

Standardization of Terminology of Pelvic Floor Muscle Function and Dysfunction: Report From the Pelvic Floor Clinical Assessment Group of the International Continence Society

Bert Messelink,^{1*} Thomas Benson,² Bary Berghmans,³ Kari Bø,⁴ Jacques Corcos,⁵ Clare Fowler,⁶ Jo Laycock,⁷ Peter Huat-Chye Lim,⁸ Rik van Lunsen,⁹ Guus Lycklama á Nijeholt,¹⁰ John Pemberton,¹¹ Alex Wang,¹² Alain Watier,¹³ and Philip Van Kerrebroeck¹⁴

¹*Pelvic Care Center 'Prinsengracht', Onze Lieve Vrouwe Gasthuis, Amsterdam, Holland*

²*University of Indiana/Methodist Hospital, Indianapolis, Indiana*

³*University Hospital Maastricht, Department of Urology, Maastricht, Holland*

⁴*Norwegian University of Sport & Physical Education, Olleval Stadion, Oslo, Norway*

⁵*Jewish General Hospital, Montreal, Canada*

⁶*National Hospital for Neurology and Neurosurgery, London, United Kingdom*

⁷*The Culgaith Clinic, Pea Top Grange, Culgaith, Penrith, United Kingdom*

⁸*Division of Urology, Changi General Hospital, Singapore, Singapore*

⁹*Academic Medical Center, Amsterdam, Holland*

¹⁰*Leiden University Medical Center, Leiden, Holland*

¹¹*Mayo Clinic, Minnesota, Rochester*

¹²*Division of Urogynecology, Chang Gung Memorial Hospital, Tao-Yuan, Taiwan*

¹³*Chus-Hotel Dieu 580, rue Bowen Sud, Sherbrooke, Canada*

¹⁴*University Hospital Maastricht, Department of Urology, Maastricht, Holland*

Key words: classification; dysfunction; function; pelvic floor muscles; standardization of terminology

STANDARDIZATION

This report presents a standardization of terminology of pelvic floor muscle function and dysfunction. No earlier documents contained definitions on this terminology. These definitions are descriptive and do not imply underlying assumptions that may later prove to be incorrect or incomplete. By following this principle, the International Continence Society aims to facilitate comparison of results and enable effective communication by investigators performing pelvic floor muscle studies.

It is suggested that acknowledgment of these definitions in written publications be indicated by a footnote to the section "Materials and Methods" or its equivalent, to read as follows: "Terminology used is conform the definitions recommended by the International Continence Society, except where specifically noted."

MULTIDISCIPLINARY

The pelvic floor is related to more than one organ system. Dysfunction of the pelvic floor therefore influences different functions at the same time. This report is on pelvic floor

muscle function and dysfunction, and not on pelvic floor disorders. It contains no terminology on pelvic organ prolapse, urinary, or fecal incontinence. Other reports refer to these subjects [Bump, 1996; Weber et al., 2001; Abrams et al., 2002a]. This report on terminology of the pelvic floor muscles is written for use, in daily clinical practice, by every health care provider working with patients who have pelvic floor muscle problems. It facilitates the communication between different carers in the field of pelvic floor muscle pathology. Because it has been developed by a multidisciplinary group, it

Bert Messelink, Jacques Corcos, Peter Huat-Chye Lim, Guus Lycklama, and Philip Van Kerrebroeck are Urologists; Thomas Benson and Alex Wang are Urogynecologists; Bary Berghmans, Kari Bø, and Jo Laycock are Physiotherapists; Clare Fowler is Neurologists; Rik van Lunsen is a Sexologist; John Pemberton is a Colon and Rectal Surgeon; Alain Watier is a Gastro-Enterologist.

*Correspondence to: Bert Messelink, Pelvic Care Center Prinsengracht, Prinsengracht 769, 1017 JZ, Amsterdam, Holland.

