

Application Effect of Comprehensive Pelvic Floor Rehabilitation Therapy in Patients with Myofascial Pelvic Pain Syndrome

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Abstract: *Objective:* To explore the application effect of comprehensive pelvic floor rehabilitation therapy in patients with myofascial pelvic pain syndrome (MPPS). *Methods:* A total of 84 MPPS patients admitted to the pelvic floor rehabilitation clinic of Shaanxi Provincial People's Hospital from December 2023 to June 2025 were divided into an observation group and a control group, with 42 cases in each group. The control group received pelvic floor electrical stimulation, while the observation group received a 5-week, 15-session comprehensive pelvic floor rehabilitation program including myofascial manual release, diaphragmatic breathing training, electrical stimulation, biofeedback, magnetic stimulation and home Kegel training. The numerical rating scale (NRS) of pelvic floor pain and the dyspareunia scores were compared before treatment, at the end of treatment and one month after treatment; the Glazer surface electromyography (sEMG) parameters and the Nottingham Health Profile (NHP) scores were compared at the end of treatment; clinical efficacy was also evaluated. *Results:* At the end of treatment and at the one-month follow-up, the observation group showed significantly lower NAS scores, pre-/post-resting potentials and the coefficient of variation of pre-resting potential, and higher amplitudes of rapid, sustained and endurance contractions, together with lower NHP scores and dyspareunia scores, than the control group (all $p < 0.05$); the total effective rate was 92.3 % in the observation group versus 73.7% in the control group ($p < 0.05$). *Conclusion:* Comprehensive pelvic floor rehabilitation therapy can effectively relieve pelvic floor pain, reduce pelvic floor muscle hypertonicity and improve pelvic floor electrophysiological function and quality of life in MPPS patients, and is superior to electrical stimulation alone.

Keywords: Myofascial pelvic pain syndrome; Comprehensive rehabilitation; Physical therapy; Pelvic floor dysfunction; Nursing

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1. Introduction

Myofascial pelvic pain syndrome (MPPS) is a chronic pelvic pain caused by involuntary spasms, tension bands, and myofascial trigger points (MTrPs) of the pelvic floor muscles, including the piriformis, levator ani, iliopsoas, and obturator internus muscles. It manifests as pelvic floor muscle hypertonicity, myalgia,

overexertion, and fatigue, which worsens with prolonged sitting and may be accompanied by dyspareunia, urinary and defecation abnormalities ^[1,2]. Epidemiological data from abroad show that the prevalence of chronic pelvic pain in women is 5.7% to 26.6%, of which about 15% are related to myofascial pain ^[3]; the reported incidence of MPPS in postpartum and reproductive-age women in my country is 14% to 23% ^[4]. The etiology of this disease is complex, the clinical manifestations lack specificity, and the diagnosis and treatment involve multiple disciplines such as gynecology, urology, and rehabilitation. The disease awareness rate is low, and it is easy to misdiagnose or miss the diagnosis. It has become a common disease that endangers women's physical and mental health and quality of life ^[1,5].

Currently, the treatment of MPPS mainly includes medication, psychological intervention, physical therapy, and acupuncture. Among them, physical therapy is the most widely used due to its simple operation, non-invasiveness, and safety ^[6]. Commonly used physical therapy methods include myofascial manipulation, transcutaneous electrical nerve stimulation, pelvic floor muscle training, biofeedback, radiofrequency and magnetic stimulation, etc., but the effect of a single treatment method is limited ^[6-8]. The European Association of Urology (EAU) guidelines for chronic pelvic pain and related expert consensus recommend that myofascial pelvic pain should be treated with an individualized comprehensive plan that combines multiple methods with pelvic floor physical therapy as the core ^[3,9]. Based on clinical needs, the pelvic floor rehabilitation clinic of our hospital has integrated myofascial release, abdominal breathing training, electrical stimulation, biofeedback, magnetic stimulation, and home training to construct a set of comprehensive pelvic floor rehabilitation techniques. This study uses a randomized controlled trial design to evaluate the application effect of this comprehensive plan in MPPS patients, aiming to provide a basis for standardized nursing intervention for MPPS. The results are reported below.

