Transcript of “The Pelvic Floor: A Doctor and Her Patient Hold It Together”

Coming Together for Sexual Health Podcast

Tammy Kremer:

Welcome to Coming Together for Sexual Health. I'm Tammy Kremer and I'm thrilled to talk with you about the world we are creating by coming together for sexual health. And yes, the pun is intended. My background in thinking holistically about health as a facilitator and a doula, helps me talk with our guests about celebrating pleasure, combating stigma, and making sexual healthcare both more accessible and more inclusive of the communities we serve. We're powered by nationally recognized experts in sexual health at the University of California, San Francisco, and the California Prevention Training Center. All these expressed are those of the person speaking and not of the CAPTC or their employer. Subscribe to get our latest episodes, share with your friends, and leave us a five-star review to help more people find us. Thank you for coming together for sexual health.

Welcome to Coming Together for Sexual Health. I'm so excited to have the two of you in studio today. We're going to be talking about pelvic floor issues and how they impact women, in particular. And so today we have Dr. Olga Ramm, a urogynecologist who specializes in women's pelvic floor conditions, and she cares for patients with issues like pelvic organ prolapse, urinary and fecal incontinence, complex urinary and rectal fistulas and surgical complications. And we're lucky to have her here at UCSF, where she serves as the director of the UCSF Center for Urogynecology and Women's Pelvic Health. And Nicole Curutchet, you are a patient of Dr. Ramm's. We'll get to hear about your story and the kind of surgical option that you chose that worked really well for you. And you have been an accomplished senior customer success manager for over 25 years, working with C-level relationships for Fortune 500 and 1,000 companies. So thank you so much for taking time to come in today.

Nicole Curutchet:

Thanks for having me.

Tammy Kremer:

So as a sexual health podcast, we are really focused on reaching providers and staff about the impact of various issues on people's sexual health. So I'm really excited to also talk today about how pelvic floor issues can impact people's sexual wellness. And I'm going to start off by asking some questions of you, Dr. Ramm, and then we'll get to really jump in and hear your story in greater depth, Nicole.

Nicole Curutchet:

Okay.

Tammy Kremer:

So can you share first what is urogynecology?

Dr. Olga Ramm:

Yeah, so urogynecology is a subspecialty that's usually entered through the field of obstetrics and gynecology, and then people who are interested in pelvic floor disorders, which we'll kind of define and talk more broadly and then in depth about, in a little bit, get an additional three years of subspecialty surgical and research training. So urogynecologists are board certified in urogynecology as well as their primary specialty, to kind of be able to offer comprehensive evaluation, counseling and patient-centered treatment for pelvic floor disorders and benign gynecologic conditions.

Tammy Kremer:

Great, thank you for that overview. Can you share a little bit about common causes for these conditions and how these conditions impact quality of life?

Dr. Olga Ramm:

Yeah, so pelvic floor disorders are basically conditions of nerve, muscle and connective tissue. And so, there are all kinds of environmental and genetic factors that can promote a pelvic floor disorder to become worse. But most commonly, the inciting injury. And it's not the only injury, but by far the most common one is birth injury to the pelvic floor and about 83% of US women give birth. So it's something that affects a whole lot of us.

Tammy Kremer:

Thank you for that overview. And so Nicole, the floor is yours. Can you tell us your story? What brought you to Dr. Ramm to begin with?

Nicole Curutchet:

Well, going to be a very detailed story here. So I was going to the bathroom one day and I was handling my business. And when I was handling my business, I noticed something down there that shouldn't have been there. I didn't put it there. So I'm like, "Okay, this is not right." I had no other signs, no other symptoms except for some incontinence, which I really didn't put too much together with it. I just kind of figured that it was aligned with menopause and doing all that. And clearly, I'm menopausal and I was going through that so I just attributed it to that and I'm like thinking to myself, "What is going on with me right now?" Luckily, I have a very dear friend of mine that is a OB-GYN nurse practitioner. She actually used me as her little subject when she was going to nursing school, so she knows me inside and out. So of course I called her up and I'm like, "What is going on? This isn't right." And I had a hysterectomy when I was 40, so-

Tammy Kremer:

And had you given birth?

