

When to Seek Pelvic Floor Assessment

Understanding Pelvic-Floor Weakness, Tightness, Pain, Incontinence, Prolapse and Sexual Dysfunction in Women and Men

By Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care

Focused Practice in Sexual Disorders & Infertility

BUMS – Hamdard University, Delhi

MD, CGO

Certificate in Infertility – MGBIMS, Delhi

Certificate in Urology – London, UK

Masters in Male Infertility – MasterHealthPro (HealthPro)

Integrated Sexual and Reproductive Health – ISRH, UNFPA

Introduction

Many people have heard the advice:

“Do pelvic-floor exercises.”

Women are often advised to do them after childbirth.

Men may be advised to do them after prostate surgery.

Some people hear that pelvic-floor exercises may help urinary leakage, erections or sexual performance.

But there is an important question that should sometimes come **before** exercise:

What is actually happening to the pelvic floor?

The muscles may be weak.

But they may also be too tight.

They may contract normally but fail to relax.

They may be painful.

They may be poorly coordinated with the bladder or bowel.

There may be prolapse, nerve dysfunction, scar tissue, chronic pelvic pain or another medical condition that requires specific treatment.

In these situations, simply doing more and more strengthening exercises may not solve the problem.



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This is why I consider **pelvic-floor assessment** an important but sometimes overlooked part of sexual, urinary, bowel and reproductive-health care.

Current NICE guidance recognises pelvic-floor dysfunction as a broad group of conditions that can include urinary incontinence, difficulty emptying the bladder, faecal incontinence, bowel-emptying problems, pelvic-organ prolapse, sexual dysfunction and chronic pelvic pain.

The European Association of Urology's current 2026 chronic-pelvic-pain guidance similarly emphasises a personalised, biopsychosocial approach rather than treating every patient with the same intervention.

In this article, I want to explain:

what the pelvic floor is,

what pelvic-floor dysfunction means,

which symptoms should make you consider an assessment,

how symptoms differ between women and men,

why pelvic-floor problems can affect sexual function,

when postpartum women should seek help,

how pelvic-floor symptoms can appear after prostate or cancer treatment,

what happens during a professional assessment,

why “Kegel exercises” are not appropriate for everyone,

and where individualized Unani supportive care may fit within responsible treatment.

What Is the Pelvic Floor?

The pelvic floor is a complex group of muscles, connective tissues, fascia, nerves and supporting structures located at the bottom of the pelvis.

You can imagine these muscles as a flexible muscular support system.

They help support and coordinate the organs of the pelvis.

In women, these include structures such as the:

bladder,

urethra,

uterus,



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vagina,

rectum.

In men, the pelvic floor supports and coordinates structures involving the:

bladder,

urethra,

rectum,

prostate region,

and genital and sexual functions.

RCOG describes the female pelvic floor as layers of muscle supporting the bladder, bowel and uterus.

In men, pelvic-floor muscles also participate in continence, erection and ejaculation. A 2025 review of pelvic physical therapy for male sexual disorders highlights their important relationship with erectile function, ejaculatory function and chronic pelvic pain.

The Pelvic Floor Has to Do More Than Be “Strong”

This is the first principle I want patients to understand.

Healthy muscles need several abilities.

They need to:

contract,

relax,

hold a contraction,

respond quickly when needed,

and

coordinate with other muscles and organs.

For example, pelvic-floor muscles may contract to help prevent urine leakage when you cough.

But they also need to relax appropriately when you pass urine or stool.

During sexual activity, pelvic-floor muscles participate in arousal, erection, ejaculation, orgasm and vaginal function.



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Therefore:

A stronger pelvic floor is not automatically a healthier pelvic floor.

A muscle that is already too tight does not necessarily need more strengthening.

It may need relaxation, coordination, pain treatment or myofascial therapy instead.

What Is Pelvic-Floor Dysfunction?

Pelvic-floor dysfunction means that the pelvic-floor muscles or related support system are not functioning appropriately.

This can occur in several different ways.

A weak or underactive pelvic floor

The muscles may not produce sufficient contraction or support.

This may contribute to:

urinary leakage,

pelvic-organ prolapse,

bowel leakage,

post-prostatectomy incontinence,

or reduced pelvic support.

An overactive or hypertonic pelvic floor

The muscles may remain excessively tense and have difficulty relaxing.

This may contribute to:

pelvic pain,

painful intercourse,

painful ejaculation,

urinary hesitancy,

constipation,

incomplete emptying,

genital discomfort.

Poorly coordinated pelvic-floor muscles



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The muscles may be strong enough but activate at the wrong time.

For example, a person may tighten instead of relax while attempting to empty the bowel.

Pelvic-floor injury

Muscles, connective tissue or nerves may be affected by:

pregnancy,

childbirth,

pelvic surgery,

prostate surgery,

pelvic radiation,

trauma.

One patient can also have more than one problem simultaneously.

Why Pelvic-Floor Assessment Matters

Suppose two women both experience painful intercourse.