2. Materials and methods

2.1. General information

The convenience sampling method was used to select MPPS patients who visited the pelvic floor rehabilitation clinic of the Department of Gynecology of Shaanxi Provincial People's Hospital from December 2023 to June 2025 as the research subjects. The diagnostic criteria were formulated with reference to "Myofascial Manipulation for Musculoskeletal Pain", and the main criteria were: regional pain; abnormal sensation in the expected distribution area of trigger point referred pain; palpable tension bands in the affected myofascia; severe punctate tenderness at a certain point of the tension band; and a certain degree of motor limitation ^[10].

2.1.1. Inclusion criteria

- (1) Meeting the above diagnostic criteria;
- (2) Chronic pelvic pain ≥ 6 months;
- (3) Having a history of sexual activity and not receiving related treatment within 1 month before enrollment;
- (4) Not participating in other clinical trials and being able to adhere to treatment and follow-up;
- (5) Informed consent and signing of informed consent form.

2.1.2. Exclusion criteria

- (1) Contraindications to electro- or magnetic-stimulation therapy (epilepsy, pacemaker implantation,

- malignant tumors, presence of local metal implants, etc.);
- (2) Pain caused by acute inflammation or tumors of the urinary, reproductive, or digestive systems;
 - (3) Mental illness or cognitive impairment;
 - (4) Comorbid severe heart, brain, liver, kidney, or vascular diseases.

This study was approved by the Ethics Committee of our hospital. Patients meeting the criteria were randomly assigned to an observation group and a control group using a random number table, with 42 patients in each group. During the study, 3 patients dropped out of the observation group (2 due to job transfer, 1 due to menstrual interruption) and 4 patients dropped out of the control group (2 due to travel difficulties, 2 lost to follow-up). Ultimately, 39 patients in the observation group and 38 patients in the control group completed the study. There were no statistically significant differences in age, disease duration, body mass index (BMI), education level, and type of medical insurance between the two groups ($p > 0.05$), indicating comparability (see **Table 1**).

Table 1. Comparison of general information between the two groups of patients

Project	Observation group (n = 39)	Control group (n = 38)	Statistic	p-value
Age (years, $\bar{x} \pm s$)	38.6 ± 7.2	39.1 ± 7.5	$t = 0.297$	0.767
Disease course (months, $\bar{x} \pm s$)	14.8 ± 6.3	15.2 ± 6.7	$t = 0.268$	0.789
BMI (kg/m ² , $\bar{x} \pm s$)	22.9 ± 2.8	23.1 ± 2.6	$t = 0.322$	0.748
Educational level (e.g., college degree or above / high school or below)	26/13	24/14	$\chi^2 = 0.116$	0.733
Medical insurance type (e.g.) Employees/Residents and others	28/11	25/13	$\chi^2 = 0.302$	0.583

2.2. Methods

2.2.1. Control group

Pelvic floor electrical stimulation therapy was administered. The patient emptied her bladder and assumed a semi-recumbent position with the backrest at approximately 120°; the legs were naturally extended with the feet externally rotated by about 30°, and the entire body was relaxed. A lubricated vaginal electrode was inserted into the vagina, ensuring the metal electrode plates were positioned against the lateral vaginal walls, and connected to a neuromuscular stimulation device (PHENIX USB 4, France). Electrical stimulation was delivered at a frequency of 5–20 Hz and a current intensity of 0–100 mA; the intensity was adjusted from low to high, reaching the maximum level the patient could tolerate without discomfort. Each session lasted 20 minutes, with treatments administered three times a week; a full course consisted of 15 sessions over five weeks, with treatment paused during menstruation.

2.2.2. Observation group

Patients in the observation group received comprehensive pelvic floor rehabilitation therapy in addition to the control group's regimen. The treatment course spanned 5 weeks, comprising 15 sessions (3 sessions per week), with each session lasting approximately 40–50 minutes and conducted in specific stages:

- (1) Week 1 (Sessions 1–3)

5 minutes of abdominal breathing for relaxation, with guidance to ensure patient cooperation; 2–3 minutes of myofascial manual therapy (applying lubricant and performing ischemic compression on pelvic

floor muscle trigger points via the vagina, moving from deep to superficial layers; each point was compressed for approximately 10 seconds with pressure adjusted to elicit slight pain); and magnetic stimulation therapy (sacral nerve S2–S4 modulation, with frequency increasing from 5 to 20 Hz based on patient tolerance).

(2) Week 2 (Sessions 4–6)

Pelvic floor electrical stimulation was added to the above regimen, using the same method as the control group.