Nicole Curutchet:

I have, yes, I have a 30-year-old son.

Tammy Kremer:

Was it a vaginal birth?

Nicole Curutchet:

It was a vaginal birth, yes. Actually, as I'm learning more about what I had, I didn't realize that a vaginal birth could attribute to some of this as well as the hysterectomy as well. I ended up finding out that it was not right, what I was feeling down in between. Also, my rectum as well. And I got in to see the nurse practitioner at my medical place that I went to in Santa Clara, and I went in there and they basically said, "Yeah, it looks like you have a prolapsed bladder and rectum." So of course, then the surgeon that performed my hysterectomy and she said, "You want to go see a urogynecologist." Well, there was an eight-month waiting list to even get in to see a urogynecologist. And I'm like, "I'm not walking around with this thing between my legs that I know it shouldn't be between my legs." And to make it a little more relatable, if you've had a tampon that's halfway coming out, that's what it feels like [inaudible 00:06:07] that's in between your legs.

Tammy Kremer:

That's a good comparison.

Nicole Curutchet:

Okay? So it was something like the size of a walnut and you couldn't push it back in there and you couldn't do that. So it was like, "Oh, no." Luckily my medical coverage that I had, I have a PPO, it gave me the option to look outside my zip code. At my work, we have a concierge service. So when I called my work concierge service, luckily a female picked up the line and I told her what was going on and I said, "I'm not waiting at eight months." And she goes, "Oh, no, honey, we're not having you wait eight months. We're going to figure this out." Right? And gave me a couple of numbers to check. Checked Redwood City, checked Mountain View. Of course, they had lead times.

So then I had to expand it broader to San Francisco, found UCSF. I knew UCSF was a very well established organization. I'm like, "Okay." I never considered San Francisco before. Called the main number and I talked to the front desk saying what was going on, found Dr. Ramm for urogynecologist. She came up in the search, which there's not a lot out there. I'm like, "Okay, I'm going to try this. Check out. Let's see." And I called and I talked to the lady there, and then she said, "Oh, there's a six-week wait time." And I'm like, "Well, it's better than the eight months that I was quoted." And then she's like, "Wait, wait, wait. Hold on a second. She has a cancellation. Can you come in three days?" "Book it."

Tammy Kremer:

Wow. Yeah.

Nicole Curutchet:

And that's how the journey began.

Tammy Kremer:

That's some good luck right there.

Nicole Curutchet:

Yeah. It was meant to be. So I saw Dr. Ramm. My husband came with me and I was just floored that, of course, I didn't know more about this. I was doing more research and everybody says, "Stay off the internet." Right? And of course, I'm looking at Wikipedia and I'm looking at all that, and we know that's all open source and everything. And I'm like, "Okay, I'm just going to stop." And then I had a wonderful appointment with you. The second you walked in, I was like, "Hmm, I don't know about this." Because

you're really vulnerable. First of all, you're like, "What the heck is going on?" Second of all, I have my husband with me who's really nervous like, "Oh my God, what's going to happen to my wife?" So we have this random stranger who is literally helping me make a decision for the rest of my sex life, basically, right, of course. I have a very healthy relationship with my husband and that means a lot to us. Intimacy is very key.

So I think she just read that off the bat. Maybe you got the feel from Alex. I don't know, you read your room or something. You could tell that he was very nervous. But as we started within the first five minutes, it was like, okay. She was very calm, very informative. I knew that Alex was getting what he needed and then I'm like, "Okay, I'm feeling better. I'm feeling better." And then you started to explain options. There are certain options that we could go through, but I already had it in my head that I wanted surgery. We have, our daughter's getting married and I'm like, I want to make sure that I'm healthy for the wedding. I want to be able to go into the water because like I said, I had had a hysterectomy before, so I knew what the requirements and the recovery was like. It wasn't the same as a hysterectomy, but I just thought, I had this hysterectomy. Within two weeks, I was feeling really good after my hysterectomy because I had it done laparoscopically, but it still took me a full eight weeks to recover.

