Comments on "Non-Invasive Pelvic Floor Rehabilitation in Cancer Population: An Incomplete Cohort"

To the Editor:

"Non-Invasive Pelvic Floor Rehabilitation in Cancer Population: An Incomplete Cohort" by Ronald et al. (1) has piqued our intense curiosity. This study appears to offer a beneficial area for treating cancer patients' chronic pelvic pain (CPP). The individuals who are included all present with symptoms unique to the pelvic area. Although the classification of CPP has been the subject of considerable debate in the literature, clinical clarity has not improved. It makes sense that an illness cannot be treated until it has been accurately identified and diagnosed. Additionally, given that we are working with cancer patients, a diagnosis might give patients better self-management strategies and help them develop confidence in their physical therapist. A promising particular metric to direct treatment when CPP is diagnosed is the UPOINT phenotypic system, which divides individuals into 6 domains: urinary, psychosocial, organ-specific, infectious, neurological/systemic, and tenderness of skeletal muscles (2). Additionally, understanding the processes of peripheral and central pain is essential to directing treatment when the symptoms are not specific to a disease or organ.

Since treatment is based on clinical findings, we would also like to elaborate on the clinical evaluation of patients with pelvic floor dysfunction performed by pain specialists. It can be very beneficial to simply watch the contraction and relaxation of the pelvic floor muscles while in the dorsal lithotomy posture. Patients with pelvic floor hypertonic dysfunction frequently have so much muscle tension during "rest" that they are unable to fully relax or are unable to develop more contractile strength, which prevents them from producing an effective squeeze. Then, using a cotton tip applicator, carefully examine the area for any allodynia or vulvodynia symptoms. At this point, the examiner can establish the myofascial component of pain by identifying active trigger points as excruciatingly sensitive nodules within a taut band of pelvic floor muscles (3).

Although the authors explain a variety of pelvic floor rehabilitation (PFR) modalities, it is always beneficial to incorporate patient education regarding the reasons of discomfort, including addressing their fears, because knowledge increases compliance with treatment. For instance, teaching people how to relax their muscles when they feel discomfort is quite helpful. This will break the vicious cycle of pain, spasm, and pain.

A multifaceted strategy that includes physical, psychological, social, and emotional components is necessary for the treatment of cancer pain. Therefore, for improved patient results, multidisciplinary engagement of doctors, physical therapists, pain management experts, psychologists, and surgeons is crucial.

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