The first has a weak pelvic floor.

The second has an overactive, painful pelvic floor.

If both are simply told:

“Do more Kegel exercises,”

one may improve while the other may become more uncomfortable.

Likewise, two men may both report urinary problems.

One has weakness following prostate surgery.

Another has pelvic-floor overactivity associated with chronic pelvic pain and difficulty relaxing during urination.

They do not require identical rehabilitation.

NICE therefore recommends actual assessment of pelvic-floor muscle contraction before supervised muscle training for women with urinary incontinence.

This is a very sensible principle:

First understand the dysfunction. Then choose the exercise.



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When Should You Consider a Pelvic-Floor Assessment?

A pelvic-floor assessment is worth considering when you have persistent symptoms involving:

bladder control,

bowel control,

pelvic pressure,

sexual function,

pelvic or genital pain,

or difficulty coordinating urination or defaecation.

You do not need to wait until symptoms become severe.

Early assessment may allow relatively conservative treatment before the condition becomes more troublesome.

Urine Leakage When Coughing, Sneezing or Exercising

If urine leaks when you:

cough,

sneeze,

laugh,

run,

jump,

lift something,

exercise,

you may have **stress urinary incontinence**.

This commonly occurs when pelvic support and urethral closure are insufficient during increases in abdominal pressure.

Pregnancy, childbirth and ageing are important contributors in women.

In men, urinary leakage can occur particularly after prostate surgery.

Pelvic-floor muscle training is one of the most established conservative treatments for female stress and mixed urinary incontinence. NICE recommends at least **three**



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months of supervised pelvic-floor muscle training for women with stress or mixed urinary incontinence.

Cochrane evidence also supports pelvic-floor muscle training for urinary incontinence in women, with better outcomes often seen when programmes are adequately supported and supervised.

Urinary Urgency and Frequent Urination

Some patients tell me:

“When I feel the urge to urinate, I have to run immediately.”

Others urinate very frequently or wake repeatedly during the night.

These symptoms may result from several causes, including:

overactive bladder,

urinary infection,

diabetes,

medications,

pelvic-floor dysfunction,

neurological problems.

Therefore, not every urgency problem is simply a weak pelvic floor.

A proper assessment can help identify the likely cause.

NICE recommends that women with urinary incontinence or overactive-bladder symptoms may benefit from structured assessment including history and a bladder diary.

Difficulty Starting Urination or Emptying the Bladder

Pelvic-floor dysfunction can occasionally produce the opposite problem.

A person may have difficulty:

starting urine flow,

maintaining flow,

relaxing to urinate,



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or feeling completely empty afterward.

This may occur when pelvic-floor muscles remain excessively active during voiding.

But similar symptoms can also result from:

enlarged prostate,

urethral obstruction,

neurological disease,

medication,

bladder dysfunction.

Therefore, difficulty urinating should not automatically be treated with pelvic-floor exercises.

NICE recommends measuring residual urine in women with symptoms suggesting voiding dysfunction or recurrent urinary infections, preferably using bladder scanning rather than catheterisation when possible.

Repeated Urinary Tract Infections

Frequent urinary infections do not automatically mean pelvic-floor dysfunction.

However, incomplete bladder emptying or pelvic-organ prolapse may sometimes contribute to urinary difficulties.

If urinary infections keep returning, especially when accompanied by:

difficulty emptying,

pelvic pressure,

prolapse symptoms,

or abnormal urinary flow,

a broader pelvic assessment may be appropriate.

Bowel Leakage

Pelvic-floor dysfunction can also affect bowel control.

Symptoms may include:

inability to control wind,



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staining of underwear,

leakage of liquid stool,

or faecal incontinence.

Patients often remain silent because these symptoms are embarrassing.

Please do not.

NICE includes faecal incontinence and bowel-emptying disorders among important pelvic-floor symptoms that should be considered during assessment.

Bowel leakage after childbirth may be particularly important when a woman has experienced a third- or fourth-degree perineal tear affecting the anal sphincter.

Constipation Can Sometimes Be a Pelvic-Floor Problem

Constipation is not always caused by diet.

Some people have a problem coordinating the muscles used during defaecation.

Instead of relaxing when stool needs to pass, the pelvic floor may tighten.

A person may report:

prolonged straining,

incomplete bowel movements,

a sensation of blockage,

needing unusual manoeuvres to empty the bowel.

This type of problem requires a different approach from ordinary constipation caused primarily by insufficient fibre or fluids.

Pelvic-floor biofeedback and coordination training may be appropriate in selected patients.

Vaginal Heaviness or a Bulge

A woman who reports:

“I feel something coming down from the vagina,”

or:

“There is a heaviness or bulge inside,”



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may have pelvic-organ prolapse.

Pelvic-organ prolapse occurs when pelvic support structures no longer maintain one or more pelvic organs in their normal position.

The bladder, uterus, vaginal vault or rectum may contribute to the bulge.

