

PREPARING THE PELVIC FLOOR FOR BIRTH



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Birth is not 100% predictable. Physiotherapists working in pelvic health have a unique set of skills and knowledge around muscle function that makes us very well equipped to help women "prepare the pelvic floor for birth". The aim of a preparing the pelvic floor for birth is to achieve the best outcomes for both mother and baby.

In relation to birth preparation, a women's health physiotherapist can assess:

- Levator distensibility
- Pelvic floor muscle function
- Pelvic/ hip mobility
- Bear down manoeuvre
- Individual birth type risk

Assessing Pelvic Floor

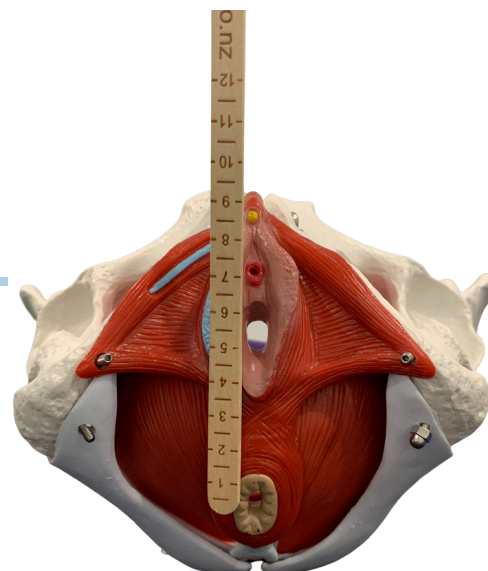
Levator Distensibility

Levator hiatal distensibility is ballooning of the levator hiatus.

Can the pelvic floor:

- Contract
- Relax
- Stretch
- Bounce back to resting tone

A measurement of GH (genital hiatus) + PB (perineal body) on bearing down has a strong relationship to the levator hiatal area on diagnostic ultrasound. GH + PB is a measurement easily performed in clinic using a POP-Q stick. There is good evidence that a larger hiatal area at 37 weeks of pregnancy relates to a shorter 2nd stage of labour and reduced risk of instrumental delivery.



Grading	GH + PB Bear Down	US area
Normal	<7cm	<25cm ²
Mild Ballooning	7-8cm	25-29.9
Moderate Ballooning	8-9cm	30-34.9
Marked Ballooning	9-10cm	35-39.9
Severe Ballooning	> 10cm	> 40

Can we predict pelvic floor trauma?

The lack of distensibility of the levator hiatus at 36+/40 of pregnancy may lead to an instrumental birth and therefore potentially a higher risk of levator muscle/ fascial trauma and 3rd or 4th degree perineal tears.

Screening to refer to a pelvic health physio:

- History of pelvic pain e.g endometriosis, adenomyosis, PCOS
- Overactive bladder
- Dyspareunia
- Vaginismus
- Voiding dysfunction: hesitancy, slow flow, incomplete emptying (without Hx of UTI's)
- Functional constipation
- Age of first birth
- History of trauma (sexual abuse)
- Previous traumatic birth
- POP/ incontinence
- Pregnancy related pelvic girdle pain (? Hypertonic pelvic floor link)

Contraindications for an antenatal VE:

- Placenta previa
- Short cervix < 25mm
- < 20/40 gestation

Baseline Measurements

	20/40	36/40
Modified Oxford Scale	<ul style="list-style-type: none">• Muscle strength levator ani & bulbospongiosus• Muscle tone (low or high)• Ability to relax pelvic floor	<ul style="list-style-type: none">• Muscle strength levator ani & bulbospongiosus• Muscle tone (low or high)• Ability to relax pelvic floor
GH + PB	<ul style="list-style-type: none">• 6-7cm at rest• 7-8cm on BDM	<ul style="list-style-type: none">• > 8cm on BDM - aiming for a 1cm increase in GH + PB per week from 36/40
Perineal Body	< 3cm	> 3cm on BD
Levator Ani Insertion Width	< 4cm	> 4cm
Bear Down Manoeuvre (BDM)	<ul style="list-style-type: none">• Motor pattern of bearing down (pelvic floor should relax & lengthen)• Assess for paradoxical puborectalis	<ul style="list-style-type: none">• Motor pattern of bearing down (pelvic floor should relax & lengthen)• Assess for paradoxical puborectalis

Treatment

- Pelvic floor muscle training to optimise tone/ tension. This may be optimising strength, length or down training.
- Improve effectiveness of the BDM
- Perineal massage
 - > 34 weeks
 - 1-2 x week increasing to daily by 36 weeks
 - 5-10 mins
- Pelvic stretches/ yoga
- Mindfulness and meditation
- Counselling high risk patients and liaising with care providers

References

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