E-mail: e.j.messelink@olv.nl

Received 10 April 2005; Accepted 26 April 2005

Published online 15 June 2005 in Wiley InterScience

(www.interscience.wiley.com)

DOI 10.1002/nau.20144

can be used by different specialties. This document is based on our current knowledge of physiology and pathophysiology of the pelvic floor muscles.

PELVIC FLOOR

The term *pelvic floor* relates to the compound structure, which closes the bony pelvic outlet. The term *pelvic floor muscles* refers to the muscular layer of the pelvic floor. The pelvic floor consists of different layers, the most cranial being the peritoneum of the pelvic viscera and the most caudal being the skin of vulva, scrotum, and perineum [DeLancey, 1992]. The middle layers of the pelvic floor are made up of predominantly muscular tissue. Apart from the pure pelvic floor muscles, fibro-muscular and fibrous elements, like the endo-pelvic fascia are found in this layer. Different well recognizable muscles together form the muscular layer of the pelvic floor: levator ani, striated urogenital sphincter, external anal sphincter, ischiocavernosus, and bulbospongiosus. All these muscles are working together to seal off the lower aspect of the pelvic cavity. Urethra, vagina, and rectum pass through the pelvic floor and are surrounded by the pelvic floor muscles. The pelvic bones are the structures to which the muscular layer is attached. The function of the pelvic floor is to support the pelvic organs. The function of the pelvic floor muscles is performed by contraction and relaxation. In its resting state, the pelvic floor gives support to the pelvic organs. Whether the support function is normal depends on the anatomical position of the muscles, on the activity of the pelvic floor muscles at rest (active support) and on the integrity of the fascia (passive support). During intra-abdominal pressure rise, the pelvic floor muscles must contract to maintain the support function of the pelvic floor. A contraction of the pelvic floor muscles results in a ventral and cranial movement of the perineum, and an upward movement of the pelvic organs together with an anterior movement caused primarily by the vaginal and rectal parts of the levator ani. When the pelvic floor muscles contract the urethra closes, as do the anus and the vagina. This contraction is important in preventing involuntary loss of urine or rectal contents. For women it can also function as a defense mechanism against sexual intercourse. For maintaining continence, it is also important to realize that detrusor activity is inhibited by pelvic floor muscle contraction.

Pelvic floor muscle relaxation following contraction results in a reduction in the support given to the urethra, vagina, and anus. The perineum and the pelvic organs return to their anatomical resting position. The pelvic floor muscles must relax in order to remove the passive continence mechanisms, thereby favoring normal micturition. The same is true for relaxation before and during defecation, allowing the anorectal angle to become obtuse, favoring rectal emptying.¹

¹In the literature, there is discussion on the action of the pubococcygeal muscle as to whether this muscle plays a role in giving rectal support against an increased abdominal pressure [Fucini et al., 2001].

Terminology

At this moment, there is no existing international agreement on terminology of pelvic floor muscle dysfunction. In the literature most studies are clinical studies for example on the effect of pelvic floor muscle therapy for urinary incontinence. Basic studies on the different aspects of the pelvic floor muscles are not available. When considering standardization of terminology, many problems have to be faced. The different aspects of the pelvic floor muscles and their function are hard to define. Furthermore even when they can be defined, they cannot be easily measured. And even when they can be measured, there is no agreement as to what is considered to be normal values.

This report adheres to the ICS principle that symptoms, signs, and conditions are separate categories and adds a category of additional tests.

Symptoms associated with pelvic floor muscle dysfunction. *Symptoms* are the subjective indicator of a disease or change in condition as perceived by the patient, carer, or partner, and may lead him/her to seek help from health care professionals. Symptoms are the complaints mentioned by the patient during the patient interview or stated on questionnaires filled in by the patient. Symptoms alone cannot be used to make a definitive diagnosis nor can they denote the pathophysiological mechanism. Because the pelvic floor muscles act as an entity, it is often the case that dysfunction of the pelvic floor muscles will lead to dysfunction of more than one organ system. Therefore, in the patient interview it is mandatory to ask about symptoms of the different tracts influenced by the pelvic floor muscles [Abrams et al., 2002b]. During the interview the following categories of questions should be asked: those relating to micturition, defecation, vaginal and sexual function, and pain.