NICE recommends that assessment of suspected prolapse include a history of:

prolapse symptoms,

urinary function,

bowel function,

sexual function,

along with physical examination.

For women with selected mild or moderate symptomatic prolapse, supervised pelvic-floor muscle training may be a first-line treatment option.

Painful Sexual Intercourse

Pain during penetration is another important reason to consider pelvic-floor assessment.

A woman may say:

“The muscles seem to close when penetration starts.”

or:

“I feel burning and tightness even though infection tests are normal.”

Pelvic-floor overactivity can contribute to:

dyspareunia,

vulvar pain,

vaginismus-type symptoms,

chronic pelvic pain.

Physical therapy for dyspareunia may involve much more than muscle strengthening.

Depending upon the findings, treatment may use:

relaxation,

manual therapy,



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biofeedback,
breathing work,
gradual muscle retraining,
and individually prescribed exercises.

A 2025 systematic review found considerable variation in pelvic-floor training protocols for women with dyspareunia, underlining why individually assessed treatment is preferable to applying one standard exercise programme to everyone.

If Intercourse Hurts, More Kegels Are Not Automatically the Answer

This deserves emphasis.

If the pain results from pelvic-floor muscles that are already excessively tight, repeatedly contracting them may not address the real problem.

The goal may instead be to teach the pelvic floor to:

relax.

Current EAU guidance for pelvic-floor dysfunction and chronic pelvic pain supports myofascial treatment and, where appropriate, biofeedback and pelvic-floor muscle therapy as part of a broader personalised treatment plan.

Chronic Pelvic Pain

Pelvic pain that continues for months deserves proper evaluation.

The discomfort may occur in:

lower abdomen,

vagina,

vulva,

perineum,

rectum,

penis,

testicles,

prostate region,



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coccyx.

It may worsen with:

sitting,

urination,

bowel movements,

intercourse,

ejaculation.

The pelvic floor is one possible contributor, but chronic pelvic pain can have many causes.

The 2026 EAU guideline emphasises that chronic pelvic pain should be managed using a **biopsychosocial, personalised approach**, often involving medical, physiotherapy and psychological components rather than searching for one universal treatment.

Men Can Have Pelvic-Floor Dysfunction Too

This is something many male patients do not realise.

Pelvic-floor physiotherapy is often incorrectly thought to be only for women after childbirth.

Men also have a pelvic floor.

In men, pelvic-floor problems may contribute to:

chronic pelvic pain,

painful ejaculation,

urinary symptoms,

post-prostatectomy incontinence,

and some sexual dysfunction.

A 2025 review in the *International Journal of Impotence Research* found that pelvic physical therapy has been studied for male erectile dysfunction, premature ejaculation and sexual dysfunction associated with chronic pelvic pain, although the quality of evidence differs between conditions and more research remains necessary.

Pelvic Pain and “Chronic Prostatitis” in Men



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Some men experience:

pelvic or perineal pain,
urinary hesitancy,
discomfort while sitting,
painful ejaculation,
genital discomfort,
for months.

They may repeatedly be told:

“You have prostatitis.”

But not every chronic pelvic pain syndrome is caused by bacterial infection.

Pelvic-floor muscle dysfunction can contribute significantly in selected men.

Current European guidance recognises the role of pelvic-floor myofascial treatment and multidisciplinary care in chronic pelvic pain syndromes.

If repeated antibiotics are not helping and no ongoing bacterial infection has been established, a broader evaluation may therefore be useful.

Painful Ejaculation

Pain during or after ejaculation may arise from several causes, including:

prostate or urinary inflammation,
pelvic surgery,
ejaculatory-duct problems,
nerve pain,
medication,
pelvic-floor dysfunction.

Pelvic-floor assessment may be particularly worth considering when painful ejaculation occurs alongside:

perineal pain,
constipation,
urinary hesitancy,



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chronic pelvic discomfort.

It should not, however, replace urological evaluation for other causes.

Erectile Dysfunction and the Pelvic Floor

An erection depends primarily on:

blood flow,

nerves,

hormones,

psychological arousal,

penile tissue.

But the pelvic-floor muscles also contribute to erectile rigidity.

They help maintain pressure within the penis during erection.

Pelvic-floor rehabilitation has therefore been investigated as an additional treatment for selected men with erectile dysfunction.

A 2025 review concluded that pelvic physical therapy shows potential for improving erectile function, ejaculatory control and sexual satisfaction in selected men, although stronger trials are still needed for several sexual disorders.

This does **not** mean that every man with ED should simply begin pelvic-floor strengthening.

A man with:

diabetes,

vascular disease,

low testosterone,

medication-related ED,

severe anxiety,

still requires evaluation of those factors.

Pelvic-floor therapy may be one component of care, not a replacement for diagnosis.

Premature Ejaculation and Pelvic-Floor Control



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The pelvic-floor muscles participate in ejaculation.

Research has therefore investigated pelvic-floor muscle rehabilitation in selected men with premature ejaculation.

A systematic review found potentially beneficial effects for both ED and premature ejaculation, but study protocols varied substantially and an optimal training programme has not been established.

