

Women's Health

A DIVISION OF THE CANADIAN PHYSIOTHERAPY ASSOCIATION

WINTER 2024 NEWSLETTER



WORD FROM THE CHAIR

Happy New Year everyone! I hope that these first weeks of 2024 have been kind to you. As we settle into the New Year and move through the cold days of winter, your team has been busy as always.



It is my absolute honour to announce that our name change has been approved by the CPA Board of Directors, and the Women's Health Division is beginning our formal transition to the Pelvic & Reproductive Health Division! This name change has been a long time coming, and I am honoured to have been a part of it. The tireless work and energy of the volunteers (past and present) who have been involved in the thoughtful and challenging work behind this transition has been so inspiring to me. We are now hard at work on finalizing this change and going through the back-end work of making this change a reality.

As we move through February and March 2024 keep your eyes on your eblasts regarding:

- Our 2024 Bursary Program will launch on February 15th - We love offering this program, and I personally get so excited and inspired by going through our applications.
- Elections for 2024-2025! We will have some roles on our executive and operations subcommittee teams. For more info, you can find the postings on our website. I would be so happy to chat with anyone who is interested in getting involved with this amazing division, so please don't hesitate to reach out.

Lastly, Congress 2024 is coming up in April! We are going all out this year, and are planning all sorts of fun events. While nothing is quite finalized as I'm writing this, please keep your eyes open and join us in beautiful Vancouver. I always look forward to Congress and the opportunity to meet with you all. This year is no exception to this (and as a Prairie-dweller, I'm also thrilled to have a reason to visit the coast in the spring!) Please keep your eyes open for some special events from us, and send us an email or direct message letting us know that you'll be joining us at Congress!

Stay in touch and stay warm as we move through this coldest part of the year. Thank you for your support of this amazing division.

Alison Gordon, MPT

Chair, Pelvic and Reproductive Health Division of Canadian Physiotherapy Association

(she/her)

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NOTE FROM THE EDITOR

Happy New Year and what an exciting year it will be!

We have so many great things happening this year - it is the 10th anniversary of our Annual Valentine's Day Challenge, we are gearing up for another great CPA Congress and are officially renaming our division!

With that being said, I would like to warmly welcome you all to the Pelvic and Reproductive Health Winter Newsletter! You can read all about the name changing process on page 6, outlined by our lovely Advocacy Lead, Catherine Rastin!

This edition is all about Endometriosis and the role that pelvic health physiotherapy plays in the management. We have information on what Endometriosis is, how physiotherapy can help, two very special and informative interviews as well as self-management strategies!

Enjoy and we hope to see you all in April at CPA Congress!

Stephanie Boone, PT

PRHD Newsletter Editor

(she/her)

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UNDERSTANDING ENDOMETRIOSIS AND THE ROLE OF PHYSIOTHERAPY

By Laura Powers, RPT (she/her)

You have a patient that presents with abdominal bloating, pain before and during bowel movements, lower abdominal pain before urination, painful intercourse, and heavy, unbearable periods. They have never spoken to a doctor or specialist about their symptoms, but they heard from a friend about pelvic health physiotherapy and thought they would give it a try. As you hear their story you may already be going through some differential diagnosis in your head....IBS, bladder pain syndrome, dysmenorrhea, and hopefully endometriosis. The gold standard for diagnosing Endometriosis is by laparoscopy and MRI or TVUS by specially trained technicians, but clinical presentation can be very helpful for establishing a treatment plan.

Endometriosis is defined as, "a chronic gynaecological condition, which is characterized by abnormal presence of endometrial glands and stroma outside the uterus, and is accompanied by chronic inflammation. Most commonly it affects organs of the pelvic cavity- ovaries, fallopian tubes, urinary bladder, intestines or peritoneum." (Lamceva et al., 2023). In rare situations there has also been evidence of endometrial tissue outside the pelvic cavity- diaphragm, pleura, abdominal wall, central or peripheral nervous system (Saunders et al., 2021).

Endometriosis is classified into 3 subtypes based on its location and histopathology: superficial peritoneal endometriosis, ovarian endometriotic cysts and deep infiltrating endometriosis. It is the deep infiltrating subtype that typically causes the most pain/symptoms for patients.

The etiology of endometriosis is one of uncertainty and multiple theories have been developed over the years. The most common theory, Sampson's theory, is based upon the process of retrograde menstruation, which is the reflux of blood backward from the Fallopian tubes to the peritoneum during menstruation. In Sampson's theory, "the viable cells in the peritoneal fluid with retrograde menstruation can implant, grow, and infiltrate the peritoneal cavity" (Tsamantioti et al., 2023). However, this theory doesn't account for the deep infiltrating endometriosis. Other theories include, Meyer's Theory of coelomic metaplasia, the theory of metastatic endometriosis, which assumes that a small amount of the

endometrial tissue can be disseminated through the uterine-draining lymph vessels during menstruation, and immune dysregulation (Lamceva et al., 2023).

