Case Report

REHABILITATIVE PELVIC FLOOR TREATMENT OF URINARY URGE AND URINARY INCONTINENCE DURING ORGASM IN WOMEN WITH NORMAL PELVIC MUSCLES.

RIABILITAZIONE DEL PAVIMENTO PELVICO NELL'URGENZA E NELL'INCONTINENZA URINARIA DURANTE L'ORGASMO IN DONNE CON MUSCOLATURA PELVICA INTEGRA.

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Abstract: The authors report three cases of young girls with severe urge during orgasmic phase of the coital intercourse without anatomical dysfunctional causes.
The empirical rehabilitative treatment of pelvic floor muscles was curative for two girls and gave a moderate response in the third.
This article demonstrates the importance of resolving this syndrome in order to avoid reduced quality of life, limited sexual activity, poor self esteem and relationship problems.

KEYWORDS: Urinary incontinence, bladder disfunction, sexual activity, coital incontinence, performance anxiety, penetration, orgasm, rehabilitative therapy.

Abstract: Gli autori riportano il caso di tre giovani donne con urgenza grave durante la fase orgasmica del rapporto sessuale in assenza di cause anatomiche disfunzionali. Il trattamento riabilitativo empirico dei muscoli del pavimento pelvico è stato risolutivo per due di loro e ha dato risultati discreti per la terza. Questo lavoro dimostra l'importanza di risolvere tale sindrome in funzione della ridotta qualità di vita, della limitata attività sessuale, della scarsa autostima e dei problemi di relazione che essa determina.

PAROLE CHIAVE: Incontinenza urinaria, disfunzione vescicale, attività sessuale, incontinenza coitale, ansia della performance, penetrazione, orgasmo, terapia riabilitativa.

Introduction

Urinary urge during sexual intercourse may have an adverse effect on almost every aspect of woman life including relations with her partner (1). Female sexuality concerns not only her sexual activity but also the perception of her own image and the formation of relationships with other people (2). Almost 50% of women with incontinence frequency or urgency report feeling different from other people because of their bladder problems and 40% feel less attractive (3).
It is well know that poor self-esteem is a frequent problem and difficulties with personal relationships may contribute to depression and social isolation often felt by women with bladder dysfunction (4). A relevant feature is finding urgency and/or urinary incontinence in young girls during intercourse because all the above mentioned adverse effects can be seen and affect the quality of life. This is especially true when medical therapy reveals inadequate.
Because of the inconclusive results of medical (anticholinergic) treatment we present our results in three cases treated with pelvic floor exercises, electrical stimulation and biofeedback.

Methods

We studied three girls (18, 25 and 28 years old) with urge and urinary escape during the orgasmic phase of sexual intercourse. The personal history regarding urinary function shows no evidence of incontinence, urge or frequency (except in coital phases). All three women were nulliparous and without symptoms of urinary tract infections. In all of them coital incontinence caused sexual problems for their partners. After informed consent the patients were treated with rehabilitative therapy. The protocol has been published previously (5). Participants were taught the anatomy of

uterus, vagina, pelvic floor and lower urinary tract and physiology, and continence mechanisms. The patients strongly contracted their pelvic floor muscles (pubococcygeal tract) and this was assessed by vaginal palpation. The pelvic floor evolution in the follicular phase of the menstrual cycle (day 8-10) was controlled clinically with pubo-coccygeal test (6).
The instrumental evaluation was carried-out with superficial perineal electromyography. Pelvic floor muscle training: the three girls were asked to do 8-12 high intensity (close to maximum) contractions three times a day at home with additional training in group once a week for 45 minutes with a physical therapist. The patients were taught to contract the elevator ani muscles for five seconds, five-ten times as though they wanted to withhold a pressing micturing stimulus and avoid contracting other muscles. All diagnostic tests were always normal.
The pelvic floor muscle therapy in the follicular phase of the menstrual cycle was performed initially with Sereme Spectral System using the functional electrical stimulation programme and the biofeedback programme and later with kinesitherapy at home the above described procedure. The electrical stimulation was performed three times a month. In two patients the coital incontinence suddenly disappeared during and after therapy (follow up for 15 months). In the third case, the treatment was ineffective after therapy and only reduced for amount of urinary escape.

Results and Discussion

The prevalence of coital incontinence is very difficult to evaluate. For example in a survey of 400 incontinent women: 324 of whom were sexually active, only two women mentioned the problem except in response to direct enquiry (7).
In our three patients the symptomatology was the main and only reason for consultation after ineffective pharmacology therapy with anticholinergic drugs. Also a psychiatric consultation was ineffective. The necessity for immediate treatment was the negative impact on the patients relationship with their partner. Our proposal for rehabilitative pelvic floor treatment is based on pathophysiology of coital incontinence. With ultrasonography, it was shown that penetrative intercourse in humans is associated with considerable displacement of the female pelvic anatomy. A high degree of relaxation and stretching of the anterior vaginal wall and bladder base occur in both the missionary and female superior positions and illustrate how the lower urinary tract may become traumatized during intercourse and cause post-coital urinary symptoms (8).
The presence of the erect penis in the vagina may therefore displace the bladder neck and disturbs the continence mechanism (9). Urodynamic studies in literature and also our (not presented) have failed to show that women who leak during penetration have lower urethral pressures than continent women (10). Penile stimulation of the trigone and bladder base may provoke abnormal detrusor contractions during intercourse, resulting in increased intravesical pressure and incontinence. A similar effect may also occur at orgasm (11).
Despite the importance of the condition and the prevalence in women of between 24 and 34% (Hilton, Korda, Vierhout), it is very difficult to be precise but it is very important to discover because the condition may lead to many sexual dysfunctions for reduced sexuality (depression, poor self-esteem, decreased libido, reduced spontaneity) performance anxiety (fear of leakage during penetration or at orgasm) adverse reaction from partner (reduced attraction, erectile dysfunction). In our patients single measures such as emptying the bladder before sex or a change of position were ineffective in reducing the risk of coital leakage. Analogous results were obtained with anticholinergic therapy.
In conclusion, our results with rehabilitative pelvic muscle therapy can probably be explained, in the absence of urogenital abnormality, by augmented local elevator ani strength with the raising of uretrobladder neck and reduction of contractions during penetration and/or at the moment of orgasm. To test this hypothesis further studies are necessary.

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