Again:

assessment should come before promising pelvic-floor exercises as a universal sexual treatment.

After Prostate Surgery

Men who undergo radical prostatectomy may develop urinary leakage.

Pelvic-floor rehabilitation is commonly used to help restore continence.

Current EAU guidance on male lower urinary tract symptoms notes that several studies and meta-analyses suggest pelvic-floor muscle training can shorten time to continence recovery after radical prostatectomy, although the evidence regarding the ideal degree of supervision remains mixed.

A pelvic-floor assessment can help determine:

whether the correct muscles are being activated,

whether compensatory abdominal or buttock muscles are being used,

whether coordination needs improvement,

and whether treatment should include biofeedback or other techniques.

After Pelvic Cancer Treatment

Pelvic-floor assessment may also be useful after treatment for:

prostate cancer,

bladder cancer,

rectal cancer,

cervical cancer,

uterine cancer,



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ovarian cancer,
other pelvic malignancies.
Surgery or radiation may alter:
muscle function,
connective tissues,
nerves,
continence,
sexual function.

Treatment should be coordinated with the oncology and surgical team.

Cancer-related symptoms should never automatically be assumed to be benign pelvic-floor dysfunction without appropriate oncological assessment.

During Pregnancy

Pregnancy places increasing mechanical and hormonal demands on the pelvic floor.

Women may develop:

urinary leakage,
pelvic heaviness,
bowel symptoms,
pelvic pain.

If symptoms are significant, assessment during pregnancy can be helpful.

NICE specifically includes pregnant women in recommendations for supervised pelvic-floor training when stress or mixed urinary incontinence is present.

After Childbirth

The postnatal period is one of the most important times to pay attention to pelvic-floor health.

Pregnancy and childbirth may affect:

muscles,
fascia,



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nerves,

perineal tissues,

anal sphincter.

Possible symptoms include:

urinary leakage,

bowel leakage,

vaginal heaviness,

painful intercourse,

reduced pelvic sensation,

difficulty contracting the pelvic floor.

NICE explicitly recommends asking women who have recently given birth about pelvic-floor dysfunction during routine postnatal care.

RCOG likewise stresses that postpartum women should receive information about pelvic-floor symptoms and know when to seek professional support rather than assuming leakage is simply an unavoidable consequence of childbirth.

“I Just Had a Baby. Should I Wait and See?”

Some mild symptoms improve naturally as the body recovers.

The pelvic floor is commonly weaker immediately after childbirth and sensation may temporarily be reduced. RCOG notes that this often improves over time.

However, assessment should be considered sooner when there is:

substantial urinary leakage,

inability to control stool,

persistent painful intercourse,

a vaginal bulge,

significant perineal pain,

difficulty activating the pelvic floor,

symptoms following a major third- or fourth-degree tear.

Do not wait for years because someone told you:



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“Every woman leaks after having children.”

Common does not mean untreatable.

Around Menopause

Pelvic-floor symptoms may become more noticeable around and after menopause.

Possible problems include:

urinary leakage,

urgency,

prolapse,

recurrent urinary symptoms,

genital dryness,

painful intercourse.

Ageing, previous childbirth, tissue changes and hormonal changes may all contribute.

RCOG specifically identifies menopause as another important life stage for pelvic-floor health education and assessment.

Persistent Lower Back, Hip or Coccyx Pain

Not every back or hip problem comes from the pelvic floor.

But pelvic muscles work together with:

abdominal muscles,

diaphragm,

hips,

spinal stabilisers.

Some chronic pelvic-pain patients experience coccyx, groin, hip or lower abdominal pain together with pelvic-floor muscle tenderness.

A specialist pelvic physiotherapist evaluates the whole region rather than considering the pelvic floor in isolation.

If Pelvic-Floor Exercises Are Making Symptoms Worse



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This is another strong reason to seek assessment.

You may be doing exercises incorrectly.

You may be:

using abdominal muscles instead,

squeezing the buttocks,

holding your breath,

contracting too intensely,

failing to relax fully.

Or strengthening may simply not be the treatment you need.

If urinary symptoms, pain, constipation or painful intercourse worsen after pelvic-floor strengthening, stop assuming:

“I need to do more.”

The programme may need to be reassessed.

What Happens During a Pelvic-Floor Assessment?

Many patients feel embarrassed because they do not know what the assessment involves.

A professional assessment should begin with conversation.

A clinician may ask about:

urinary symptoms,

bowel symptoms,

pregnancy and childbirth,

pelvic surgery,

prostate surgery,

sexual function,

pain,

medications,

medical conditions,

exercise,



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constipation,

previous treatments.

NICE recommends that initial assessment for women consider a broad history including bladder, bowel, prolapse, sexual and chronic-pain symptoms.

Bladder and Bowel Diaries

Sometimes you may be asked to keep a diary recording:

how much you drink,

how often you urinate,

leakage episodes,

urgency,

bowel movements,

pain.

