

different in each group is mentioned as a possible confounding factor [311]. In an RCT of 84 patients with PPPS comparing so-called conventional therapy (α -blockers, anti-inflammatory drugs and sitz baths) with biofeedback and pelvic floor muscle relaxation therapy, the authors were able to demonstrate an improvement in both groups after three months, but three months after the end of treatment, the effects only persisted in the biofeedback and pelvic floor muscle relaxation therapy patients [312].

Myofascial trigger point release

Treatment of myofascial trigger points can be done by manual therapy, dry needling and wet needling. The evidence for all the different treatments is weak, with most studies showing no significant difference between these techniques, though most studies were small and heterogeneous with regards to the patients and methods. There is no evidence that manual techniques are more effective than no treatment [313]. Most studies of dry needling have compared with wet needling. Different SRs have come to the conclusion that, although there is an effect of needling on pain, it is neither supported nor refuted that this effect is better than placebo [314].

Physiotherapy in PBPS

Transvaginal manual therapy of the pelvic floor musculature (Thiele massage) in PBPS patients with high-tone dysfunction of the pelvic floor significantly improved several assessment scales [315]. The role of specific levator ani trigger point injections in women with chronic pelvic pain has been studied [316]. Each trigger point was identified by intravaginal palpation and injected with bupivacaine, lidocaine and triamcinolone. Seventytwo percent of women improved with the first trigger point injection, with 33% being completely pain-free. Efficacy and safety of pelvic floor myofascial physical therapy has been compared with global therapeutic massage in women with PBPS; global response assessment (GRA) rate was 59% and 26%, respectively. Pain, urgency and frequency ratings, and symptoms decreased in both groups during follow-up, and did not differ significantly between the groups. This suggests that myofascial physical therapy is beneficial in women with PBPS [317].

Primary Anal Pain Syndrome

An RCT demonstrated that biofeedback treatment was superior to electrogalvanic stimulation and massage of the Levator muscle for treating chronic primary anal pain syndrome [119]. One hundred and fifty-seven patients who had at least weekly rectal pain were investigated, but only patients with tenderness on traction of the pelvic floor showed a significant treatment benefit. In patients with tenderness of the puborectalis muscle (Rome II: "Highly likely Levator Ani Syndrome"), 87% reported adequate relief after one month of biofeedback vs. 45% for electrogalvanic stimulation, and 22% for massage. These results were maintained at twelve months with adequate relief after nine sessions of biofeedback in 58% of the whole group (Rome II: "Highly likely" and "Possible Levator Ani Syndrome"), after galvanic stimulation in 27% and massage in 21% of patients. As previously described in dyssynergic defecation, the ability to expel a 50 mL water filled balloon and to relax pelvic floor muscles after biofeedback treatment were predictive of a favourable therapeutic outcome [119]. The pathophysiology of the chronic primary anal pain syndrome is therefore similar to that of dyssynergic defecation, and this favours the role of the pelvic floor muscles in the pathophysiology of both conditions. Other treatment modalities have been less successful.

Treatment of sexual dysfunctions and chronic pelvic pain

Couples often benefit from early referral for relationship and sexual counselling during their treatment course [318]. It needs to be remembered that sexual difficulties will arise as a result of pelvic pain syndromes as well as those disorders potentially being primary. Specific behavioural strategies for women who have urogenital complaints and female sexual dysfunction often include exploring alternatives to sexual intercourse (manual or oral pleasuring), different coital positions (female superior or side lying), and pacing, such as limiting the activity to less than that which causes pain. Planning for the time of intercourse is important, and scheduling a clinic visit after intercourse might be useful to identify specific sites and causes of post-coital flares. The corresponding evidence in men is lacking, but similar principles would apply. Other behavioural changes involve pre- and post-coital voiding, application of ice packs to the genital or suprapubic area [318, 319], and increased use of vaginal dilators, fingers or sex toys. Lubricants can also be used and women with signs of vulvovaginal atrophy may benefit from oestrogen cream [320]. Optimising the pelvic floor muscle is indicated when dysfunction is present and will relieve the pain [321-323].