But mentally and physically, I felt really good after two weeks. So I already had it in my brain that I was going to do the surgery. No ands, ifs or buts. I wanted to be good. I didn't want anything falling out of me when I go on vacation. I didn't want my sex life to change. I didn't want all that. And she was very good about saying, "You still can have sex. It's okay. She's okay. You're not going to hurt her." She knew right away I was ready to go into the surgery. So she explained the process of what the surgery was and the steps. I had also had some incontinence issues as well. So there was a procedure that needed to be done before I did the surgery so she could measure what I was at. And basically, it's a little bit of tightening of, so this way you don't tinkle or when you sneeze or you cough. And those of us who have had issues, understand this, even with laughing as well too. And that was it. We just kind of went from there and went to surgery.

Tammy Kremer:

Dr. Ramm, can you share from your perspective what that first appointment was like and what your assessment was?

Dr. Olga Ramm:

Yeah, so I think patients with prolapse fall into two categories. People who realize that things don't feel normal, like Nicole, and come right in. And then there are people for whom this indolent process has been going on for years and it's really quite advanced, and they've normalized it to themselves for a number of reasons, and then they just really get to a threshold where they can't normalize it anymore. And so I felt like with Nicole, because she was in to see someone, it was very clear that there was a sense of urgency around it, et cetera. And I think one of my primary thrusts with patients like that is to kind of just say, "This isn't life threatening. Yes, it's annoying. Yes, it's a nuisance. No, it's not normal, but also, we have good solutions for this and it's not a tumor. It's not going to kill you." Right? And I think was that helpful for you to hear?

Nicole Curutchet:

Oh, my gosh, that was helpful. I mean, that was also helpful, again, for my husband to hear that too. I mean, we both feed off of each other, so if I have confidence, that I'm going to be okay, it's going to give him the confidence. So hearing that is just, all right.

Dr. Olga Ramm:

And prolapse is not something women talk about a whole lot. It is probably the least common of the pelvic floor disorders, still affects anywhere from 4 to 12% of the population, depending kind of at what population study you look. I think that if you were in a room of 20 women and were to ask-

Nicole Curutchet:

Yeah, at least two or three people.

Dr. Olga Ramm:

"Does anyone pee their pants when they sneeze?" A lot of people would be like, "Well..." Yeah. So prolapse isn't quite like that. It's not that common. So I think just letting people know that they are in good company, even though they may not be aware of it, was a big part of that initial encounter. Yeah.

Nicole Curutchet:

Yeah, definitely.

Tammy Kremer:

And 4 to 12% is pretty high.

Dr. Olga Ramm:

Yeah, it is.

Tammy Kremer:

I mean, I guess that means one in 200, let's say, at low, if you're in a room of 200 women?

Dr. Olga Ramm:

Yeah, but I mean more common estimates are kind of closer to one in eight to one in 12.

Tammy Kremer:

Yeah.

Dr. Olga Ramm:

Yeah, it's not that uncommon, but we don't talk about it.

Tammy Kremer:

Right. I mean, growing up and just in general, being around people over time, you start to hear about what you said, peeing when you sneeze, peeing when you jump, peeing when you cough, peeing when you laugh, but the degree of impact that you're talking about where you're actually experiencing your organs bulging or moving and to be able to even discover that, it makes me think about some folks who might not have such an intimate relationship with their own bodies to even be able to sense what is happening. So the importance of people getting to know their own bodies ahead of time so that we can actually recognize when there's something that needs to be addressed. And like you said, folks that just live with these conditions and normalize them over time until it's impossible to kind of hide from it

anymore. Just think about the number of the years that people might spend living that way without knowing the kind of care that's possible.

Nicole Curutchet:

As you can see, I'm not afraid to talk here, so I don't mind talking to people and asking them things and learning and educating myself. And I have no problem trying to explain that to other women as well because we don't talk about it. And it's just such a natural part of life.

