



Position of the Ibero-American Society of Neurourology and Urogynecology (SINUG) on the treatment of musculoskeletal phenotype in chronic pelvic pain syndrome

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ABSTRACT

Background and objective: Given the high prevalence of the musculoskeletal component in chronic pelvic pain syndrome (CPPS), and the need for improved understanding of its management among healthcare providers, we aimed to review the available evidence addressing musculoskeletal management in primary CPPS.

Methods: The SINUG (Iberoamerican Society of Neurourology and Urogynecology) has designated a multidisciplinary panel including urologists, gynecologists, physiatrists/rehabilitation specialists, and physiotherapists, all with recognized clinical and academic expertise in the field. The development process followed a structured, multi-step methodology inspired by modified Delphi procedures and current guideline-development standards.

Key findings: The musculoskeletal phenotype of CPPS requires multimodal interventions including behavioural, physical, and psychological aspects, combined with multidisciplinary oral or invasive treatments. Isolated interventions tend to have limited effectiveness, and the active participation of the patient is required. Thus, treatment should be delivered by specialized physiotherapists trained not only in the musculoskeletal

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component, but also in the psychological mechanisms underlying this pain process. They must also be prepared to incorporate future therapies that demonstrate scientific efficacy in the management of CPPS. Direct communication between physiotherapists and urologists, gynaecologists, colorectal surgeons, and rehabilitation specialists is essential to coordinate and implement all interventions in this multidisciplinary therapeutic plan. As in all chronic pain processes, referrals of CPPS patients to physiotherapy should occur without delay.

Conclusions: SINUG considers physiotherapy an indispensable therapeutic option within the multidisciplinary treatment of CPPS, not only when a musculoskeletal phenotype is identified, but also when the patient develops a secondary, self-perpetuating painful contracture of the pelvic floor in other phenotypes.

1. Introduction

The European Association of Urology (EAU) defines Chronic Pelvic Pain (CPP) as chronic or persistent pain perceived in structures related to the male or female pelvis, which is often associated with negative cognitive, behavioural, sexual, and emotional consequences, as well as with symptoms suggestive of lower urinary tract, sexual, intestinal, or gynaecological dysfunction [1]. The term “perceived” indicates that pain localization is based on clinical assessment (history, examination, and investigations when appropriate).

The duration must be at least three months, with longer observation sometimes appropriate for cyclical pain. This definition and timeframe are consistent with those proposed by the American College of Obstetrics and Gynaecology (ACOG) [2].

The 11th revision of the World Health Organization's International Classification of Diseases (ICD-11) [3] distinguishes between chronic primary pain, when pain has no clear underlying cause, and chronic secondary pain, when pain is associated with a known diagnosis or condition [4]. This aligns with EAU terminology, distinguishing primary chronic pelvic pain syndrome (PCPPS) from disease-associated CPP syndrome (CPPS) [1].

CPPS comprises heterogeneous symptoms across urological, gynaecological, anorectal, myofascial, sexual, or psychosocial domains, supporting phenotype-based assessment to guide diagnosis and management [5]. These phenotypes aim to create subgroup of patients with a condition, disease, or syndrome who share a similar expression of specific symptoms, signs, and diagnostic parameters [5], but they should only be used when there is adequate evidence (for example, pain localized to a specific organ) to support its application [1,6].

The UPOINT classification, published by Shoskes in 2009 [7] proposed a six-domain classification system (Urinary, Psychosocial, Organ-Specific, Infection, Neurologic/systemic, and Tenderness [UPOINT]) to support multimodal, phenotype-directed treatment [8]. The reproducibility of the UPOINT system and the effectiveness of domain-specific therapy have been re-evaluated in various patient populations worldwide [9]. Subsequently, the Sexual domain was added to this classification (UPOINTS) [10].

The EAU [1] proposes a series of successive axes for the diagnosis of CPPS. The second axis is the system axis, which includes urological, gynaecological, gastrointestinal, sexological, psychological, musculoskeletal, and peripheral nervous system.