Symptoms associated with pelvic floor muscle dysfunction are divided into five groups: lower urinary tract symptoms, bowel symptoms, sexual function, prolapse, and pain.²

Lower urinary tract symptoms.

- urinary incontinence
- urgency and frequency
- slow or intermittent stream and straining
- feeling of incomplete emptying

Bowel symptoms

- obstructed defecation³
- functional constipation⁴

²The definitions of lower urinary tract symptoms, vaginal symptoms, and pain can be found in: The Standardization Report of Terminology of Lower Urinary Tract Function [Abrams et al., 2002a].

³Obstructed defecation can be described as having the urge to defecate but being unable to completely empty the rectum with or without straining.

⁴Following the diagnostic criteria for functional gastrointestinal disorders (Rome II), functional constipation presents as persistent difficult, infrequent, or seemingly incomplete defecation [Thompson et al., 1999] (www.romecriteria.org).

- fecal incontinence⁵
- rectal/anal prolapse

Vaginal symptoms

- pelvic organ prolapse⁶

Sexual function

- in women: dyspareunia⁷
- in men: erectile and ejaculatory dysfunction
- in both: orgasmic dysfunction

Pain

- chronic pelvic pain⁸
- pelvic pain syndrome⁹

Signs suggestive of pelvic floor muscle dysfunction.

Signs are observed by the examiner, including simple means, in order to verify symptoms and quantify them. It should be remembered that not all signs have associated symptoms (e.g., pelvic organ prolapse). Some functions of the pelvic floor muscles can be tested during physical examination. For instance a voluntary contraction of the pelvic floor muscles can be assessed by inspection and palpation.¹⁰ Quantification of the function of the pelvic floor muscles is not easy, due to the lack of simple to use and reliable measurement techniques, and the lack of cut-off values for pathological conditions. Furthermore, the reproducibility of testing is questionable.

*Visual inspection.*¹¹

⁵Fecal incontinence in the Rome II criteria is defined as: recurrent uncontrolled passage of fecal material [Whitehead et al., 1999].

⁶Pelvic organ prolapse is frequently associated with a feeling of rectal fullness of pelvic heaviness or a bearing down sensation especially when standing [Bump et al., 1996].

⁷Dyspareunia is the symptom of painful sexual intercourse.

⁸Chronic pelvic pain is non-malignant pain perceived in structures related to the pelvis of either men or women [Fall et al., 2004].

⁹Pelvic pain syndrome is the occurrence of persistent or recurrent episodic pelvic pain associated with symptoms suggestive of lower urinary tract, sexual, bowel, or gynecological dysfunction. There is no proven infection or other obvious pathology [Abrams et al., 2002a].

¹⁰Apart from contraction and relaxation other terms are also thought to be appropriate to the pelvic floor muscles: tone, volume, and force. *Tone* of the pelvic floor muscles is difficult to define and cannot be measured. The *volume* of the pelvic floor muscles can probably be measured with an MRI but the definition of what is to be considered as pelvic floor muscles is not well defined. The *force* of the pelvic floor muscle contraction and related terms like strength, power, endurance, and exhaustion are yet not applicable in clinical practice.

¹¹It is mandatory to give the patient a full explanation as to what to expect during the physical examination, before starting it. An assessment must be discontinued if the patient exhibits any symptoms of distress during the examination. Patient dignity must be considered and maintained at all times [www.gmc-uk.org/standards/intimate.htm].