Dr. Olga Ramm:

One of my mentors used to call it the sisterhood of silence. Everyone's kind of afflicted in one way or another, and no one talks about it.

Tammy Kremer:

Yeah. That really speaks to the issues around kind of the impact, how taboo and stigma can lend directly into people not getting the care that they really need. We talk on this podcast a lot about STIs and HIV too, and just the kinds of fears that people might have, and then the fear of getting a diagnosis can keep people away because of that stigma that develops around different conditions. So just really appreciating having an open conversation today. Can you tell us what the process was like with surgery for you and what your recovery was like?

Nicole Curutchet:

So the surgery process, the actual process of getting the approval and doing everything, especially since I was so far out of my network, and again, because I had a PPO, I was able to go ahead and do that. And the front desk people were great because I wanted to ensure, I knew this was not going to be a cheap surgery, so I wanted to dot the I'S and cross the T's and do all that, and that went very smoothly. The whole team at Dr. Ramm's office were, bam. I was like, "Is this real?" Because you're just-

Dr. Olga Ramm:

We do have a great team. I'm really fortunate.

Nicole Curutchet:

Yeah, you do. You have a great, and I had to do a shout-out because they were great. There was lots of questions, there was lots of coordination that we had to do. And because I wanted to move so quickly, I had to get that one procedure, that test done before I got the surgery done. And we had to combine multiple appointments together into one because we were trying to get me into your schedule so quickly.

Dr. Olga Ramm:

I remember that.

Nicole Curutchet:

That took a lot of coordination and advocating and communication and doing all that. Plus, I didn't want to have to make multiple trips coming from Santa Clara to San Francisco-

Tammy Kremer:

That's far.

Nicole Curutchet:

Right? Again, I don't have a problem communicating. So we did the surgery. I'll never forget it, and I hope I don't tear up here. Nervous, went in, had to be there at 5:30 in the morning. Of course, nervous the night before, doing all the prep, doing all that. As a matter of fact, I had mentioned to Dr. Ramm, I said, "I know my body and I know I'm not going to sleep the night before." I had asked her to give me some Valium for the night before because I'm a nervous Nellie. That's just how I am. So I did that, but still I was pretty worked up when I came in, and again, just the unknown. Got in, the whole thing was great, registered, they took me in. Within 20 minutes, I was in there. I had an IV in me within 10 minutes.

I feel bad for the crew because I kind of teased them a little bit. Each person that came in, and I don't know what the terms are for everybody, but there was four people that came in at different times to validate the surgery that I was having, right? And to make sure, "And the procedure that you are going to have, is this." And of course, they're using the medical term and I'm just saying, "I got a prolapse bladder [inaudible 00:16:58]." So by the time the fourth person came in, and I believe it was the anesthesiologist, you could just see he was being very professional. And so when he came in and he goes, "Okay, and the procedure we're going to be doing is this, this, and this."

And I said, "Well, yeah, we're going to be doing a little nip here and a little tuck there, and maybe a little lift here." And he kind of just stopped. And then he looked at me and then he kind of got a little smirk and I said, "I'm really nervous." I'm like, "Can you give me something please?" And he goes, "Don't worry, we'll get to take care of you." And I'm thinking to myself, "Well, this guy wants to go ahead and really put me out because I just went ahead and yanked his chain." Within five minutes, they were taking me back. And what was really nerve wracking was when you got back there, all the lights, all the people, I was like, holy crap. I don't know. There was seven or eight people in the room there. Am I over exaggerating or at least six people?

Dr. Olga Ramm:

Yeah, because we've got, usually it was a robotic surgery, yours was, remember? So we've got two circulators to just get everything. It's the final push to get everything ready.

Nicole Curutchet:

So that's intimidating. And I remember hearing the monitor, the pulse monitor go up and I remember being really nervous and they were getting ready to put the mask over my face and I started to panic. And then you came over to me and you rubbed my hand and you said, "You're going to be okay. I need you to breathe and you're going to be okay." And when I woke up, you were there and you said, "I told you you'd be okay."