Diagnostic evaluation and identification of phenotypes cannot rely solely on clinical presentation; each aspect requires specific assessment. Evaluation should include targeted assessment of musculoskeletal contributors (including pelvic floor muscles, and myofascial trigger points (MTrPs)), as well as neurological and psychological contributors to clarify whether psychosocial factors are contributing drivers and/or consequences [1]. In many settings, specialized pelvic floor physical therapists contribute substantially to initial assessment, including identification of musculoskeletal phenotype as primary or secondary to other CPPS conditions (e.g., bladder pain syndrome or endometriosis) [1,3]. Therefore, a thorough physical examination is essential. In addition, previous pelvic or abdominal surgery should be considered during clinical evaluation, as postoperative scar tissue, nerve irritation, or altered pelvic biomechanics may contribute to secondary pelvic floor

muscle dysfunction or persistent musculoskeletal pain [11].

CPPS has a major negative impact on those who suffer from it. Studies comparing women with and without CPPS report significantly lower quality of life (QoL) scores across physical health, emotional well-being, pain, and mental health domains [12]. Mathias SD et al. demonstrated a strong association between CPPS and distress, disability, poor general health, low satisfaction levels, and substantial healthcare costs [13]. Individuals with CPPS experience greater physical and occupational deterioration, mistrust of treatment, and reduced health-related QoL, and frequently exhibit anxiety, somatization, and depression [14].

Associations have been demonstrated between pain catastrophizing and pain intensity in chronic cases. Pain catastrophizing is associated with greater pain and poorer outcomes, supporting prioritization of psychosocial assessment and management as part of care [12].

1.1. Objective of the document

Considering the high prevalence of the musculoskeletal involvement in CPPS and the need to improve understanding of its management among healthcare providers, SINUG (Iberoamerican Society of Neurourology and Urogynecology) developed this document addressing conservative management of the musculoskeletal phenotype in PCPPS based on available scientific evidence and expert consensus.

2. Materials and methods

This document was developed by SINUG with the objective of providing practical, evidence-informed guidance on the conservative management of the musculoskeletal phenotype PCPPS, with pelvic floor physical therapy (PFPT) as the standard conservative intervention for pelvic floor dysfunction within a multidisciplinary, multimodal care pathway. This is a narrative synthesis used to inform a structured expert consensus process.

A SINUG-appointed multidisciplinary group performed a clinically focused narrative review on musculoskeletal involvement and conservative management strategies. The consensus document was developed by a multidisciplinary panel convened by the SINUG, with clinical and academic expertise in CPPS and pelvic floor dysfunction. Members were selected based on the following criteria:

- ≥ 10 years of clinical experience in CPPS,
- academic or scientific contributions in the field,
- participation in national or international consensus or guideline-development activities,
- geographical representation within the Ibero-American region.

Source selection was guided by clinical relevance and expert judgment, using four main sources: 1. International Continence Society (ICS) terminology standardization documents [5]; 2. recent literature on myofascial pelvic pain; 3. international clinical practice guidelines; and 4. expert opinion from SINUG-appointed members.

Publications were considered when they: 1. included adults with CPPS or myofascial/musculoskeletal pelvic pain; 2. addressed assessment, phenotyping, or mechanisms related to pelvic floor dysfunction

and increased muscle tone (hypertonicity); 3. evaluated rehabilitative, physiotherapeutic, or multimodal interventions applicable to clinical practice; increased muscle tone; or 4. represented international guideline recommendations or terminology standardization documents.

No restrictions were placed on study design, and evidence from clinical trials, observational studies, reviews, and expert guidelines was accepted when deemed clinically informative. Studies outside the scope of musculoskeletal mechanisms or unrelated to the therapeutic modalities discussed in this consensus were excluded.

A modified Delphi methodology was used to develop consensus statements: topic outline development; narrative evidence review; an initial online rating round (9-point Likert scale, assessing relevance/clarity/applicability); a structured virtual consensus meeting to resolve discrepancies and standardize terminology (ICS-aligned); a second rating round for revised statements; and final unanimous approval of the document. Statements with <75% agreement were revised and resubmitted.