(3) Weeks 3–4 (Sessions 7–12)

Biofeedback therapy was introduced, converting pelvic floor electromyographic signals into visual and auditory feedback; patients were guided in abdominal breathing, relaxation of the anal and perineal regions, and Kegel exercises using a template (20 minutes per session: 5 minutes of breathing relaxation followed by 15 minutes of template-guided training), alternating between 5–10 seconds of contraction and 10 seconds of relaxation in a progressive manner.

(4) Week 5 (Sessions 13–15)

Consolidation training and instruction on home-based Kegel exercises for post-discharge, requiring at least 120 repetitions daily, totaling over 30 minutes. The entire treatment process was administered by a single rehabilitation nurse who had undergone standardized training and certification, while a physician was responsible for medical management and clinical guidance.

2.3. Observation indicators and evaluation tools

(1) Numerical rating scale (NAS) for pelvic floor muscle pain

Pain intensity is assessed on a scale of 0 to 10, with 0 indicating no pain, 1–3 indicating mild pain, 4–6 indicating moderate pain, and 7–10 indicating severe pain. The higher the score, the more severe the pain. The assessment is conducted by the same nurse before treatment, at the end of treatment, and one month after the end of treatment.

(2) Glazer surface electromyography (sEMG) assessment of pelvic floor muscle

Detected using a biofeedback therapy device, the mean amplitude and coefficient of variation (CV) of the following measurements are recorded sequentially: 60 seconds before rest (relaxation function), 5 rapid contractions (fast-twitch muscle function), 5 consecutive 10-second sustained contractions (10 seconds of contraction followed by 10 seconds of relaxation) (slow-twitch muscle strength and coordination), 60-second endurance contraction (slow-twitch muscle endurance), and 60 seconds after rest (fatigue recovery ability).

(3) Nottingham Health Profile (NHP)

Used to evaluate health-related quality of life. Part 1 contains 38 items in 6 dimensions: physical activity, energy, pain, sleep, social connection, and emotional response. Each dimension has a score of 0 to 100. The higher the score, the more severe the health impairment. The scale has a Cronbach's α coefficient of 0.89 and a content validity index of 0.88^[11].

(4) Painful intercourse score

The painful intercourse diagnostic scale included in the Behavioral Medicine Scale Handbook was used for evaluation. The higher the score, the more severe the painful intercourse.

(5) Clinical efficacy

The NAS reduction rate was used for evaluation. The reduction rate = (pre-treatment score - post-treatment score) / pre-treatment score $\times$ 100%. A reduction rate of $\geq 75\%$ is considered cured, 50% to <

75% is considered significantly effective, 25% to < 50% is considered effective, and < 25% is considered ineffective. The total effective rate = (number of cured + significantly effective + effective cases) / total number of cases $\times$ 100%.

2.4. Statistical methods

Data was entered using EpiData 3.4 with dual-user input and logical error checking. Statistical analysis was performed using SPSS 26.0 software. Normally distributed continuous data were expressed as mean $\pm$ standard deviation ($\bar{x} \pm s$), and independent samples *t*-tests were used for comparisons between two groups. Repeated measures data were analyzed using repeated measures ANOVA. Count data were expressed as number of cases or percentages, and the χ^2 test was used for comparisons. Rank-sum tests were used for comparisons of ordinal data. A *p*-value < 0.05 was considered statistically significant.

3. Results

3.1. Comparison of NAS scores before and after treatment in the two groups

There was no statistically significant difference in NAS scores between the two groups before treatment (*p* > 0.05); at the end of treatment and one month after treatment, the NAS scores of both groups decreased compared with those before treatment, and the observation group was lower than that of the control group, with statistically significant differences (*p* < 0.05). See **Table 2**.

Table 2. Comparison of NAS scores before and after treatment in the two groups (scores, $\bar{x} \pm s$)

Group	Cases(n)	Before treatment	At the end of treatment	One month after treatment
Observation group	39	6.8 $\pm$ 1.3	2.1 $\pm$ 0.9	1.8 $\pm$ 0.8
Control group	38	6.7 $\pm$ 1.4	3.4 $\pm$ 1.1	3.1 $\pm$ 1.0
<i>t</i> -value	—	0.324	5.647	6.321
<i>p</i> -value	—	0.747	< 0.001	< 0.001

3.2. Comparison of Glazer pelvic floor surface electromyography parameters before and after treatment in the two groups

Before treatment, there were no statistically significant differences in Glazer parameters between the two groups (*p* > 0.05). At the end of treatment, the mean amplitudes of the pre- and post-resting potentials and the coefficient of variation of the pre-resting potential were lower in the observation group than in the control group, while the maximum amplitude of rapid contraction, the amplitude of sustained contraction at 10 s, and the amplitude of endurance contraction at 60 s were higher in the observation group than in the control group, and all differences were statistically significant (*p* < 0.05). See **Table 3**.