Dr. Olga Ramm:

Yeah.

Nicole Curutchet:

You're scared. You're scared of all the stuff. We had to figure out if I was going to need to have a catheter to come home with. And she already prepped me for this, that it's not uncommon that your bladder is kind of all whacked out with all the drugs that you may not be able to urinate after surgery, so

we may have to send you home with a catheter. So she had already forewarned me with that. It's very overwhelming. When you're coming out of the surgery and you start to hear all these instructions. So thank God I had my husband there, which they always say, you need to have somebody take you home and they have the follow-up. It is, because obviously, you're high as a kite.

I'm just so grateful that I had my husband to help me out because the first 24 hours were like a blur. I wasn't in too much pain. She prepped me very well for, make sure you take your stool softeners before the surgery because you will be constipated with your narcotics. I'm not a big narcotic person, so I think I only took the pain pills for 48 hours just to keep everything under control. But again, I was gauging it towards my hysterectomy. And that's when I got humbled. Basically after two weeks, I'm like, you go through this process, you think you're doing okay, and then all of a sudden at two weeks you're like, bam. You get humbled and you get knocked down again because I started doing too much.

Tammy Kremer:

Uh-huh, yeah, started to feel good enough to do things and then it's easy to overdo it. How long would you say it took for your sense of being fully back to yourself?

Nicole Curutchet:

I'd definitely say it was about 16 weeks. It took me a little bit longer. I had other things that I was dealing with personally as well, and I just think the mental state of mind that I was in just might've prolonged that. When your mental state is not completely there, it also can impact your physical state. And I really think that's what happened. And I also knew that I didn't want to push it to go back to work too fast because of my job, there's no gradually working into it. It's like, you're there. So I chose for my health and my recovery to utilize whatever time I could. I think it was the 10-week mark. That's when we decided to do physical therapy.

Tammy Kremer:

Oh, okay. Yeah.

Nicole Curutchet:

And didn't know you could do physical therapy on a pelvic [inaudible 00:20:57]. I'm like, "What the hell? How is this going to work? What am I supposed to do? Sit there with my legs open and they're supposed to tell me to clamp down with the little speculum that's in me and stuff." I didn't know what that was about. And I had my first physical therapy appointment via Zoom, and she laughed at me a lot and she gave me some great idea for exercises and it was great.

And again, this is where the Kegel part comes in and then pushing down on your pelvic and tensing, but not pushing out, and just all these kind of little tricks and things. I'm like, "Oh, my God. I didn't know you could go ahead and do that stuff." So it was great because I could do that at home and it really helped. I mean, it really helped and I was like, "Whoa." In fact, some of the exercises I still do right now and pooping is definitely, I think I'm finally back to normal again, but it definitely changed. Took me about six months for basically start to finish, I guess.

Tammy Kremer:

Well, thanks for telling that tail end because I think that's something that can sometimes be difficult to grasp when getting ready for some kind of a procedure. I know I've had that experience, where you're told, this is what might happen. But until you're in it, it's very difficult to internalize that and plan for it.

Dr. Ramm, how does that kind of surgery experience and recovery fit into what you've seen with other patients of yours?

Dr. Olga Ramm:

So I think that the thing that I really try to stress to patients is that there's not a switch that gets flipped. You're not recovering, recovering, recovering, and then boom, you're recovered, right? Just as you're talking about, it's gradual. There may be a point where you feel like you can walk and get groceries and take your kids to school, but you don't feel that same level of vitality because all the energy that you had before that was going into managing your life and probably a bunch of other people's, is going into wound healing.

This is essentially a reflection of what I tell patients and there's only so much you can prepare people for that. Some people interpret what I say in a way that's kind of more ominous and are like, "Oh, you told me this would take forever and I'm fine and I'm back to work at three to four weeks and I'm managing." And other people are like, "Yeah, I didn't realize that it would take me to get back to my baseline and that it would be such a long runway." And I think your baseline's pretty high too. You've pack a lot of things into a day.

Nicole Curutchet:

I do. I do. I have a lot.