The prevalence of endometriosis in women of reproductive age is commonly cited as 10%, but global estimates vary widely, ranging from 2% to 45% and anywhere from 2% to 77% in women with infertility. Given the challenges of confirming the condition it can take 8-10 years to get a formal diagnosis (Singh et al., 2020).

There is evidence that individuals can have endometriosis and be asymptomatic, however the most common symptoms associated with endometriosis are:

- Dysmenorrhea (pain is chronic, cyclic and progressive)
- Dyspareunia
- Dysuria
- Dyschezia (pain before, during or after defecation)
- Gastrointestinal issues such as bloating, cramping, constipation (due to the inflammatory process)
- Infertility
- Anxiety and depression
- Hyperalgesia

Additionally, patients with endometriosis have higher stress levels, report worse quality of sleep, and lower physical activity compared to healthy women (Marinho et al., 2018).

Currently the "gold standard" for treatment is excision of the infiltrating tissue, however research has shown that surgery does not reduce pain in 20-28% of patients (Abbott et al., 2004). This statistic gives us an indication that there can be other factors contributing to the patient's pain. Physiotherapy cannot "cure" the endometrial tissue. However, by breaking down the patient's problem list and taking a biopsychosocial approach we can help identify the drivers of the patient's symptoms and ultimately create a tailored treatment plan.

Using questionnaires such as the CSI, DASS, PCS and TSK can be a helpful start in identifying a generalized state of their central nervous system, mental health dynamics and thoughts and beliefs of pain. If there is evidence of CNS sensitivity, this can be addressed through meditation, mindfulness and

gentle, relaxing exercise programs (yoga, Qi Gong, and even forest bathing/mindful nature walks). If mental health factors are present you may need to discuss a referral to a counsellor or therapist to help address those issues. And if they have misguided beliefs or fears about pain and movement, then it is an excellent opportunity for pain education.

Assessing the pelvic floor is important to determine if there is any sensitivity or tension/stiffness that may be contributing to the patient's symptoms and using our manual skills to invoke change.

To help with period pain and cramping, there is some research indicating that TENS can be a helpful adjunct treatment. There is evidence supporting decreased pain, less analgesic use and increased time with less pain (Arik et al., 2022, Parsa et al., 2013).

If the individual is having bladder and bowel issues, you may need to integrate strategies to improve their stool quality, teach toilet positioning and relaxation strategies for evacuation/voiding, and hydration modification.

Many patients that experience dysmenorrhea often avoid exercise, particularly before and during menses, but gentle movement can be incredibly comforting. Integrating restorative yoga poses and gentle movements can help to decrease one's pain and improve quality of life (Goncalves et al., 2017).

Overall, the moral of the story is that physiotherapy has the potential to greatly improve a patient's symptoms. If you feel that your skills are lacking in any of these areas, know that there are excellent courses available to help build your skill set.

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OUR DIVISION HAS A NEW NAME!