- Investigators reporting pelvic floor muscle studies should state the position of the patient (supine, lithotomy, lateral, standing) and the time of the day. When appropriate the verbal instructions given to the patient should be literally written down. Also, additional instruments used should be described.
- Inspection of the vulva,¹² perineum and anus in women and of perineum and anus in men is performed to look for skin pathology and anatomical abnormalities. Testing for pelvic organ prolapse¹³ is an integral part of the physical examination of every patient with pelvic floor muscle complaints. A vaginal and rectal exam is part of this investigation.
- During inspection, the patient is asked to perform a pelvic floor muscle contraction. Good instruction is mandatory: ask the patient to prevent the escape of gas or urine. In the normal situation, a pelvic floor muscle contraction will lead to ventral and cranial movement of the perineum.
- When the patient is asked to cough, the perineum should show no downward movement; ventral movement may occur because of the guarding action of the pelvic floor muscles.
- Anal/rectal prolapse can be evaluated by asking the patient to strain, as if defecating, while seated on a commode chair.
- Perineal elevation is the inward (cephalad) movement of the vulva, perineum, and anus.
- Perineal descent is the outward (caudal) movement of the vulva, perineum, and anus. The position of the anus and the perineum should be noted at rest and during straining. If perineal descent is seen, when the patient has been asked to contract the pelvic floor muscles, this indicates that the patient is straining instead of contracting the pelvic floor muscles.
- Extra-pelvic muscle activity is the contraction of muscles other than those that comprise the pelvic floor, for example the abdominal, gluteal and adductor muscles. Extra-pelvic muscle activity is needed for maximal pelvic floor muscle effort.¹⁴

¹²The condition of the vulva and vagina (atrophy, inflammation) should be noted. A touch test is advised. In this test, the introitus is touched lightly with a cotton swab at different points. Normally this does not hurt but in patients with a vulval pain syndrome it will be classified as painful.

¹³In female patients, the ICS POPQ system is advised [Bump et al., 1996]. In female and male patients attention should also be focused on the anus, looking for rectal or anal prolapse.

¹⁴The two muscle groups, pelvic floor, and transversus abdominis are now understood to be part of the local muscle system of lumbo-pelvic stability. The other components are the diaphragm and the deep fibers of musculus multifidus. Increase in abdominal muscle activity is synergistic with increase in pelvic floor muscle activity [Sapsford et al., 2001; Neumann and Gill, 2002].

*Digital palpation*¹⁵

- Investigators reporting pelvic floor muscle studies should state the position of the patient (supine, lithotomy, lateral, standing) and the time of the day. When appropriate the verbal instructions given to the patient should be literally written down. Also additional instruments used should be described. In the case of digital palpation, the number of fingers used should be noted.
- Digital palpation of the pelvic floor muscles is an easy to perform physical examination. Digital palpation is used to assess the pelvic floor muscles and surrounding areas at rest, and during contraction and relaxation. The pelvic floor muscles are palpated circumferentially.
- Digital palpation is also used to test for pain. Digital pressure on the pelvic floor muscles may reproduce or intensify the patient's pain. This pain-sign can be unilateral.
- **Voluntary contraction** of the pelvic floor muscles means that the patient is able to contract the pelvic floor muscles on demand. A contraction is felt as a tightening, lifting, and squeezing action under the examining finger. A voluntary contraction can be absent, weak, normal, or strong.¹⁶
- **Voluntary relaxation** of the pelvic floor muscles means that the patient is able to relax the pelvic floor muscles on demand, after a contraction has been performed.¹⁷ Relaxation is felt as a termination of the contraction. The pelvic floor muscles should return at least to their resting state. A voluntary relaxation can be absent, partial, or complete.¹⁸

¹⁵The gloved and lubricated index finger of the examiner is introduced into the vagina (women) or the anus (women/men). Digital palpation should be performed with the patient in the supine and standing position. In the supine position, the hips and the knees should be flexed. If the knees are bent, the patient should not hold the legs herself, legs should be relaxed. Palpation is performed with one finger because two fingers may stretch the pelvic floor muscles and thereby influence the ability to contract. It is important to be very clear as to what is expected from the patient. Asking for a pelvic floor contraction will not be enough in most cases. The instruction "lift" and "squeeze" are useful. Palpation with two fingers in the supine position is used to measure the genital hiatus and to get information on the pelvic organs. For anal palpation, the patient is put in left lateral position.