NICE recommends at least a three-day bladder diary as part of the initial assessment of women with urinary incontinence or overactive-bladder symptoms.

A symptom diary can reveal patterns that may not be obvious during a short consultation.

Physical Examination

Depending upon the symptoms and the patient's consent, examination may assess:

posture,

breathing,

abdomen,

hips,

back,

external pelvic region.

A specialist may also assess pelvic-floor muscles internally using a vaginal examination in women or, in selected male patients, rectal examination.

This can provide information about:



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muscle strength,
endurance,
resting tone,
tenderness,
trigger points,
ability to relax,
coordination.

NICE includes digital assessment of pelvic-floor contraction and relaxation among the competencies required within pelvic-floor services.

Internal Examination Should Be Explained and Consensual

A pelvic-floor examination is intimate.

The clinician should explain:

why it is recommended,

what it involves,

what information it may provide.

The patient can ask questions.

The patient can decline.

The patient can request that the examination stop.

Assessment should be performed professionally and respectfully.

There should never be pressure to continue an examination that the patient does not consent to.

Assessing Pelvic-Organ Prolapse

When prolapse is suspected, the clinician may ask a woman to bear down while examining the vaginal support structures.

Specialist assessment may document the degree of prolapse using a recognised system such as **POP-Q—Pelvic Organ Prolapse Quantification**.



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NICE also recommends assessing pelvic-floor muscle activity and looking for vaginal tissue changes during specialist prolapse evaluation.

Routine MRI or CT scanning is not necessary simply to diagnose every vaginal prolapse when physical examination already demonstrates it.

Other Tests Are Sometimes Needed

Pelvic-floor assessment is not only an examination of muscles.

Depending on the symptoms, further evaluation may include:

urine testing,

bladder scan,

uroflowmetry,

urodynamic testing,

pelvic ultrasound,

bowel investigations,

specialist imaging.

Not every patient needs these tests.

NICE recommends first considering other possible causes of pelvic-floor symptoms, including:

urinary infection,

diabetes,

neurological disease,

medication effects,

pelvic masses,

cancer,

inflammatory bladder or bowel conditions,

endometriosis.

This is why simply diagnosing oneself with “pelvic-floor weakness” from internet symptoms can be misleading.



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Pelvic-Floor Treatment Is More Than Kegel Exercises

Treatment may involve:

strengthening,
relaxation,
coordination,
bladder retraining,
bowel retraining,
breathing techniques,
posture,
manual therapy,
myofascial treatment,
biofeedback,
lifestyle modification.

The exact treatment depends on the findings.

When Strengthening Is Appropriate

Strengthening may be useful when true weakness is contributing to problems such as:

stress urinary incontinence,
post-prostatectomy urinary leakage,
selected mild prolapse.

NICE recommends supervised pelvic-floor training for at least three months in women with stress or mixed urinary incontinence and at least four months for selected symptomatic prolapse.

When Relaxation Is More Important

A patient with an overactive pelvic floor may need to learn:

diaphragmatic breathing,
pelvic-floor relaxation,
gradual lengthening,



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coordinated voiding,
myofascial release.

Current EAU chronic-pelvic-pain guidance recognises myofascial treatment and biofeedback as useful components in selected pelvic-floor dysfunction and supports pelvic-floor muscle therapy as part of treatment for sexual complaints associated with chronic pelvic pain.

Biofeedback

Biofeedback can help a patient understand what the pelvic-floor muscles are actually doing.

Sensors or other techniques provide information about muscle activity.

This can help someone learn:

“This is what contraction feels like.”

and just as importantly:

“This is what relaxation feels like.”

EAU guidance reports that biofeedback can improve the outcomes of myofascial treatment in selected pelvic-floor pain conditions.

Manual and Myofascial Therapy

When painful trigger points or excessive muscle tone are present, a specialist physiotherapist may use carefully selected manual techniques.

These are different from strengthening exercises.

The intention is to reduce abnormal muscle tension and restore normal movement and relaxation.

Such treatment should be performed by someone properly trained in pelvic health.

Pelvic-Floor Rehabilitation and Sexual Function

Pelvic-floor rehabilitation can sometimes improve sexual function indirectly by reducing:

pain,

fear of penetration,
urinary leakage during intimacy,
pelvic muscle dysfunction.

In men, emerging evidence also supports pelvic physical therapy as an additional intervention for selected erection and ejaculation problems.

But it should not be marketed as a universal cure for sexual dysfunction.

Sexual problems can also result from:

cardiovascular disease,
diabetes,
hormonal disorders,
medication,
nerve disease,
relationship factors,
psychological distress.

Treatment should address the whole patient.

Pelvic-Floor Dysfunction and Infertility

Pelvic-floor dysfunction is **not a common direct cause of biological infertility** in the same way as:

low sperm production,
blocked fallopian tubes,
ovulation disorders.

However, pelvic-floor problems can indirectly interfere with conception.

For example:

severe painful penetration may make intercourse difficult.