Table 3. Comparison of Glazer pelvic floor surface electromyography parameters between the two groups at the end of treatment ($\bar{x} \pm s$)

Index	Observation group (n = 39)	Control group (n = 38)	<i>t</i> -value	<i>p</i> -value
Pre-resting potential amplitude (μ V)	2.6 $\pm$ 0.9	3.8 $\pm$ 1.2	4.913	< 0.001
Post-resting potential amplitude (μ V)	2.9 $\pm$ 1.0	4.2 $\pm$ 1.3	4.876	< 0.001
Coefficient of variation of pre-resting potential	0.21 $\pm$ 0.07	0.30 $\pm$ 0.09	4.872	< 0.001

Rapid contraction of maximum amplitude (μV)	48.6 ± 10.2	39.4 ± 9.1	4.147	< 0.001
10 s sustained contraction amplitude (μV)	36.8 ± 8.4	29.5 ± 7.6	3.979	< 0.001
60 s endurance contraction amplitude (μV)	29.4 ± 7.1	23.1 ± 6.5	4.035	< 0.001

3.3. Comparison of NHP scores before and after treatment in the two groups

Before treatment, there were no statistically significant differences in the NHP scores of the two groups ($p > 0.05$). At the end of treatment, the scores of the observation group in all six dimensions—physical activity, energy, pain, sleep, social connection, and emotional response—were lower than those in the control group, indicating a more significant improvement in health-related quality of life ($p < 0.05$). See **Table 4**.

Table 4. Comparison of NHP scores between the two groups at the end of treatment (scores, $\bar{x} \pm s$)

Dimension	Observation group (n = 39)	Control group (n = 38)	t-value	p-value
Physical activity	12.4 ± 6.8	18.7 ± 7.5	3.842	< 0.001
energy	18.6 ± 9.4	28.3 ± 10.6	4.223	< 0.001
pain	15.2 ± 8.1	27.6 ± 9.8	6.021	< 0.001
sleep	16.8 ± 9.2	26.4 ± 10.3	4.286	< 0.001
Social connection	10.5 ± 6.3	16.9 ± 7.4	4.062	< 0.001
Emotional response	17.3 ± 8.6	26.8 ± 9.7	4.513	< 0.001

3.4. Comparison of dyspareunia scores before and after treatment in the two groups

Before treatment, there was no statistically significant difference in the dyspareunia scores between the two groups ($p > 0.05$); at the end of treatment and one month after treatment, the dyspareunia scores in the observation group were lower than those in the control group, and the difference was statistically significant ($p < 0.05$). See **Table 5**.

Table 5. Comparison of sexual dyspareunia scores before and after treatment in the two groups (scores, $\bar{x} \pm s$)

Group	Cases(n)	Before treatment	At the end of treatment	One month after treatment
Observation group	39	7.2 ± 1.5	2.6 ± 1.1	2.2 ± 1.0
Control group	38	7.1 ± 1.6	4.1 ± 1.3	3.8 ± 1.2
t-value	—	0.281	5.429	6.338
p-value	—	0.779	< 0.001	< 0.001

3.5. Comparison of clinical efficacy between the two groups

At the end of treatment, in the observation group, 12 cases were cured, 16 cases showed significant improvement, 8 cases showed improvement, and 3 cases showed no improvement, with a total effective rate of 92.3% (36/39); in the control group, 6 cases were cured, 12 cases showed significant improvement, 10 cases showed improvement, and 10 cases showed no improvement, with a total effective rate of 73.7% (28/38); the difference in efficacy between the two groups was statistically significant ($Z = 2.764$, $p = 0.006$).