¹⁶A voluntary contraction can be absent: if no contraction is palpated or present: if a contraction is palpated which can be either weak, normal, or strong. If there is no voluntary contraction noted this does not exclude involuntary or unconscious contractions. Contraction should be tested in both the supine and the standing position to see if contraction against gravity is possible.

¹⁷Relaxation of the pelvic floor muscles should be tested after a contraction. Therefore the investigator should always start with a contraction and then ask for relaxation.

¹⁸A voluntary relaxation after a contraction means that this pelvic floor contraction is terminated. The pelvic floor will come back to its resting state (partial relaxation) or below (complete relaxation). When there is no relaxation palpable it is called absent; this does not exclude involuntary or unconscious relaxations.

- The quantification of a contraction is problematic.¹⁹ There is no validated scale to quantify contractions of the pelvic floor muscles. Therefore quantification, more than absent, weak, normal, or strong is not recommended.
- **Involuntary contraction** of the pelvic floor muscles is the contraction that takes place preceding an abdominal pressure rise, such as due to a cough, to prevent incontinence. An involuntary contraction can be absent or present.²⁰
- **Involuntary relaxation** of the pelvic floor muscles is the relaxation that takes place when the patient is asked to strain as if defecating. An involuntary relaxation can be absent or present.
- **Non-contracting pelvic floor** means that during palpation, there is no palpable voluntary or involuntary contraction of the pelvic floor muscles.
- **Non-relaxing pelvic floor** means that during palpation, there is no palpable voluntary or involuntary relaxation of the pelvic floor muscles.
- **Non-contracting, non-relaxing pelvic floor** means that during palpation, there is neither a palpable contraction nor a palpable relaxation of the pelvic floor muscles.
- If vaginal palpation shows a marked asymmetry in pelvic floor muscle function this should be stated. There can be a difference between the posterior and anterior muscles of the pelvic floor or between left and right.

Additional tests for pelvic floor muscle dysfunction.

Additional test can be used to get more, partly indirect information, on the function of the pelvic floor muscles. Electromyography, pressure measurements, and imaging are the most important additional tests to be used.

EMG

- Investigators reporting pelvic floor muscle studies should state the position of the patient, the type of electrode, and the recording equipment used. When appropriate the verbal instructions given to the patients should be literally written down.
- EMG of the pelvic floor muscles may be performed using surface- or needle-electrodes. The techniques are quite different, as is the inconvenience for the patient. The results are also quite different in nature. Surface electrodes are non-selective because of their large surface area; they yield information on normal function and dysfunction (either neurological or non-neurological). Needle electrodes are

¹⁹The Oxford scale is used most frequently, but inter-observer variability has been reported to be high. Modified scales have been used but the simplest classification is absent, weak, normal, and strong. With every scale one has to realize that there is no gold standard to refer to [Bo and Finckenhagen, 2001].

²⁰In an effort to raise abdominal pressure the thoracic, diaphragmatic, and abdominal muscles act together with the pelvic floor muscles. Anticipatory or feed forward contractions help to increase urethral closing pressure before the increase in abdominal pressure.

more selective and can also be used to assess neurological conditions that may involve the pelvic floor muscles.

- Intra-vaginal or intra-anal EMG probes will give the same (functional) information as surface electrodes.²¹
- During a voluntary contraction of the pelvic floor muscles, the intensity of the EMG signal should increase. When the patient is asked to hold the contraction, a sustained high intensity on the EMG can be observed. At the subsequent relaxation, the intensity will fall to or even below baseline.

Pressure measurements

- Investigators reporting pelvic floor muscle studies should state the position of the patient and the type of transducers, balloons, and EMG was used.
- Urodynamics can be done to obtain insight into the function of the lower urinary tract. Special attention should be paid to the function of the pelvic floor muscles in relation to the bladder. Simultaneous measurement of the pelvic floor EMG, during the micturition phase can demonstrate the mechanism of dysfunctional voiding.
- Anorectal manometry assesses continence mechanisms by determining: (a) rectal volume required for sensation of distension and urgency to defecate, (b) rectal compliance, (c) voluntary contractions of the external anal sphincter, and (d) the resting pressure in the anal canal. Water perfused and solid state pressure transducers are used in combination with a balloon positioned in the anal canal. EMG of the anal canal can be added but should not be used alone.²²