Vaginismus-type symptoms can prevent vaginal intercourse.

Severe pelvic pain may reduce intercourse frequency.

Male pelvic pain or painful ejaculation may interfere with sexual activity.

Therefore, when infertility and sexual difficulty coexist, both should be assessed.



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This is particularly relevant to my clinical work because my focused practice includes both **sexual disorders and infertility**.

The Unani Perspective on Pelvic-Floor-Related Symptoms

The modern anatomical concept of pelvic-floor dysfunction is not identical to classical Unani terminology.

However, classical Unani literature describes several conditions whose symptoms overlap with today's pelvic-floor disorders.

Examples include:

Salasal al-Bawl for urinary incontinence,

and traditional descriptions of uterine prolapse such as **Inzilāq al-Raḥim / Nutu-e-Rahim**.

CCRUM's standard Unani medical terminology describes *Inzilāq al-Raḥim* as a prolapse of the uterus associated in the traditional framework with weakening of uterine supports.

A review of Greco-Arabic/Unani literature on urinary incontinence similarly documents classical descriptions of bladder and muscular weakness, pregnancy and constipation among factors considered in traditional writings. Importantly, the authors also concluded that modern evidence for many herbal interventions remained weak and needed further research.

This distinction is important.

Traditional concepts can inform supportive care.

But modern anatomical and functional pelvic-floor assessment provides information that classical medicine could not measure directly.

How I Use Unani Principles in Pelvic-Floor Patients

As a physician trained in the Unani system, my approach is not to give every patient with urinary leakage or pelvic pain the same herbal medicine.

I first want to understand the clinical problem.

Is there:

true muscle weakness?

muscle overactivity?



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urinary infection?

prolapse?

constipation?

prostate disease?

chronic pelvic pain?

painful sexual activity?

post-surgical dysfunction?

Only then can treatment be rational.

Where appropriate, individualized Unani supportive care may give attention to:

general health,

bowel regularity,

diet,

hydration,

weight,

sleep,

physical activity,

digestive wellbeing,

and selected urinary or reproductive symptoms.

But the structural and muscular problem itself may require pelvic-floor rehabilitation, gynaecological treatment, urological treatment or surgery.

Is There Research on Unani Medicine and Pelvic-Floor Disorders?

There is some preliminary research, but the evidence is much smaller than the evidence supporting established pelvic-floor rehabilitation.

One randomized trial involving 60 women with stress urinary incontinence compared pelvic-floor training plus a combination of *Boswellia serrata* and *Cyperus scariosus* with pelvic-floor training plus placebo.

The study reported greater improvement in the treatment group over eight weeks.

This is interesting and supports further investigation.

However, it was a small study.

It does **not** prove that Unani medicines treat every type of urinary incontinence or pelvic-floor dysfunction.

Similarly, a published Unani case report described management of a patient with advanced uterovaginal prolapse, but a single case report cannot establish a treatment as an alternative to established prolapse management or surgery when surgery is indicated.

Responsible medicine requires us to distinguish:

promising evidence

from

proven standard treatment.

Unani Care Should Complement Pelvic-Floor Rehabilitation

In appropriate patients, I consider the most sensible approach to be integrative.

For example, a woman with stress incontinence may benefit from:

supervised pelvic-floor rehabilitation,

weight and constipation management,

appropriate lifestyle measures,

and individualized Unani supportive treatment where clinically suitable.

A man with chronic pelvic pain may need:

urological evaluation,

pelvic-floor therapy,

pain management,

psychosexual or psychological support,

and carefully selected supportive Unani care.

This does not require choosing one system and rejecting the other.

The patient needs whichever combination safely addresses the actual problem.

Saira Health Care's Approach to Pelvic-Floor Symptoms



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At **Saira Health Care**, my focused practice in sexual disorders and infertility means I frequently encounter pelvic symptoms indirectly.

A patient may initially say:

“I have erectile difficulty.”

Further history reveals chronic pelvic tightness and painful ejaculation.

A woman may say:

“I have lost interest in sex.”

Further discussion reveals that intercourse hurts because the pelvic floor is overactive.

Another patient may present after prostate surgery because urinary leakage has destroyed his sexual confidence.

Therefore, I believe pelvic-floor function should be considered whenever the symptom pattern suggests it.

My Clinical Approach

I begin by asking:

What is the main symptom?

When did it begin?

Was there childbirth?

Pelvic surgery?

Prostate treatment?

Radiation?

Is there leakage?

Pain?

Constipation?

A vaginal bulge?

Difficulty urinating?

Painful ejaculation?

Pain during penetration?

Once the likely pattern is understood, appropriate referral may include:



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pelvic-health physiotherapist,
urologist,
gynaecologist,
urogynecologist,
colorectal specialist,
pain specialist,
psychologist or psychosexual therapist.

Individualized Unani supportive management may then be used where appropriate and safe.

Pelvic-Floor Dysfunction Is Not Something Patients Should Be Embarrassed About

Some patients tolerate leakage for ten years before discussing it.