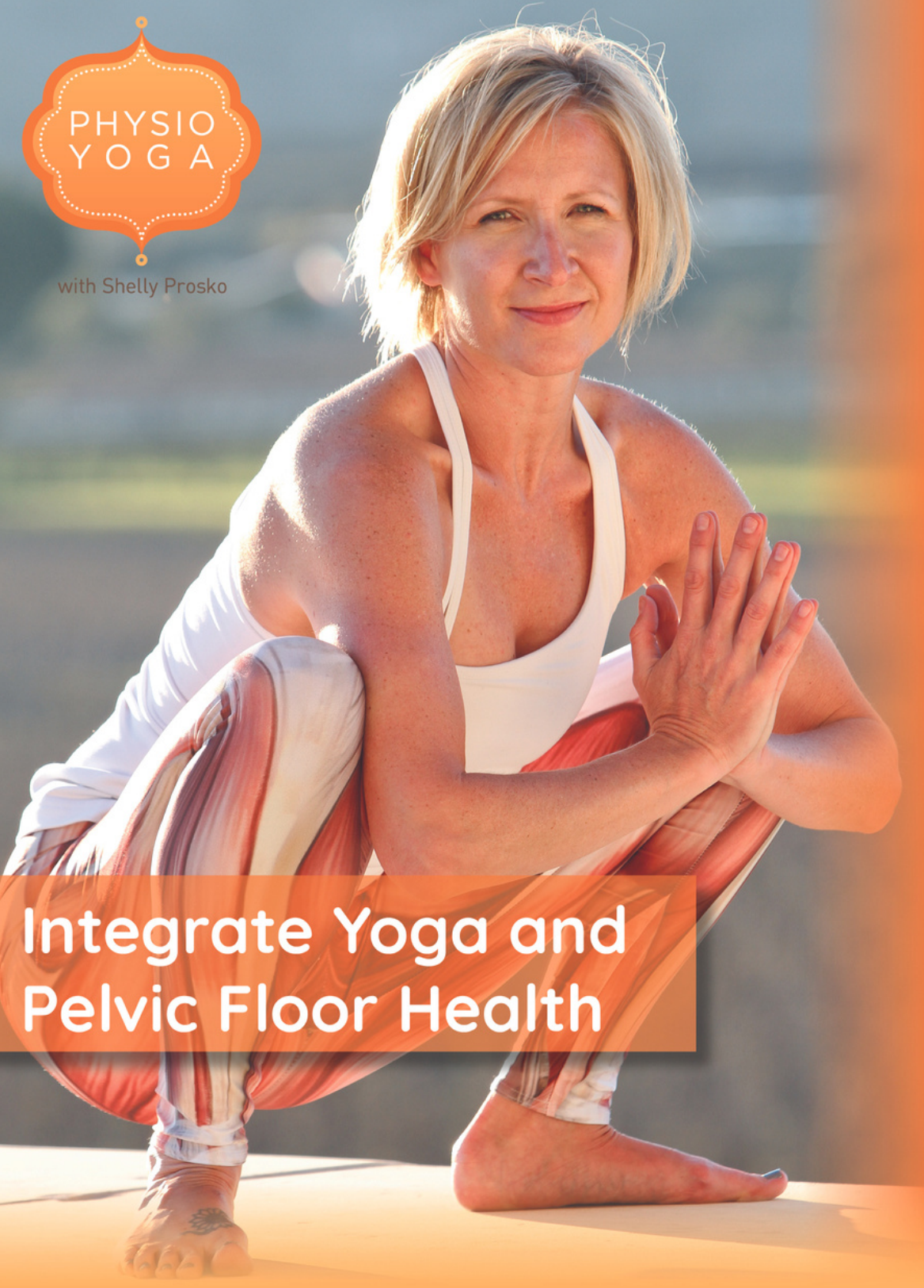
Over the past year, we teamed up with Dr. A.J. Lowik's (they/them/theirs), a Postdoctoral Fellow at the University of British Columbia who primarily works on trans research in the reproductive space. A.J. led the division through a thoughtful process to arrive at the new name, The Pelvic and Reproductive Health Division. They reviewed the history of gender language in health care, why a shift to inclusive language is necessary, aspects to consider when choosing a new name, and facilitated open discussion and brainstorming about a name that would capture what the women's health division has to offer in an inclusive way. Our goal was to keep the focus of the division on supporting underserved populations. This new name focuses on the important services that our division provides while including people of all genders.

Catherine Rastin

Advocacy Lead



with Shelly Prosko



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Shelly Prosko, PT, C-IAYT
physiotherapist, yoga therapist

USING A BIOPSYCHOSOCIAL APPROACH TO SUPPORT PEOPLE WITH ENDOMETRIOSIS: INTERVIEW WITH JILL MUELLER, PT

By Kaeleigh Brown PT, PhD Candidate (she/her)



About Jill Mueller, PT

Being a physiotherapist since 2001, Jill's decision to pivot her career into pelvic health emerged from her own experience of years with period pain and fertility challenges due to endometriosis.

Diving into pain science and research on pelvic pain, Jill realizes there are a lot of opportunities for our profession to help people suffering with pelvic health issues. Whether 1:1 or in groups with clients, speaking internationally, or teaching other health practitioners

worldwide, Jill uses a biopsychosocial approach to looking at the whole person, and relays these opportunities to helping people improve their quality of living.

CAN YOU TELL ME ABOUT YOURSELF AND YOUR AREA(S) OF PRACTICE?

I have been a physiotherapist for over 20 years, but it was my journey with endometriosis and 10-year fertility challenges that pivoted my career into pelvic health. After learning about pain science, and implementing the strategies on myself, I realized there is a big missing piece in healthcare to helping people with persistent pain.

I primarily focus on helping those with complex pelvic pain and endometriosis; and have developed, and teach a course to both practitioners and patients on how to use a biopsychosocial approach for endometriosis pain.

THIS PRHD NEWSLETTER ISSUE IS FOCUSED ON ENDOMETRIOSIS. WHAT ARE SOME COMMON MYTHS OR MISCONCEPTIONS ABOUT THIS CONDITION YOU'D LIKE TO DISPEL?

Oh, there are many! One of the most common myths starts culturally. We are told by family, friends, and even by medical practitioners, that period pain is normal. Some discomfort may be common, but pain that keeps you home from school or work may indicate something more, and should be investigated.