Imaging

- Investigators reporting pelvic floor muscle studies should state the position of the patient and the type of equipment used. For measurements, it should be stated which referral points and lines are used, and how for example the descent is computed. For ultrasound and MRI the type of transducer or coil should be stated. When appropriate the verbal instructions given to the patient should be literally written down.
- Several imaging techniques are used to assess the pelvic floor and the organs of the pelvis. Most techniques are radiological and many still have to be classified as experimental.²³
- Ultrasound can be performed with an endovaginal or endoanal probe, or with an external probe on the introitus

²¹EMG of the pelvic floor muscles using surface electrodes gives insight into the function of the pelvic floor muscles both to the examiner and to the patient. It should be kept in mind that with the use of surface electrodes other muscles will contribute to the EMG signal.

²²For a complete description see the Rome II report: functional disorders of the anus and the rectum [Whitehead et al., 1999].

²³In a state of the art article in Radiology, an overview of the imaging techniques that are available, their indications and limitations was presented [Stoker et al., 2001].

or perineum. The position of the bladder neck in relation to the symphysis pubis is an important landmark. During the investigation, the patient can be asked to contract the pelvic floor muscles and this can be seen to result in an elevation of the bladder neck. Anal ultrasound is used to define structural defects in the anal sphincter.

- Fluoroscopy is the oldest technique used to indirectly image the pelvic floor and the pelvic organs. Filling of the intestine, colon, rectum, and vagina with contrast medium is known as evacuation proctography or defecography. A lateral projection is important to get the best information. At rest the anatomical position of the pelvic organs and the pelvic floor can be visualized. Subsequently the patient can be asked to strain and can be asked to contract the pelvic floor muscles. The changes in the anatomical positions can then be observed.
- Video-urodynamics combines the techniques of urodynamics and fluoroscopy. This will give extra insight into the relationships between pelvic floor anatomy and function of the bladder and urethra.
- MRI is the newest technique for imaging of the pelvic floor. The use of endoluminal coils is advised in order to obtain adequate images of the pelvic floor and the related structures. Dynamic MRI can be used to observe the movement of the pelvic floor during Valsalva manoeuvre, a defecatory effort and during pelvic floor muscles contraction. It can also be used for the detection of pelvic organ prolapse.
- Different imaging techniques are used for different indications.²⁴

Other techniques. Several diagnostic tests can be used to get more indirect proof of the function of the pelvic floor muscles.

- A bladder diary is an important investigation in lower urinary tract symptoms.
- A defecation diary will help in investigating anorectal symptoms.
- Neurophysiological investigations like pudendal nerve latency time is used when there is suspicion of a neurological problem causing pelvic floor muscle dysfunction.

²⁴*Cystourethrography*, the oldest technique used to indirectly image the pelvic floor is especially useful in detecting cystoceles. *Evacuation proctography* is used for detecting rectoceles, enteroceles, intussusception, anal prolapse, and obstructive defecation. *Ultrasound* of bladder and urethra has still not to be seen as a routine investigational technique for pelvic floor muscle imaging but certainly has advantages: no ionizing radiation and little discomfort for the patient. Ultrasound of the anal sphincter is a cornerstone of the diagnostic work-up of anal incontinence. *Magnetic resonance imaging* is the latest developed technique and seems to have great ability to image all the different structures in the pelvis including the pelvic floor itself. For *urinary incontinence* none of the imaging techniques plays a cardinal role in the diagnostic workup. The value of imaging lies in the detection of concomitant anatomical and functional defects. The use of imaging techniques has to be considered when surgical reconstruction of the pelvic floor is planned. For *anal incontinence*, endo-anal ultrasound is the most important single test.

Conditions. *Conditions* are defined by the presence of characteristic symptoms associated with specific signs. Based on symptoms and signs the following conditions can be determined.²⁵

Normal pelvic floor muscles. A situation in which the pelvic floor muscles can voluntarily and involuntarily contract and relax. Voluntary contraction will be normal or strong and voluntary relaxation complete. Involuntary contraction and relaxation are both present.