Others avoid sex because of pelvic pain.

A man may hide painful ejaculation.

A woman may believe that a vaginal bulge is a normal result of ageing.

These problems can significantly affect:

confidence,

sexual activity,

exercise,

work,

relationships,

mental health.

Seeking help early may prevent years of unnecessary restriction.

When You Should Seek Urgent Rather Than Routine Assessment

Most pelvic-floor symptoms are not medical emergencies.

However, certain symptoms should not be treated simply as routine muscle dysfunction.



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Seek urgent medical assessment if you develop **new severe back pain together with sudden changes in bladder, bowel or sexual function, or new numbness around the genitals, anus or inner thighs.**

These can be warning signs of **cauda equina syndrome**, a rare but serious nerve-compression emergency.

NICE recommends immediate referral when severe lower-back pain is accompanied by new bladder, bowel or sexual dysfunction or new perineal numbness.

Likewise, urgent evaluation is needed for symptoms such as:

inability to pass urine,

severe sudden pelvic or testicular pain,

major unexplained bleeding,

fever with significant pelvic pain,

sudden neurological weakness.

A physiotherapy appointment should not delay emergency medical care when neurological or other serious symptoms are present.

Frequently Asked Questions

How do I know if my pelvic floor is weak?

Symptoms such as urine leakage or prolapse can suggest weakness, but symptoms alone cannot always tell us whether the muscles are weak, poorly coordinated or excessively tight.

A professional assessment is more reliable.

Can I test my pelvic floor myself?

You may be able to notice pelvic-floor contraction, but self-testing does not reliably evaluate:

strength,

relaxation,

endurance,

pain,



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coordination.

Avoid repeatedly stopping urine midstream as a routine exercise.

Professional assessment is more appropriate when symptoms exist.

Are Kegel exercises safe for everyone?

No exercise is appropriate for every pelvic-floor condition.

Strengthening is useful for many patients with true weakness.

But patients with overactive or painful pelvic-floor muscles may require relaxation and coordination rather than additional contraction.

How long does pelvic-floor training take to work?

It depends upon the problem.

For female stress or mixed urinary incontinence, NICE recommends at least three months of supervised training.

For selected prolapse, programmes may continue for at least four months.

Pelvic pain treatment follows a different timeline.

Is pelvic-floor physiotherapy only for women?

No.

Men may benefit after prostate surgery and in selected cases involving chronic pelvic pain, urinary dysfunction, erectile difficulties or ejaculation-related problems.

Can pelvic-floor problems cause painful sex?

Yes.

Overactive, painful or poorly coordinated pelvic-floor muscles may contribute to dyspareunia.

But painful sex also has many other possible causes, so proper evaluation is important.

Can pelvic-floor dysfunction cause erectile problems?



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It can contribute in some men.

The pelvic-floor muscles participate in erectile rigidity, but ED is often multifactorial.

Cardiovascular, metabolic, hormonal, neurological and psychological causes still need consideration.

Can pelvic-floor problems cause premature ejaculation?

Pelvic-floor function is involved in the ejaculatory process, and rehabilitation has been studied as one possible treatment for selected men with premature ejaculation.

Evidence is promising but an optimal programme is not yet established.

Can pelvic-floor problems cause constipation?

Yes.

Some patients have difficulty relaxing or coordinating the pelvic floor during defaecation.

This can contribute to obstructed bowel emptying.

Should every woman after childbirth have a pelvic-floor assessment?

Not every woman requires an internal specialist examination.

However, postpartum women should be asked about pelvic-floor symptoms, and those with persistent leakage, bowel-control problems, prolapse, pain or difficulty with muscle control should receive appropriate assessment.

NICE specifically recommends asking recently postpartum women about pelvic-floor dysfunction.

Is urine leakage after childbirth normal?

It is common, but it should not automatically be regarded as something a woman must live with permanently.

If leakage is persistent or troublesome, assessment and treatment are appropriate.

Does a vaginal bulge mean I need surgery?



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Not always.

Treatment depends on severity, symptoms and patient preference.

Selected mild or moderate prolapse may be managed with pelvic-floor therapy, lifestyle management or a pessary.

More advanced or troublesome prolapse may require specialist surgical discussion.

Can pelvic-floor therapy help after prostate surgery?

Yes, especially for urinary continence.

Current European evidence indicates that pelvic-floor training can help shorten continence recovery in some men following radical prostatectomy.

Can Unani medicine strengthen the pelvic floor?

Traditional Unani medicine includes descriptions of conditions such as urinary incontinence and uterine prolapse, and some preliminary clinical research has studied Unani formulations alongside pelvic-floor training.

However, current evidence does not justify claiming that a Unani medicine alone can correct every structural or muscular pelvic-floor disorder.

Direct rehabilitation remains important when muscle function itself is abnormal.

Can I combine Unani care with pelvic-floor physiotherapy?

In appropriately selected patients, yes.