Another common myth about endometriosis is that it always means there will be pain. The truth is, the extent of

endometriosis has not been found to correlate to someone's pain experience. This has been well documented in other structural findings as well, disc herniations and osteoarthritis to name a few. So it is much more than a tissue issue!

If pain continues after surgery they must have missed it, or it has grown back. The truth is not all pain comes from the tissues. Pain is complex, and inflammation and Endometriotic tissue is just one data point the brain considers when pain is produced. With continued pain after surgery, we also need to consider nociplastic pain (i.e., central sensitization); better yet, screen for it ahead of time because recent research shows that the presence of central sensitization increases a person's risk of not responding to traditional medications and surgery.

“Most of us have had years of not being believed, misdiagnosed, or not taken seriously; so to have someone that instantly gets it must be so relieving.”

WHAT RESOURCES HAVE BEEN HELPFUL TO ENSURE YOU STAY UP TO DATE ON BEST PRACTICES AND CURRENT RESEARCH ON ENDOMETRIOSIS?

I have found going to pain or endometriosis-specific conferences to be most helpful in keeping up to date with the latest research. Fortunately, endometriosis is a massive growing area of research, and new discoveries are continuously coming out. The research comes out faster than guidelines, so I find going straight to the source the most helpful.

I have also befriended many other passionate people worldwide in the field - gynaecologists, researchers, and fellow colleagues and practitioners; so they are always an email, text or phone call away when I have a question.

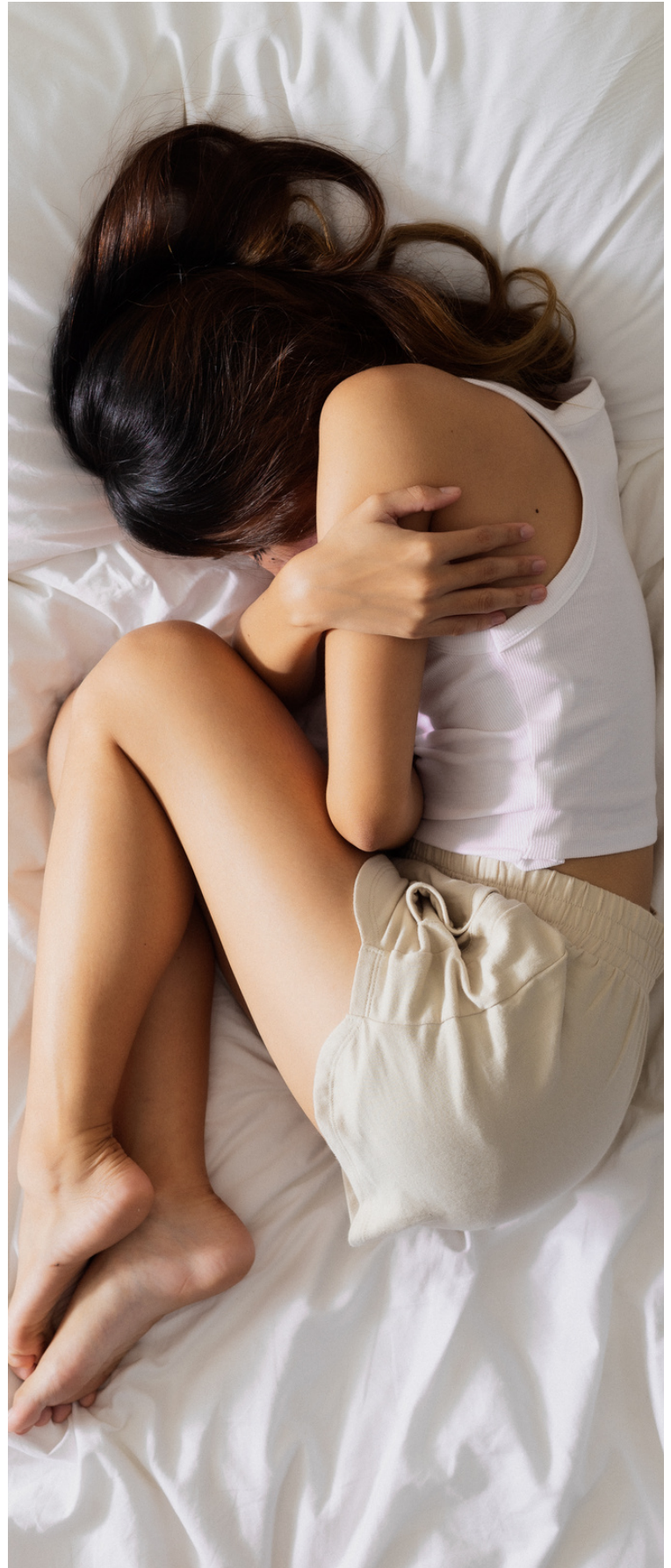
“After learning about pain science, and implementing the strategies on myself, I realized there is a big missing piece in healthcare to helping people with persistent pain.”