Panel members independently reviewed the evidence and proposed preliminary statements, which were discussed and refined through iterative rounds of review. Consensus was predefined as agreement by $\geq 80\%$ of panel members. Disagreements were addressed through structured group discussion and iterative revision of statements. Final recommendations were approved. Recommendations reflect expert consensus informed by available evidence (without formal evidence grading) and may require updating as new evidence emerges.

Consensus was defined a priori as:

- Strong consensus: $\geq 80\%$ of experts rating a statement 7–9.
- Consensus: $\geq 70\%$ agreement (ratings 7–9).
- No consensus: <70% agreement.

All final statements achieved $\geq 80\%$ agreement, indicating strong consensus across the panel.

3. Theory

3.1. Urogynecological pain, increased muscle tone and muscular pain

3.1.1. Differential diagnosis

CPPS is a symptomatic complex that may originate from gastrointestinal, urological, musculoskeletal, neurological, or reproductive system disorders. When the cause of pain is apparent, treatment is directed towards it, but a musculoskeletal component is almost always present. This document addresses pelvic pain and/or dysfunction originating from the pelvic floor muscles, whether in the deep layers (levator ani) or superficial ones (perineal muscles).

Pelvic pain complexity reflects visceral-somatic interactions, shared innervation, peripheral and central sensitization, and psychological factors such as fear and anxiety. Such psychological states may trigger involuntary contraction and increased tone of the pelvic floor muscles. This increased muscle tone may contribute to symptoms such as tension, sexual dysfunction, and difficulty emptying the bladder or bowels. Furthermore, a subset of patients continues to experience pain, often of musculoskeletal origin, despite successful treatment of the underlying cause(s) [15].

Muscle pain generators may arise from dysfunction of the levator ani, piriformis, or perineal muscles due to overuse, strain, sprain, or postural dysfunction [11], or may be secondary to visceral changes or referred from other pelvic structures (hip, sacroiliac joint, vertebrae, pubic symphysis, or coccyx) [16].

Myofascial pain and MTrPs are influenced by interacting mechanical, metabolic, nutritional, and psychological factors affecting muscle tension and nociception. Mechanical factors such as trauma, poor posture, ergonomic stressors, joint hyperlaxity, limb length discrepancy, scoliosis, and pelvic torsion may perpetuate this syndrome [17].

Primary pelvic floor muscle pain syndrome (PPFMPs) shares with

CPPS of various visceral origins the absence of a well-defined aetiology and clear diagnostic markers. Moreover, pelvic floor muscle dysfunction and increased tone do not always imply pain, and vice versa [18].

Referral for conservative management is commonly prompted by pelvic floor myalgia, increased tone of pelvic or adjacent musculature, impaired body awareness, or fear of movement (kinesiophobia).

The main muscular disorders associated with pelvic pain and/or increased tone include [18]:

1. Pelvic floor tension myalgia.
2. Pelvic floor myofascial pain syndrome.
3. Pelvic floor myalgia.
4. Vaginismus.

3.1.2. Terminology for the assessment of pelvic floor muscles in patients with CPPS

The ICS terminology report [18] standardizes terms for pelvic floor muscle assessment to reduce variability across disciplines. Key terminology includes:

1. Tenderness refers to pain or discomfort on palpation, reflecting increased sensitivity [16,18,19]. Digital palpation using a numerical rating scale (NRS) correlates with algometry and is acceptable when instrumentation is unavailable. Tenderness may occur with or without increased tone [19].
 2. Pelvic floor muscle tone reflects resting tension, comprising active (neural) and passive (viscoelastic) components. Digital palpation cannot distinguish these components [19].
 3. Measurement tools (dynamometry, manometry, electromyography (EMG), and elastography) assess distinct tone properties. The term hypertonicity should be reserved for neurological conditions; EMG-specific activity should be termed hyperactivity [16,18,19].
 4. Digital palpation terminology should use increased, normal, or decreased tone [16,18,19].
 5. Spasm refers to an involuntary contraction that cannot be voluntarily reduced; painful spasms may be described as cramps and are characteristic of vaginismus [19].
 6. Myofascial MTrPs remain poorly standardized; ICS recommends describing findings as tender point and increased tone rather than diagnostic [18].
2. Conservative management techniques and minimally invasive options. Scientific evidence.

