment of the pelvic floor must include the clinical reasoning required for the diagnostic decision-making, but are not limited only to competency of the assessor, the assessment protocol must be conducted taking into account that this is a sensitive examination
of an intimate body part, and for ethical and legal reasons, appropriate informed consent must be obtained. Furthermore, it should be mentioned the importance of using standardized nomenclature, validated quality of life scales and questionnaires, in order to assess the impact and severity of the dysfunction in the individual's life and also to analyze the improvement with the therapeutic approach adopted.[6]

The literature reports that anal incontinence is a more common condition in women and is mainly due to obstetric injury with damage to the anal sphincter or pudendal nerve. However, other common risk factors include irritable bowel syndrome, and neurological disorders such as diabetes. Therefore, more information is needed about nal incontinence and other anorectal disorders and their treatments, emphasizing that an accurate, detailed assessment based on the best available scientific evidence is essential.[7,8]

Based on the above considerations, it is evident that this is an women's health area, which presents multifactorial and complex problems that require a thorough and multiprofessional approach.

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References

1. Rao SSC, Bharucha AE, Chiarioni G, Felt-Bersma R, Knowles C, Malcolm A, et al. Functional anorectal disorders. Gastroenterology. 2016;S0016-5085(16)00175-X. DOI

2. George SE, Borello-France DF. Perspective on physical therapist management of functional constipation. Phys Ther. 2017;97(4):478-93. DOI

3. Guillaume A, Salem AE, Garcia P, Chander Roland B. Patho-physiology and therapeutic options for fecal incontinence. J Clin Gastroenterol. 2017;51(4):324-30. DOI

4. Rao SSC, Patcharatrakul T. Diagnosis and treatment of dyssynergic defecation. J Neurogastroenterol Motil. 2016; 22(3): 423-35. DOI

5. Rao SSC, Benninga MA, Bharucha AE, Chiarioni G, Di Lorenzo C, Whitehead WE. ANMS-ESNM position paper and consensus guidelines on biofeedback therapy for anorectal disorders. Neurogastroenterol Motil. 2015;27(5):594-609. DOI

6. Frawley H, Shelly B, Morin M, Bernard S, Bø K, Digesu GA, et al. An International Continence Society (ICS) report on the terminology for pelvic floor muscle assessment. Neurourol Urodyn. 2021;40(5):1217-60. DOI

7. Sharma A, Yuan L, Marshall RJ, Merrie AEH, Bissett IP. Systematic review of the prevalence of faecal incontinence. Br J Surg. 2016;103(12):1589-97. DOI

8. Santoro GA, Wieczorek AP, Sultan AH. Pelvic Floor Disorders: Multidisciplinary Textbook. 2 ed. Cham, Switzerland: Springer; 2021. 926 p.