YOUR BIO AND WEBSITE MENTION YOUR APPROACH TO TREATMENT, AND I NOTICED SOME PAIN SCIENCE/RETRAIN PAIN FLAVOURS IN YOUR WRITING. HOW DOES PAIN SCIENCE INFLUENCE YOUR ASSESSMENT AND TREATMENT STRATEGIES?

THIS is what drives my passion and curiosity! When I was able to use pain science strategies that changed my pain experience entirely (I had surgery, I was on medications... and neither of those helped me); I was in utter amazement. And then when I discovered that this ‘decades-old’ research had even been looked at with endometriosis, I started to become angry - why wasn’t anyone talking about this? Why don’t people who are suffering for YEARS from this disease know about this? I honestly felt drawn to where I am now, like it is my purpose to get this information out there.

So I screen for 5 patterns that I have started to notice with people with endometriosis:

1. **Pain system hypersensitivity (central sensitization):** I use the Central Sensitization Inventory to screen for this. This is the questionnaire shown in research to identify people at risk of not responding well to medications and even surgery (Orr et al, 2023; Orr et al, 2022). Addressing this in treatment is instrumental in helping those with sensitization to change their pain experience, and/or optimize their recovery after surgery.
2. **Worry pain cycle:** I use the Pain Catastrophizing Scale to measure magnification, rumination and helplessness. Higher pain catastrophizing was associated with a reduced pain health-related quality of life in those with endometriosis (McPeak et al, 2018). “Pain catastrophizing” was also shown to predict who was at risk of ongoing pain at 1 year after treatment (Martin et al, 2011).
3. **Sensory-motor dysregulation (cortical smudging):** this area doesn’t have a lot of research for the pelvis, however, studies are currently being done. Right now I assess for this internally, seeing if someone can tell where I am palpating. I have found that it isn’t uncommon for someone who has



experienced physical, medical or emotional trauma to have dysregulation here. Like with phantom limb and CRPS, remapping this area appears to be helpful for pain, and control of the pelvic floor muscles. I review how to do this in my course for practitioners.

4. **Predictive processing:** like Pavlov's dog, sometimes anticipating pain, having an App that lets you know when your period is coming, getting out your hot pack and cancelling plans, are all behaviours that may in and of themselves contribute to pain being produced. I explain a cool example of this with one of my clients in my course. Sometimes it is just about changing up their period routine.
5. **Local factors:** in our profession, assessing for these may be by process of elimination, as a tender pelvic floor may be a symptom of central sensitization. Where all others have been addressed, this is where my manual skills of fascial mobilization, and exercise and movement education may be most helpful.

We are told by family, friends, and even by medical practitioners, that period pain is normal. Some discomfort may be common, but pain that keeps you home from school or work may indicate something more, and should be investigated.

YOUR WEBSITE, [ENDOTOGETHER.COM](https://endotogether.com), ALSO DETAILS YOUR EXPERIENCES WITH PELVIC PAIN AND ENDO. HOW DOES HAVING THAT SHARED EXPERIENCE WITH YOUR CLIENTS INFORM YOUR APPROACH TO TREATMENT AND THE THERAPEUTIC RELATIONSHIP?

It's funny, when I first started doing pelvic physiotherapy my bio didn't even include that I have endometriosis. It wasn't until a few patients cried when I mentioned that I understood what they had been through that I felt it might be important for me to mention. Most of us have had years of not being believed, misdiagnosed, or not taken seriously; so to have someone that instantly gets it must be so relieving. They can feel my passion to help them. There is an instant trust that I will do my best to help them reach their goals (and perhaps goals they didn't even know they could reach for), whether it be with me or a trusted colleague. I'm an optimist at heart, we are only given one life, and I push my clients to aim for the life they want to live.

IS THERE ANYTHING ELSE ABOUT ENDOMETRIOSIS YOU'D LIKE TO SHARE WITH PRHD MEMBERS?

I really feel passionate that as Pelvic Health Physiotherapists we are positioned well to help people with endometriosis, especially if we can take a biopsychosocial approach to therapy. If we are treating people with pelvic pain (not just period pain), chances are we are treating people with endometriosis, whether diagnosed or not. It is our duty to understand this disease, learn how to suspect it, who to include on the healthcare team, and how to address it as primary care practitioners.

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Claudia Brown, M.Sc.(P.T.)



Marie-Josée Lord, B.Sc.(P.T.)