4. Discussion

4.1. Comprehensive pelvic floor rehabilitation therapy can effectively relieve pelvic floor pain in MPPS patients.

The results of this study showed that the NAS score and dyspareunia score of the observation group were significantly lower than those of the control group at the end of treatment and 1 month after treatment, and the total effective rate was higher than that of the control group ($p < 0.05$), which is consistent with the results of relevant studies at home and abroad [12–14]. Analysis of the reasons: The core pathological change of MPPS is that the long-term overactivity of the pelvic floor muscles leads to continuous contraction of muscle fibers, local ischemia and hypoxia and the formation of MTrPs [2]. Myofascial release can directly destroy the tension band, relieve muscle spasm, promote local blood circulation and clear pain substances by accurately locating the trigger point through the vagina and applying ischemic pressure; electrical stimulation activates A β nerve fibers through the gate control mechanism, inhibits the transmission of pain signals and promotes the release of endogenous opioid peptides [7]; magnetic stimulation uses pulsed magnetic field to non-invasively regulate the sacral nerve and reduce the excitability of the sympathetic nerve. The three combined with breathing relaxation and biofeedback form a synergistic analgesic effect of “peripheral release–neural regulation–central re-education”, so the analgesic effect is better than that of simple electrical stimulation.

4.2. Comprehensive pelvic floor rehabilitation therapy can improve the electrophysiological function of pelvic floor muscles.

Glazer surface electromyography assessment is an objective indicator for quantifying pelvic floor muscle function. The pre- and post-resting potentials and coefficient of variation reflect the hypertonic state and relaxation ability of the pelvic floor muscles, while the contraction amplitude reflects the strength and endurance of fast and slow muscles. In this study, the resting potentials and coefficient of variation of the observation group were significantly reduced and the contraction amplitudes of each muscle were significantly increased after treatment ($p < 0.05$), suggesting that comprehensive treatment not only reduced the abnormal hypertonicity of the pelvic floor muscles but also enhanced the contraction strength, endurance and coordination of the pelvic floor muscles. This is consistent with the report by Yang Zhijuan et al. on how electrical-stimulation biofeedback combined with manual massage can improve the electromyographic indicators of pelvic floor muscles in MPPS patients [15]. Biofeedback helps patients establish a conditioned reflex between the brain and pelvic floor muscles through sound and image signals, correcting the pattern of “not being able to relax and contracting incorrectly”; abdominal breathing reduces the excitability of the sympathetic nerves and relieves the excessive activity of the bladder detrusor muscle, thereby improving the fatigue and spasm state of the pelvic floor muscles [8].

4.3. Comprehensive pelvic floor rehabilitation therapy can improve patients’ health-related quality of life.

Patients with MPPS suffer from chronic pain, dyspareunia, and abnormal urination and defecation, often leading to secondary anxiety, depression, and sleep disorders, significantly impacting their social and family life [3,4]. In this study, the observation group showed greater improvement in NHP pain, energy, sleep, and emotional response scores compared to the control group after treatment ($p < 0.05$), indicating that with pain relief and improved pelvic floor function, patients’ overall physical and mental well-being and daily activities are enhanced. The comprehensive approach combines nursing assessment, health education, treatment

implementation, and home training guidance, emphasizing patient participation and long-term adherence management, reflecting a patient-centered holistic nursing philosophy.

4.4. Nursing key points and compliance management

MPPS treatment has a relatively long cycle (15 sessions over 5 weeks), and most patients are working women. Because it involves transvaginal procedures, patients are prone to feelings of embarrassment and discomfort. Nursing care should include:

- (1) Thoroughly explaining pelvic floor anatomy and treatment principles before treatment to protect patient privacy and alleviate anxiety;
- (2) Gradually increasing the intensity of manual techniques and electrical stimulation to a level tolerable to the patient;
- (3) Establishing a WeChat follow-up group to remind patients of treatment times and supervise home Kegel exercises to minimize interruptions due to menstruation or work conflicts;
- (4) Having a designated nurse perform treatment and assessments to ensure consistency and data reliability.

5. Conclusion

Comprehensive pelvic floor rehabilitation therapy integrates myofascial manipulation, breathing exercises, electrical stimulation, biofeedback, magnetic stimulation, and home training. It can effectively relieve pelvic floor pain in MPPS patients, reduce pelvic floor muscle hypertonia, improve pelvic floor muscle electrophysiological function, and enhance health-related quality of life. Its short-term efficacy is superior to simple electrical stimulation therapy, and it has good safety profiles, making it worthy of widespread application in gynecological pelvic floor rehabilitation nursing. However, this study was a single-center study with a limited sample size, short follow-up period, and the inability to implement assessor blinding, thus limiting the extrapolation of its conclusions. Future research should include multi-center, large-sample, randomized controlled trials with long-term follow-up and sham stimulation controls to further validate its long-term efficacy and explore standardized operating procedures.

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Disclosure statement

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