Tammy Kremer:

And that kind of gets to the ways that this kind of care, whether it's surgical or the physical therapy that you mentioned, can really improve people's quality of life. That's something that's really standing out to me in this conversation, is the impact on quality of life, especially as we know, people are living longer, in particular after having children, and how can we address the way that we take care of our bodies accordingly. Can you talk a little bit about prevention for some of these issues and what you think some key points are around prevention?

Dr. Olga Ramm:

Yeah, it's always a little bit tricky because we can't change our genetics, obviously. So if you really want to prevent pelvic floor disorders, the common ones, urinary incontinence, fecal incontinence, pelvic organ prolapse, you're going to forego vaginal delivery and possibly even pregnancy. And in the words of the great Bard, "The world must be peopled." Right? So I don't think people are making decisions about their family structures, et cetera, based on risks to their pelvic floor, which is just normal. So the pathophysiology of pelvic floor disorders is sort of this linear thing. So you've got predisposing factors, right? Genetics, your nutrition growing up, et cetera, and then you've got the inciting injuries.

So oftentimes that can be pregnancy delivery, but it can also be other pelvic floor trauma that happens outside of these things. And then you've got promoting factors. And I think those promoting factors are where we can really focus our energy, although if we have time, we can talk about how we counsel women about delivery, and I'm of the mindset that we're kind of under counseling and we should trust women and empower them more to make their own choices. But in terms of the promoting factors, so keeping a strong core, keeping a healthy weight, being physically active, doing what... It's a disorder of nerve and muscle, so doing whatever you can to create an environment in your body that fosters healthy nerve and muscle function.

Tammy Kremer:

And can you talk about how to distinguish between what we might consider the range of normal, so to speak, from something that needs to be addressed clinically?

Dr. Olga Ramm:

Yeah, I think normal is in the eyes of a bookholder. When you talk about quality of life issues, there's not a pre-cancerous and then a cancerous phase where it's all relatively objective. I tell a lot of women that it's like arthritis, right? Some women might have this knee pain and come in and be told you have osteoarthritis. And some might say, "Oh, okay. Well, that's a function of me being a human biped for the last 55 years. I guess I'll just go on with my life." And others might say, "Wow, I'm not going to put up with this." And so they go on and get a knee replacement. Right? So I think it really is about what symptoms do you have and what impact, whether it is physical in the form of limitation of activities or psychological, how much headspace is it taking up to have this thing there, is it having on your life? And so when I talk to patients about treatment options, I'm trying to gauge their symptoms and the risks of treatment within the context of their own personal value system.

Tammy Kremer:

And can you share what is the kind of suite of treatment options available depending on how advanced someone's situation is?

Dr. Olga Ramm:

Yeah, so we're kind of conflating and grouping a lot of pelvic floor disorders together. But the three main ones that are super common are urinary incontinence, fecal incontinence and pelvic organ prolapse. And not all urinary incontinence is the same. They're kind of two big buckets. There's stress incontinence, which has nothing to do with emotional stress really. It's just a weak urethral sphincter muscle at the bladder outlet. So when the bladder pressure increases through things like sneezing, coughing, doing jumping jacks, et cetera, there's urine that escapes because the sphincter just can't hold it back. And so, that can be approached through strengthening of the accessory pelvic floor muscles. It can be approached through using an intravaginal device like a pessary that's kind of insertable and removable or it can be surgically approached.

And then in Nicole's case, she had that, but she also had pelvic organ prolapse, which is essentially a herniation of the organs in the pelvis through the muscles of the pelvic floor that normally serve to hold up those organs. By the time that patients come to me and actually have symptoms of prolapse, usually pelvic floor muscle strengthening isn't going to help so much, the neuromuscular damage is severe enough and the data bears that out as well. So then we're left with either pessary, the intravaginal device to kind of help mechanically support things or surgical treatments. And there are lots of different surgical approaches that I think need to be really carefully, individually tailored to the patient's symptoms, their goals, and their risk tolerance.

Tammy Kremer:

Can we take a look at the model that you brought?

