

PREPARING THE PELVIC FLOOR FOR BIRTH



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Birthing 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 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

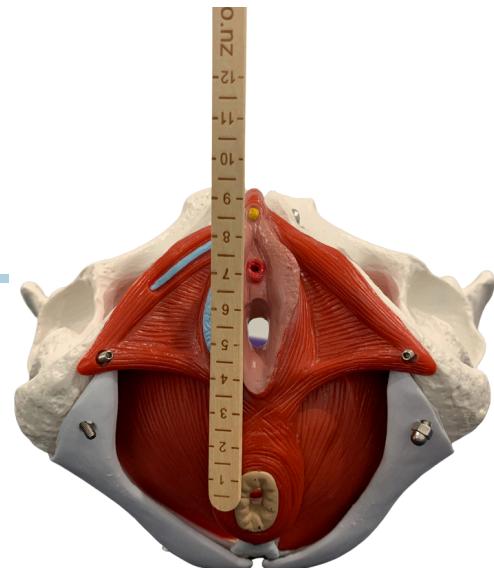
Levator Distensibility

Levator hialt distensibility is ballooning of the levator hiatu.

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 hialt 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 hialt 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 hiatu 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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