Pioneers in their field, Claudia and Marie-Josée created the first Canadian pelvic floor physiotherapy course in 1991 and continue to share their expert knowledge with physiotherapists across Canada. Their teaching style is very practical, well-organized, clear, and fun. Uro-Santé courses are full of valuable information, enabling their students to immediately apply their knowledge and techniques to their current treatment practice.

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In person (Laval, QC) - In English

***with special guest Johanne Sabourin**

Pre-requisite: Female Urinary Incontinence (or equivalent)

[Click here](#) to learn more about this course.

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No previous internal pelvic health education is required to enrol in this course.

[Click here](#) to learn more about this course.

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HYBRID, in English

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Early bird prices end: February 12th, 2024

Pre-requisite: Female Urinary Incontinence (or equivalent)

[Click here](#) to learn more about this course.

NEW COURSE

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HYBRID, in English

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"Marie Josée never disappoints. Her dedication to research based practice, her caring personality and her ability to throw in an occasional worthy fun story made for a great weekend. Thank you!" (Dyspareunia course)



CHRONIC PELVIC PAIN: AN INTERVIEW WITH DR. JANE CHALMERS

By Katie Kelly, PT (she/her)



About Dr. Jane Chalmers

Dr. Jane Chalmers is the Pelvic Pain Research Theme Lead for IIMPACT in Health at the University of South Australia, Adelaide. She is a Senior Lecturer in Pain Sciences and Post Doctoral Research Fellow at the University of South Australia. Jane is an early career researcher who is passionate about solving the problem of pelvic pain.

A physiotherapist by background, Jane's research focuses on the assessment and management of pelvic pain. She is particularly interested in the role of pain science education and exercise in the physiotherapy management of pelvic pain.

WHEN IT COMES TO RESEARCH INVOLVING ENDOMETRIOSIS AND MODERN PAIN SCIENCE PRACTICES FOR REHABILITATION, MANY WOULD CONSIDER YOU A LEADER IN YOUR FIELD. WHAT HAS BEEN THE MOST SURPRISING FINDING IN YOUR RESEARCH TO DATE?

My work has recently moved more into the qualitative space. One finding that continues to surprise and disappoint me is the ongoing dismissal of people with pelvic pain, with so many still told their pain is 'normal' - I've never had a research participant who hasn't shared a story of some variation on this experience. We unequivocally know that pelvic pain is not a normal experience, nor something people should have to put up with, and yet this continues to be the rhetoric people receive.

The result of this dismissal and normalization is devastating. People avoid seeking further help leading to awful diagnostic delays, they are left to learn how to manage their pain on their own, and they often turn to unregulated and unresearched management options. One of our surveys on self-management found a significant portion of people with endometriosis turn to alcohol and illicit cannabis for pain reduction despite them often being associated with unwanted or adverse events. This risk/reward tradeoff that people are forced to make highlights how far we still have to go in providing appropriate care for people with pelvic pain.

“Pelvic pain is incredibly complex – I would argue the most complex of all areas to experience persistent pain!”

IN CONDITIONS LIKE ENDOMETRIOSIS, THE ROLE OF CENTRAL SENSITIZATION (OR NEWLY ADAPTED TERMINOLOGY NOCIPLASTIC PAIN) IS JUST NOW BEING RECOGNIZED AS AN IMPORTANT FACTOR IN TREATMENT. HOW MIGHT THIS AFFECT THE WAY PHYSIOTHERAPISTS APPROACH TREATMENT WITH THIS PATIENT POPULATION? CAN TOP-DOWN TREATMENT METHODS PREVIOUSLY USED FOR CHRONIC LOW BACK PAIN, OR CPRS, BE APPLIED TO THE PELVIC ORGANS?

I think many physiotherapists have been applying their understanding of modern pain science and viewing endometriosis and persistent pelvic pain as nociplastic pain for a long time. Many physiotherapists have been telling me for years that their treatment of pelvic pain has been in line with this understanding, with a focus on top-down methods. The research is yet to catch up! There are some fantastic research teams across the globe looking at best practice physiotherapy treatment of pelvic pain and novel treatments for pelvic pain - most of which are focused on top-down approaches.

I am particularly interested in the role of pain science education as part of a multimodal approach to treating pelvic pain. We know from other persistent pain conditions that helping someone understand the biopsychosocial nature of pain can improve pain outcomes, and preliminary work suggests that similar improvements happen in people with pelvic pain. My team has recently been working on exactly what people with pelvic pain need to learn about their pain in

order to improve – we're hoping that optimizing our pain science education will help to maximise clinical outcomes.

We certainly have a long way to go before we understand endometriosis and pelvic pain in the same way we do other persistent pain conditions such as back pain, but the current research momentum provides so much hope for the future of how we understand and manage pelvic pain.

“One finding that continues to surprise and disappoint me is the ongoing dismissal of people with pelvic pain, with so many still told their pain is ‘normal’.”