Dr. Olga Ramm:

Oh yeah, sure.

Tammy Kremer:

And if you can show us on here and we can try to describe it verbally as much as possible for those who are listening to this podcast, as opposed to watching the video that is also available on YouTube.

Dr. Olga Ramm:

Mm-hmm.

Tammy Kremer:

Can you show us what it might look like, where the prolapse might happen in simple terms?

Dr. Olga Ramm:

Yeah. So I wish this were kind of more pliable and dynamic, silly putty instead of hard plastic. But I think what this exemplifies here nicely, is that the sides of the pelvis are outlined by bone and that bone serves as attachment for the pelvic floor. And so the entirety of the pelvic floor, the base of the pelvis is made completely of soft tissue. And that soft tissue, as you can see here, roughly resembles the letter U. It's like a horseshoe with really wide arms. You can see here's the outlet from the bladder, that's the urethra, the vagina here, and the rectum and anus would be there. And so, the pelvic floor just kind of forms this diaphragm on which the bladder, the uterus, the rectum, all the small bowel, everything from your diaphragm on down, rests on the pelvic floor musculature.

So when these muscles are damaged or the nerves that supply them are damaged or weakened, they kind of tend to sag and separate. And so then with gravity, the organs just sag down and the vagina is essentially just a little canal, like a sock made out of skin. It's not meant to support anything, it's just an inlet to the pelvis. And so when the pelvic floor shelf above the vagina separates these organs start to push on the vagina, which then starts to evert, it turns inside out. And so what you were feeling, remember us talking about it, is actually the skin lining the vagina coming down with the organs behind it.

Tammy Kremer:

Got you. That's really helpful to take a look at this and really understand the role of soft tissue here and that that's what we're addressing. It also helps explain a bit more about why it would be that really, like you said, that kind of working out, whatever version of that, having good overall health can support these soft tissues.

Dr. Olga Ramm:

Yeah.

Tammy Kremer:

Great. Can you talk about childbirth? And I would love to hear how it is that you counsel people about childbirth and thinking a little bit more about how it might impact their long-term pelvic health.

Dr. Olga Ramm:

Yeah, so this is something that's near and dear to my heart, and we've actually done quite a bit of research in this field, but the reality is that childbirth inevitably is going to cause neuromuscular injury, right? And I think that the pendulum of the culture around obstetrics swings in the sixties, seventies, potentially even eighties. I think women's input and ownership over their birth process was really

marginalized and devalued. And I think that the kind of natural shift was toward childbirth being seen as a natural process in which women are active participants.

And I'm a big believer in that, but oftentimes when we call things natural, it means that somehow they're good and beautiful and are always going to have a wonderful outcome. And again, I don't want to sound like a Debbie Downer, but a heart attack, in a way, is natural. Right? And so, I think that what a lot of women don't realize is that going through a vaginal birth is a bit like having a stroke in the pelvis. The nerves and the muscles are affected, right? And there are lots of ways in which that injury happens.

You can read the orthopedic literature and they've done these studies on these sad little rabbits about how much you can stretch a nerve before it causes irreparable nerve death while we've evolved in a way that actually makes our nerves in the pelvis a little bit more forgiving of stretch injury than they are say, in the arm or the leg. But still, sometimes those nerves are stretched upwards of 300% of the limit to which you can stretch nerves before you have the result of irreparable injury.

So I think informing women, a priori, that there are going to be differences, that the birth does come with a certain cost to the body is important because I think the thing that I hear the most from patients, especially ones who have had significant birth trauma is like, "I didn't even know this could happen. I really did not know." And then I think the discussions around different routes of delivery and what risks they pose, should be had not in labor because I think that is arguably a very vulnerable situation in which someone may or may not be taking in the information, synthesizing it appropriately and be able to make a sound decision. But well before that.