My preference is to identify the pelvic-floor problem accurately, use established rehabilitation where indicated, and incorporate individualized Unani supportive care for relevant general, urinary, reproductive or lifestyle factors when safe.

About Dr. Nizamuddin Qasmi

Dr. Nizamuddin Qasmi

Founder & Chief Physician – Saira Health Care

Focused Practice in Sexual Disorders & Infertility

My professional qualifications and training include:



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BUMS – Hamdard University, Delhi

MD

CGO

Certificate in Infertility – MGBIMS, Delhi

Certificate in Urology – London, UK

Masters in Male Infertility – MasterHealthPro (HealthPro)

Integrated Sexual and Reproductive Health – ISRH, UNFPA

My focused clinical work includes sexual disorders, male reproductive health and infertility.

This frequently requires looking beyond the reproductive organs themselves.

Urinary symptoms, pelvic pain, painful intercourse, painful ejaculation, sexual-performance problems and post-prostate-treatment concerns can sometimes have a pelvic-floor component.

At **Saira Health Care**, my aim is to recognise these connections and help patients reach the correct pathway of treatment rather than repeatedly treating a symptom without identifying its cause.

Saira Health Care's Contribution to Sexual Disorders and Infertility

At Saira Health Care, pelvic-floor assessment is considered when the clinical history suggests that muscle function may be contributing to a sexual or reproductive complaint.

The goal is not to label every sexual condition a pelvic-floor problem.

The goal is to avoid missing a treatable contributor.

Where appropriate, care may involve:

sexual-health assessment,

reproductive-health evaluation,

individualized Unani supportive management,

pelvic-floor physiotherapy,

urological evaluation,

gynaecological or urogynecological assessment,

psychosexual support.

This multidisciplinary approach is particularly useful in conditions where:



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pain, muscle function, sexual function and psychological response interact with one another.

My Message to Patients

If you leak urine when you cough, please do not simply accept it because you have had children.

If sex hurts, do not repeatedly strengthen already tense muscles without knowing why.

If you have pelvic pain, do not assume every symptom is an infection.

If ejaculation hurts, do not remain silent because you are embarrassed.

If you have a vaginal bulge, do not assume surgery is your only option without assessment.

And if exercises from an internet video make you worse, do not assume:

“I need to exercise harder.”

Your pelvic floor is a functional muscular system.

Like any other muscular system, it can be:

weak,

tight,

painful,

injured,

or poorly coordinated.

The correct treatment depends on which of these is happening.

Final Words From Dr. Nizamuddin Qasmi

One of the biggest misconceptions about pelvic-floor health is that every problem requires the same solution:

“Do Kegel exercises.”

Modern pelvic medicine tells us something much more sophisticated.

A patient with weakness may need strengthening.



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A patient with prolapse may need prolonged supervised rehabilitation and sometimes a pessary or surgery.

A patient with chronic pelvic pain may need relaxation and myofascial treatment.

A postpartum woman may need rehabilitation after birth trauma.

A man after prostate surgery may need continence retraining.

A patient with painful sex may have an overactive rather than a weak pelvic floor.

This is why assessment matters.

As a physician trained in Unani medicine and focused clinically on sexual disorders and infertility, I value the traditional whole-person approach—diet, bowel health, sleep, activity, psychological state and general wellbeing.

Traditional Unani literature also contains important historical descriptions of urinary incontinence and uterine-support disorders.

But modern pelvic-floor assessment allows us to understand muscle function in ways that traditional medicine alone cannot directly measure.

I therefore believe in using both responsibly.

At **Saira Health Care**, the aim is not to make exaggerated claims that every pelvic-floor problem can be treated with medicine alone.

The aim is to identify the cause, offer individualized supportive treatment, and involve the appropriate pelvic-health, urological, gynaecological or other specialist when required.

Because the most important question is not:

“Which exercise should I do?”

The first question is:

“What is my pelvic floor actually doing?”

Once that is understood, treatment becomes much more logical, safer and more likely to help.

Important Medical Disclaimer

This article is intended for general patient education and awareness. It does not replace individual medical, urological, gynaecological, colorectal or pelvic-floor physiotherapy assessment.

Pelvic-floor symptoms may sometimes be caused by urinary infection, neurological disease, prostate disease, endometriosis, pelvic masses, cancer, bowel disease or other conditions that require separate investigation.

Do not assume that every urinary, bowel, sexual or pelvic-pain symptom is caused by weak pelvic-floor muscles.

Pelvic-floor strengthening is not appropriate for every patient. Patients with excessive pelvic-floor tone or chronic pelvic pain may need relaxation, myofascial treatment or other specialist therapy.

Unani medicine can contribute supportive, individualized care where appropriate, but should not replace medically indicated pelvic-floor rehabilitation, urological or gynaecological treatment, pessary care, surgery or emergency medical assessment.

Seek urgent medical attention for new severe back pain accompanied by sudden bladder or bowel dysfunction, new genital/perineal numbness, or significant leg weakness because these may indicate serious nerve compression requiring emergency assessment.



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