Isolated myofascial treatment rarely yields sustainable benefit. On the other hand, combined interventions generally outperform single-modality approaches [1,20]. Management should be multimodal, addressing both the primary pain generator and myofascial contributors [20]. Conservative management (including PFPT and psychological therapy) is central within multidisciplinary care [21].

Conservative management aims to reduce pain, improve QoL, urinary/genital symptoms, sexual function, and psychological outcomes. Detailed protocols are provided in [Supplementary Material 1](#).

Core conservative components include [16,22]:

- a. **Cognitive-behavioural therapy (CBT) strategies and pain education.** Catastrophizing is associated with worse pain and disability; pain education combined with PFPT reduces pain and disability in musculoskeletal CPPS. [23]. Relaxation retraining may improve voiding-related symptoms [24].
- b. **Manual therapy (myofascial release, MTrP techniques).** Maladaptive neuroplasticity contributes to chronic pain [25,26]. Myofascial techniques may outperform general massage in selected populations [27]. Evidence for ischemic compression alone is inconsistent [28]. Combined internal MTrP release and relaxation may reduce medication use [29,30]. External myofascial

mobilization shows short-term benefit in men with spastic CPPS, though durability is uncertain [31].

- c. **Therapeutic exercise and relaxation.** Physical activity improves QoL and pain in chronic pain populations [32,33]. Stretching protocols should be individualized [29,30]. Body-awareness approaches and aerobic exercise show benefit in selected RCTs [34–36].
- d. **Adjunctive modalities and Complementary Therapies:**
- Biofeedback: May enhance PFPT outcomes and is recommended in selected CPPS phenotypes [1,34–42].
 - Transcutaneous Electrical Nerve Stimulation (TENS): Safe adjunct; may reduce pain and improve QoL [28].
 - Percutaneous/Transcutaneous tibial nerve stimulation (PTNS/TTNS): Emerging evidence; potential benefit with low adverse events [43–46].
 - Capacitive-Resistive Monopolar Radiofrequency (CRMRF): RCT suggests short-term benefit when combined with PFPT [47].
 - Graded motor imagery/transcranial Direct Current Stimulation (tDCS): Experimental adjuncts; limited evidence [48–52].
 - Extracorporeal Shock-Wave Therapy (ESWT): Short–medium term benefit in men; long-term durability uncertain [53–60].
 - Minimally invasive options: Considered second-/third-line adjuncts [61,62].
 - Dry needling: May be used selectively; evidence limited [63].
 - Local anaesthetic blocks: Potential benefit in selected cases [64].
 - Botulinum NeuroToxin Type A (BoNT-A): Mixed evidence; reserved for refractory cases [65–68].
 - Platelet-Rich Plasma (PRP): Evidence remains preliminary and limited; therefore, PRP should be considered an experimental option requiring investigation before routine clinical use [69–71].
 - Acupuncture: Meta-analyses support pain reduction; long-term benefit uncertain [60,72–75].

4. Results

4.1. Differences among guidelines by specialty and country

Guidelines meeting quality and multidisciplinary criteria include EAU (2025) [1], Society of Obstetricians and Gynaecologists of Canada (SOGC, 2024) [76], ACOG (2020) [77], and American Urological Association (AUA, 2025)[78–80].

- EAU: Multidisciplinary, phenotype-driven care; PFPT central; adjuncts for refractory cases [1,81].
- SOGC: Non-invasive, interdisciplinary care prioritizing PFPT and CBT [76].
- ACOG: Emphasizes neuromuscular underdiagnosis; PFPT, CBT/sex therapy; selective injections [77].
- AUA: Multimodal male CPPS care with PFPT and phenotype-directed adjuncts [78–80].