CAN YOU SHARE YOUR INSIGHT ON HOW THE FACT THAT BECAUSE PELVIC PAIN IS DIFFICULT TO SEE, IT MIGHT AFFECT HOW PEOPLE PERCEIVE PAIN FROM THIS AREA?

Pelvic pain is incredibly complex – I would argue the most complex of all areas to experience persistent pain! Much of this complexity is also spoken about – how the stigma and taboo around menstruation and reproduction makes it difficult to discuss, lack of general anatomical knowledge makes it difficult to describe, and how many people are told that pelvic pain is ‘normal’.

I have a theory that an added complexity to pelvic pain is the fact that much of the pelvis is hidden from view. Previous research has shown that visualizing one's own body part can reduce the reported pain intensity during experimental pain trials, and in clinical populations, visual distortion (minimization) of the size of painful body parts can provide similar analgesia. My theory is that the opposite may also be true and of particular relevance to pelvic pain – because we struggle to ‘see’ much of the pelvis, noxious stimuli are experienced as more painful than similar stimuli applied elsewhere that we can see. This might then lead the pelvis to being vulnerable to overprotection by the brain and result in persistent pain. I have no empirical, pelvic-based data to support this theory yet, but it's something I'm interested in exploring further.

“We know from other persistent pain conditions that helping someone understand the biopsychosocial nature of pain can improve pain outcomes.”

WHEN EXAMINING THE MOST COMPREHENSIVE WAYS TO TREAT ENDOMETRIOSIS, WHERE DO YOU THINK CURRENT TREATMENT STANDARDS MIGHT BE LACKING?

One of my fantastic PhD students, Amelia Mardon, has recently published a systematic review of pelvic pain clinical practice guidelines in BJOG that clearly highlights where we are lacking. Unfortunately, there are many areas. Many clinical practice guidelines are not developed in accordance with best practice recommendations which results in limited guidance for clinicians seeing patients with pelvic pain. Within these clinical practice guidelines, there remains a heavy focus on pharmacological and surgical interventions despite these interventions often being associated with sub-optimal patient outcomes. Where multidisciplinary management is recommended, the guidelines generally lack enough detail to be helpful. Physiotherapy is recommended in almost half of the guidelines, but exactly what that physiotherapy management should include is missing. Improving the quality of clinical practice guidelines and the research base on which these guidelines are made is one way in which we can improve treatment standards.

Future research trials in endometriosis and pelvic pain should look to investigate particular treatments and approaches that are in line with a contemporary understanding of pain – recognizing the biopsychosocial nature of pain and the plethora of contributing factors both within and outside of the pelvis. Without this focus, we will continue to see sub-optimal clinical outcomes for people with pelvic pain.



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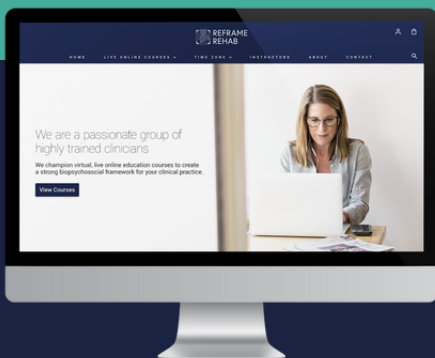
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SELF-MANAGEMENT TECHNIQUES FOR ENDOMETRIOSIS

By Alyssa Brunt, PT (she/her)

Endometriosis is a chronic inflammatory condition that has a significant impact on the lives of women. Disease symptoms including pelvic pain, dysmenorrhea, dyspareunia, stress, and chronic fatigue, considerably affect an individual's quality of life as well as their biological, psychological and social wellbeing.^{1,2}

Despite best efforts, surgical and pharmacological treatment methods do not provide sufficient reductions in pain or have unwanted side effects.³ Laparoscopic removal of endometriosis associated with improved overall pain post-operatively, however there are increased rates of repeat surgeries even after 2 years and some individuals find their pain unchanged or worsened.⁴

Given that it has no cure, the management and treatment of endometriosis is ongoing. Women must often seek out self-management methods to better cope with endometriosis-associated pain.⁴ Pelvic physiotherapists are integral members of the multidisciplinary healthcare team for endometriosis and ultimately play a pivotal role in ensuring patients are aware of self-management strategies that may mitigate pelvic pain, dyspareunia and other endometriosis symptoms.

