Introduction: Sexual dysfunction is defined as “the disturbance in sexual desire and psychophysiological changes that characterize the sexual response and cause interpersonal difficulty and marked distress.” Studies estimate the prevalence in women to be in the 30 to 49% range. Pelvic floor muscle training (PFMT) has been shown to improve UI and POP and in several studies has also secondarily improved some aspects of a woman’s sexual function (SF) and sexual life. Studies suggest physiological mechanisms by which PFMT could improve SF however much of the information comes from lower levels of evidence.

Aim: Primary aim was to conduct of systematic review of the literature studying the impact of PFMT on female SF through RCTs. Secondary aim was to investigate the association between changes in PFM function and improvement in SF.

Study Design: Systematic review

Methods:
- See article for search strategies, study selection process, and data collection process. (Figure 1, pg 1737)
- Risk of bias for the included studies was evaluated using valid and reliable tool: Physiotherapy Evidence database Scale (PEDro).
- Data: Because of trial heterogeneity and lack of standardized outcome measures, the authors chose to do a qualitative analysis. These results are summarized in the Tables. Except where specifically noted, interpretation of the included trials, methods, definitions, and units conformed to the standards recommended by the International Continence Society and the International Urogynecological Association.

Results (analysis found 8 RCTs totaling 1341 women)
Data analysis results are grouped under the following headings:
1. Control and Interventions
2. Sexual Function Outcome Measures
3. PFM Function Outcome Measures
4. PFM Function Results
5. Justification Provided for Undertaking PFMT to Affect Sexual Function

This outline will focus on #1 (specifically interventions), 3, 4

Interventions:
- Ranged from PFM strength training alone to PFM strength training with adjunct therapies and group training, POP/continence support strategies, and the addition of non-pelvic muscle exercise (core, stretching, breathing, posture education). All studies examined in the review included instructions to do PFMT at home.
- For details, see Table 3 pgs 1741-1742; my summary of interventions includes: 2/8 used 6 to 8 sec holds followed by 3 or 4 quick contractions (Bo’s protocol). Biofeedback added in 2 protocols and cones added in 1 study. Exercise training progression mentioned only in 1 study, another study had no mention of exercise dose and remaining 6/8 stated frequency and duration goals for study (no mention of how to progress).
• PFM contraction intensity was specified in 3 studies as near-maximum or maximum and the remaining studies did not report on contraction intensity.
• Duration of training ranged from 1 to 9 months.
• Supervision ranged from 1 session of PFM training over 3 months (minimal) to weekly sessions over 6 months (maximal).

PFM Function Outcome Measures
• See Table 5.
• Data related to PFM function found in 5/8 studies; for 2 others, additional data was available in a previous manuscript and a primary study, both predated RCTs used in this review.
• No PFM-related data found in 2 studies.
• Max voluntary contraction and PFM endurance were measured using manometry in 5/8 studies.
• One study each used Modified Oxford Grading Scale, two-channel EMG used to estimate PFM function, and Brink Scale to measure PFM function.

PFM Function Results
See Table 5.
• Increase in PFM strength reported in groups receiving PFM training compared to control group in 2 studies however, there no analysis on whether improved strength was associated with improvements in sexual function.
• No difference in manometry between groups found in 1 study.
• Study found improved Brink score associated with improvements in SUI treatment however, improved PFM function assessed with Brink score was not associated with changes in sexual function related to UI and POP.
• Medium and small correlations found between changes in sexual function and PFM strength and endurance respectively in one study. Women who reported improved sexual function demonstrated increase in PFM strength compared to women who reported unchanged sexual function.
• Adherence to PFMT reported in 5/8 studies listing varied methodologies including attendance to appointments, exercise diaries during active phases and mailed questionnaires post-intervention. Adherence ranged from 19 to 97%.

Discussion

Summary
Authors list clinical recommendations stating this review demonstrates “Level 2 evidence that PFMT seems to improve at least some aspects of sexual function in women either postnatally or those with PFM dysfunction.”

Grade B recommendations that “clinicians may prescribe PFMT to improve sexual function; however, we [study authors] strongly advise that adherence to a dose-effective level of therapy be emphasized and the effects carefully evaluated to confirm whether benefit is conferred.”

Additional benefits of therapy listed including low cost, no adverse advents, may benefit other existing PF disorders and doesn’t preclude treatment for other aspects of sexual dysfunction if required.

Research recommendations: urgent need for RCTs designed to investigate effect of PFMT on sexual function and treatment of sexual dysfunction.