4.2. Synthesis of International Guidelines and Consensus Statements (2024-2025)

In summary, there is substantial convergence among the current international clinical guidelines:

1. Pelvic floor muscle dysfunction is underdiagnosed [1,76].
2. Treatment should address increased tone and MTrP; [1,76].
3. Biofeedback may enhance PFPT outcomes [76].
4. Psychological therapies are essential [76,77].
5. Electrotherapy/neuromodulation may benefit selected patients [76].
6. PFPT should be delivered by trained specialists within multidisciplinary care [76,77].
7. Body awareness and movement therapies may reduce pain [34,35].
8. Education is central to biopsychosocialcare [76,77].
9. Early multimodal, multidisciplinary care is recommended [76,77].

5. Discussion

Regarding the evaluation and conservative management of CPPS, particularly its musculoskeletal phenotype, the SINUG presents its position in this statement.

It should be acknowledged that most currently available clinical guidelines originate from Europe and North America. The present document aims to integrate these recommendations while providing a perspective from the Ibero-American clinical community.

Recent growth in the evidence base reflects increasing clinical recognition of CPPS. There is a pressing need for the various specialties involved in CPPS to become familiar with the therapeutic possibilities offered by conservative management, particularly PFPT, and to adopt a unified and standardized terminology. Clinical and scientific research supports that PFPT delivered within a multidisciplinary, multimodal care pathway is both safe and effective.

The musculoskeletal phenotype of CPPS requires multimodal conservative management addressing behavioural, physical, and psychological domains, integrated with phenotype-directed medical or procedural care when indicated. Isolated interventions tend to have limited effectiveness, and the active participation of the patient is required. The collaborative involvement of the rehabilitation physician, urologist, or gynecologist and the pelvic floor physical therapist is essential. The rehabilitation physician plays a central role in comprehensive functional assessment, differential diagnosis of musculoskeletal and neuropathic pain contributors, and the formulation of an individualized rehabilitation plan, while coordinating pharmacological or interventional strategies when necessary. Treatment should be delivered by specialized pelvic floor physical therapists trained not only in the musculoskeletal contributors to pain, but also in psychological mechanisms and central nervous system contributions to chronic pain. They must be capable of applying behavioural, physical, and psychological strategies within a multimodal framework to improve pain, QoL, and sexual function. In selected patients, particularly those with suspected systemic musculoskeletal disorders or generalized pain syndromes (e.g., inflammatory rheumatologic disease or fibromyalgia), collaboration with rheumatology specialists may be appropriate as part of the multidisciplinary evaluation [1,4].

Although the principles of multidisciplinary management remain consistent across age groups, treatment strategies should be individualized in elderly patients. Factors such as frailty, reduced mobility, comorbidities, polypharmacy, and tolerance to therapeutic exercise may require adaptation of physiotherapeutic protocols and rehabilitation goals [1,23].

Despite increasing recognition of the role of pelvic floor physical therapy in CPPS management, access to trained professionals and reimbursement of specialized therapies remain variable across health-care systems. Expanding training opportunities and improving health-care support for multidisciplinary pain management may therefore represent an important future priority [76].

PFPT clinicians are well-positioned to deliver education, promote healthy behaviours, and support long-term self-management across care settings. Direct communication between pelvic floor physical therapists and medical specialists is essential to coordinate pharmacological or surgical interventions within a multidisciplinary care pathway. As in other chronic pain conditions, referral to PFPT should not be delayed.

Position of the SINUG on the management of the musculoskeletal phenotype in CPPS with conservative management (Conclusions)

SINUG considers PFPT an indispensable component of multidisciplinary CPPS management. PFPT is essential when a musculoskeletal phenotype is identified, and may benefit other CPPS phenotypes that develop secondary pelvic floor contracture. Within this framework, the rehabilitation physician plays a key role in the clinical assessment, phenotypic stratification, and integration of PFPT within a comprehensive, multimodal, and, when indicated, minimally invasive treatment strategy. Accordingly, PFPT is recommended by the UPOINT and

endorsed by EAU guidelines [82], and other international clinical practice guidelines [83–85].