Overactive pelvic floor muscles. A situation in which the pelvic floor muscles do not relax, or may even contract when relaxation is functionally needed for example during micturition or defecation. This condition is based on symptoms such as voiding problems, obstructed defecation, or dyspareunia and on signs like the absence of voluntary pelvic floor muscle relaxation.

Underactive pelvic floor muscles. A situation in which the pelvic floor muscles cannot voluntarily contract when this is appropriate. This condition is based on symptoms such as urinary incontinence, anal incontinence, or pelvic organ prolapse, and on signs like no voluntary or involuntary contraction of the pelvic floor muscles.

Non-functioning pelvic floor muscles.²⁶ A situation in which there is no pelvic floor muscle action palpable. This condition can be based on any pelvic floor symptom²⁷ and on the sign of a non-contracting, non-relaxing pelvic floor.

Directions for future research.

The ICS wants to stress the need for future research in the field of pelvic floor muscle function and dysfunction. The following directions are thought to be important.

- Studies on inter- and intra-observer variability for testing of the pelvic floor muscle signs as described in this report.
- Studies on the development of disease specific pelvic floor muscle dysfunction questionnaires.
- Studies on the normal values for pelvic floor muscle function when measured with EMG.
- Studies on the possibility to measure and quantify pelvic floor muscle tone, force, and volume.
- Studies on the relation of pelvic floor muscle dysfunction as described in this report and the symptoms mentioned by the patients.

²⁵There is no strict relation between a symptom and the condition of the pelvic floor muscles. An overactive pelvic floor muscle can lead to voiding problems but in some situation also to incontinence. The examples in this text are the most common relations.

²⁶Non-functioning means that there is no activity at palpation. This does not exclude activity of the muscles in other situations neither does it rule out activity that is below the detection border of palpation.

²⁷When there is no contraction or relaxation palpable, it is the resting activity of the pelvic floor muscles that determines the symptoms. When there is a high resting activity the symptoms will likely be: voiding symptoms, obstructive defecation, or dyspareunia. When the resting activity is low, symptoms like stress urinary incontinence, fecal incontinence, or prolapse may be the complaints presented by the patient.

ADDENDUM

The ICS Pelvic Floor Clinical Assessment group was announced at the ICS meeting in Denver in 1999. The members of the committee were invited to be active in the group right after that meeting. The members invited are all experts on their own field of healthcare in relation to pelvic floor muscle function. Members are from seven different disciplines: urology, gynaecology, surgery, gastro-enterology, physical therapy, sexology, and neurology. Members came from seven different countries reflecting the worldwide covering of the ICS. The group had a yearly discussion during every ICS meeting. The first draft of the report was put on the Internet at the ICS website (www.icsoffice.org) in 2001 and presented in 2002 in Heidelberg. As a result of the discussion with the members of ICS, the report was rewritten and made more compact. This version was then commented on by 25 ICS members and put on the website. During the meeting in Florence in 2003, the new version based on this comments was discussed and accepted by the ICS general meeting. The document was then again put on the internet for further comments.

Members of the committee were: John Benson, Bary Berghmans, Kari Bø, Jacques Corcos, Clare Fowler, Jo Laycock, Peter Lim Huat Chye, Rik van Lunsen, Guus Lycklama ⁶ Nijeholt, Bert Messelink (chairman), John Pemberton, Alex Wang, Alain Watier.

The committee wants to say special thanks for their extensive and repeated comments to Paul Abrams, Linda Cardozo, and John DeLancey.

ACKNOWLEDGMENTS

We thank the persons who have given their written comments on the document: Walter Artibani, Wendy Bower, Grace Dorey, Karel Everaert, Jannet Haslam, David Fonda, Helena Frawley, Marijke Van Kampen, Francesco Pesce, Pirkko Raivio, Dirk De Ridder, Ruth Sapsford, Bernard Schuessler, Mark Vierhout, Ragi Wiygul, Jean Jacques Wyndaele.