DIETARY CHANGES

Endometriosis is an inflammatory condition with a high prevalence of GI-related symptoms and co-morbidities.⁴ Individuals may experience increased gas production leading to abdominal pain, bloating and constipation.⁵⁻⁷ Dietary interventions including supplementation, exclusion/elimination of foods, and/or complete diet changes have been shown to reduce endometriosis-associated pain.⁴⁻⁹

Anti-inflammatory diets, specifically low FODMAP, gluten-free and Mediterranean diets are effective at reducing gas production in the body. Individuals with endometriosis have found improvements in self-reported levels of pain after following both low FODMAP and gluten free diets. Mediterranean diets, high in antioxidant rich foods, have also been shown to reduce pain in women with endometriosis. Additionally, diets high in fiber and low in dairy, caffeine, alcohol, animal fats, and preservatives may also reduce endometriosis symptoms.⁴ Supplementation of omega 3s, linoleic acid/omega 6s, vitamin D, lactobacillus, resveratrol, melatonin and mineral salts (Ca, Mg, Se, Zn, Fe) have also shown a reduction in pelvic pain in endometriosis.^{1,8,9}

Due to a lack of high quality evidence, there are no specific guidelines on dietary changes for individuals with endometriosis.¹ As no two cases of endometriosis are the same, individuals may respond differently to similar dietary changes. Ultimately, individuals should be referred to a dietician and/or gastroenterologists to help provide them with an individualized approach to dietary changes.⁴

HEAT THERAPY

Heat therapy, including the use of heat patches, heating pads and hot water bottles, has been shown to improve dysmenorrhea, specifically when placed along the lower abdomen.^{10,11} However, individuals may find greater improvement with stick-on heat patches as compared to heat packs and water bottles as they provide stable temperatures for longer periods of time (8-12hrs).¹¹

SLEEP HYGIENE

Sleep is a key component to physical, social, and emotional wellbeing. It is well understood that individuals suffering from chronic pain have higher reports of sleep disruptions. Research suggests that women with endometriosis who reported higher levels of severe pain, poor quality of life and more depressive symptoms experienced overall reduced quality of sleep.^{10,12,13} To help manage symptoms, individuals with endometriosis should obtain 7-9hrs of sleep each night, implement mindfulness techniques to help them fall asleep, and identify any barriers to sleep (surrounding light and/or noise, distractions) in addition to speaking to their GP about melatonin supplements.^{12,13}

EXERCISE

The benefits of regular exercise are far reaching and can improve pain in those with chronic pain conditions, including endometriosis.¹¹ Regular physical exercise can improve blood flow to organs, release endorphins for pain management and improve circulation in the body. Regular physical exercise significantly reduced menstrual pain severity in women with primary dysmenorrhea.^{3,10,11,15} Hatha yoga demonstrated significant improvements in reported levels of control and powerlessness, emotional wellbeing, self image, work and quality of life in women with endometriosis compared to controls after 8 weeks.¹⁴ However, some studies have shown adverse events following exercise, including increased pelvic pain, flare ups and increased levels of

fatigue.^{3,10,15} Unfortunately, there are no guidelines on what types of exercise are most beneficial for reducing endometriosis-associated pain as well as the dose response needed to improve symptoms.^{1,10} Individuals with endometriosis may struggle with adherence to regular exercise programs given the possibility of increased pain symptoms and must be educated to understand when exercise should be avoided.

MEDITATION/BREATHING EXERCISES

Relaxation-based exercises have significant improvements on chronic pelvic pain. In Australia, 47% of women with endometriosis reported using meditation and breathing exercises to self-manage their pain.³ Breathing exercises, including yoga have been shown to reduce pelvic pain through relaxation and breathing techniques.¹⁴ Women with endometriosis have also shown a significant reduction in pain after completing physical therapy combined with CBT, yoga, biofeedback, and mindfulness techniques.¹⁶ The pelvic floor has many implications for everyday functions. In endometriosis, the pelvic floor muscles can be hypertonic and overactive. Pelvic physiotherapists can help assess and evaluate tension in the pelvic floor muscles and provide women with endometriosis exercises on how to relax and coordinate the pelvic floor muscles rather than strengthen them.^{11,17}

EDUCATION

In order to better self-manage endometriosis associated pain, individuals must better understand the disease itself.^{3,10,11,17} Being informed about endometriosis can empower women to make decisions about their health. Education must focus on explaining downstream effects like chronic pelvic pain and central sensitization rather than solely the physical manifestations of the disease.¹⁸ Most women are unaware of the services that are offered to them, including physiotherapy. As healthcare providers, we can educate individuals on self-management strategies and provide them with resources and organizations that can further help manage their symptoms.

CONCLUSION

Although education, exercise, diet, sleep, heat and meditation may all improve endometriosis-related pain, the sparsity and poor quality of research does not allow us to truly make any definite suggestions.^{1,10,11} We are, however, beginning to understand that people with endometriosis who self-manage their pain have better outcomes than those who don't. Unfortunately, the literature just does not suggest that these are the best self-management techniques or that they will work for everyone. For now, we must continue to conduct high quality research to better understand self-management strategies and guide clinical practice.

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