SINUG supports specialized training, terminological standardization, and evidence-based integration of emerging therapies for CPPS.

CRedit authorship contribution statement

Inés Ramírez-García: Writing – review & editing, Writing – original draft, Investigation, Data curation, Conceptualization. **Roberto Martínez-García:** Methodology, Investigation, Conceptualization. **Carlos Errando-Smet:** Methodology, Investigation, Conceptualization. **Bárbara Padilla-Fernández:** Writing – review & editing, Resources, Conceptualization. **Salvador Arlandis-Guzmán:** Writing – review & editing, Visualization. **David Manuel Castro-Díaz:** Visualization. **Francisco Cruz:** Visualization. **Montserrat Espuña-Pons:** Visualization. **Carmen González-Enguita:** Visualization. **Luis López-Fando:** Writing – review & editing, Visualization. **Alicia Martín-Martínez:** Visualization. **Esther Martínez-Cuenca:** Writing – review & editing, Visualization. **José Medina-Polo:** Writing – review & editing, Visualization. **Carlos Müller-Arteaga:** Visualization. **Ana Belén Muñoz-Menéndez:** Visualization. **Cristina Ros-Cerro:** Visualization. **Pedro Blasco-Hernández:** Writing – review & editing, Visualization, Supervision. **Isabel Montes-Posada:** Writing – original draft, Supervision, Investigation, Conceptualization.

Ethics approval statement

The authors declare that this study did not involve Humans or Animals.

Declaration of generative AI in scientific writing

The authors declare that no AI or AI-assisted technology was used in the writing process.

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Appendix A. Supplementary data

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- A-PRPz*: Autologous Platelet-Rich Plasma
AUA: American Urological Association
BoNT-A: Botulinum Neuro-Toxin Type A
CBT: Cognitive-behavioural therapy
CP: Chronic prostatitis
CPP: Chronic Pelvic Pain = CPPS
CPPS: Chronic Pelvic Pain Syndrome
CRMRF: Capacitive-Resistive Monopolar Radiofrequency (=TECAR)
EAU: European Association of Urology
EMG: Electromyography
ESWT: Extracorporeal Shock Wave Therapy
FDA: U.S. Food and Drug Administration
ICD: 11th revision of the World Health Organization's International Classification of Diseases
ICS: International Continence Society
MM: Myofascial Mobilization
MTrP(s): Myofascial Trigger Point(s)
NIH: U.S. National Institutes of Health
NIH-CPSI: NIH Chronic Prostatitis Symptom Index
NRS: Numerical Rating Scale
PBPS: Primary Bladder Pain Syndrome
PCPPS: Primary Chronic Pelvic Pain Syndrome
PFPT: Pelvic Floor Physical Therapy
PPFMPS: Primary Pelvic Floor Muscle Pain Syndrome
PRP: Platelet-Rich Plasma
PTNS: Percutaneous Tibial Nerve Stimulation
QoL: Quality of Life
RCT(s): Randomized Controlled Trial(s)
SINUG: Sociedad Iberoamericana de Neurourología y Uroginecología (Iberoamerican Society of Neurourology and Urogynecology)
SOGC: Society of Obstetricians and Gynaecologists of Canada
tDCS: Transcranial Direct Current Stimulation
TENS: Transcutaneous Electrical Nerve Stimulation
TTNS: Transcutaneous Tibial Nerve Stimulation
UPOINT: Urinary, Psychosocial, Organ-Specific, Infection, Neurologic/systemic, and Tenderness
UPOINTS: Urinary, Psychosocial, Organ-Specific, Infection, Neurologic/systemic, Tenderness and Sexual
VAS: Visual Analogue Scale

Abbreviations

ACOG: American College of Obstetrics and Gynaecology