REFERENCES

- Abrams P, Cardozo L, Fall M, et al. 2002a. The standardisation of terminology of lower urinary tract function: Report from the Standardisation Subcommittee of the International Continence Society. *Neurourol Urodyn* 21:167–78.
- Abrams P, Cardozo L, Khoury S, et al., editors. 2002b. 2nd International Consultation on Incontinence. 1081p.
- Bo K, Finckenhagen HB. 2001. Vaginal palpation of pelvic floor muscle strength: Inter-test reproducibility and comparison between palpation and vaginal squeeze pressure. *Acta Obstet Gynecol Scand* 80:883–87.
- Bump RC, Mattiasson A, Bø K, et al. 1996. The standardization of terminology of female pelvic organ prolapse and pelvic floor dysfunction. *Am J Obstet Gynecol* 175:10–17.
- DeLancey JOL. 1992. Anatomy of genital support. In: Benson JT, editor. *Female pelvic floor disorders*. New York: Norton Medical Books. pp 19–26.
- Fall M, Baranowski AP, Fowler CJ, et al. 2004. EAU guidelines on chronic pelvic pain. *Eur Urol* 46:681–89.

- Fucini C, Ronchi O, Elbetti C. 2001. Electromyography of the pelvic floor musculature in the assessment of obstructed defecation symptoms. *Dis Colon Rectum* 44:1168–75.
- Neumann P, Gill V. 2002. Pelvic floor and abdominal muscle interaction: EMG activity and intra-abdominal pressure. *Int Urogynecol J* 13:125–32.
- Sapsford RR, Hodges PW, Richardson CA, et al. 2001. Co-activation of the abdominal and pelvic floor muscles during voluntary exercises. *Neurourol Urodyn* 20:31–42.
- Stoker J, Halligan S, Bartram CI. 2001. Pelvic floor imaging. *Radiology* 218:621–41.
- Thompson WG, Longstreth GF, Drossman DA, et al. 1999. Functional bowel disorders and functional abdominal pain. *Gut* 45:1143–47.
- Weber AM, Abrams P, Brubaker L, et al. 2001. The standardization of terminology for researchers in female pelvic floor disorders. *Int Urogynecol J Pelvic Floor Dysfunct* 12:178–86.
- Whitehead WE, Wald A, Diamant NE, et al. 1999. Functional disorders of the anus and rectum. *Gut* 45:1155–59.

Pelvic floor dysfunction is an umbrella term for a variety of disorders that occur when pelvic floor muscles and ligaments are impaired. Although this condition predominantly affects females, up to 16% of males suffer as well. Symptoms include pelvic pain, pressure, pain during sex, incontinence, incomplete emptying of feces, and visible organ protrusion. Tissues surrounding the pelvic organs may have increased or decreased sensitivity or irritation resulting in pelvic pain. Underlying causes of Original Editor - Kirsten Ryan. Top Contributors - Redisha Jakibanjar , Laura Ritchie , Mandy Roscher , Kirsten Ryan and Nicole Hills. Related online courses on Physioplus. Online Course: Functional Anatomy of the Male Pelvic Floor Online Course: Functional Anatomy of the Male Pelvic Floor Explore the important aspects of the structures and functions of the male pelvic diaphragm Powered by Physiopedia Start course Presented by: Pierre Roscher Pierre is a South African Physiotherapist with a special What causes pelvic floor dysfunction? What is the best exercise for the pelvic floor? Key facts about the muscles of the pelvic floor. Gross anatomy. The pelvic floor muscles also provide additional support during childbirth to the presenting fetal part “ the part closest to the uterine outlet. It holds the fetus in place while the uterine cervix dilates and contracts. It also keeps the presenting part of the fetus in the anteroposterior plane of the pelvic outlet to further support the process of delivery. The weakening of the pelvic floor muscles can lead to incontinence as well as a pelvic organ or rectal prolapse. There are some exercises that can help improve problems with urine leakage or bowel control.