And I think so often we just kind of assume that things are going to be on autopilot and someone's going to give birth vaginally because the reality of it is it's not necessarily something that was always medically attended. And if somebody goes into labor outside of the hospital, that baby is coming out, medical consent or not, right? But that's what makes it tricky. Now, most women, at least in the United States, do give birth in a hospital and we do have access to a variety of different interventions that carry very different risks. And so I think it's important to talk to women about those in the late second, early third trimester so that they have time to really absorb that information, sit with it, and make a decision about what their birth plan is and what are the worst case scenarios they want to avoid and what outcomes are most valuable to them.

Tammy Kremer:

I'm a trained doula and so it makes me think about what kinds of roles, other kinds of reductions in experiences of pain during labor. I'm just thinking about, for example, when I've been in a birth and a birthing parent might be under a lot of stress, might feel like... I've seen folks responding from trauma, for example, in the birth room and to try to push something out of your body when you are clamped down like that, I can only imagine how much more pain there would be. So I'm just curious from your perspective, what are some things, so we're talking about different interventions and different pathways, whether we're talking about vaginal delivery and the various options that exist within that or cesarean, what's your take on things that can be done in the birth space to reduce injury?

Dr. Olga Ramm:

So our group looked at a population of 22,000 women who have given birth in Northern California under the supervision of a variety of providers, right? So OB-GYNs from training programs all over the country, midwives, that kind of thing, and tried to identify risk factors for higher order birth injury. Now mind you, that higher order birth injury was proxy measured by having an injury to the anal sphincter, so a third or fourth degree perineal laceration. And certainly, sometimes women don't have that specifically and can still have globally, a lot of injury to their pelvic floor, but at least this was an objective

capturable outcome that we could look at. And we looked at what are the risk factors that contribute to the development of this higher order birth trauma and specifically which are kind of modifiable.

And one thing is the duration of the pushing phase. In our effort to prevent cesarean delivery, we've really leaned into permissive pushing, which on the one hand is not unreasonable, but I don't think that women are actually getting counseled about what that means to their bodies because when that fetal head is engaged and you're pushing, that's really when the bulk of injury to the nerves and muscles happens. And so just like in a stroke, time is nerve and time is muscle, same here. Right? And if you look at the kind of biologic bell curve of, well, okay, so those who have a successful vaginal delivery, on average, how long do they push for?

A first time mom pushes for about 97 minutes, based on the data that we got from that population. So you add a couple standard deviations to that and I think it's reasonable to just then say, "This may not be happening, and maybe for the sake of your pelvic floor, your baby, whatever, all these different factors, we need to somehow expedite this delivery." And I think we don't place an emphasis on how long women push for outside of the baby. Right now, if the baby's tolerating the pushing, we just let it go. And I think it's more nuanced than that. And then I also think it's important to talk about route of delivery in the context of that individual person's goals, right? If someone, this is their one pregnancy and for one reason or another, they're certain of that, right? There are situations that come up that are like that.

I don't actually think it's unreasonable to offer a scheduled cesarean delivery without labor because that can actually significantly diminish the risks of things like pelvic organ prolapse and fecal incontinence. The data for urinary incontinence is less robust just because you don't need to lose a lot of nerve and muscle function to develop urinary incontinence. It's one of those things that kind of shows up earlier and that's almost taboo in the world of obstetric culture, where we're so obsessed with sort of getting our cesarean delivery rates as low as possible for good historical reasons, right, and from maybe a population health basis or standpoint that makes sense, but not always from an individually focused standpoint.

Tammy Kremer:

I appreciate hearing that perspective. It does butt up against some of the perspectives that I hold from the information that I have. And so I appreciate in thinking about it, the other impacts that I might not have been considering and developing my own take on how I imagine I might want a birth for my own self going forward.

Dr. Olga Ramm:

It's so funny that comes up all the time and I think that the healthcare professionals within obstetrics and gynecology that I find myself most aligned with in terms of how to counsel patients before delivery and intrapartum, are midwives, because we're kind of saying the same thing. Let the patient make the choice. You don't have to follow a specific algorithm. Let the patient make the choice based on their individual values, their goals for themselves, and their own personal case scenarios that they want to avoid.

Tammy Kremer:

Yeah, I appreciate that, patient focus. So we've talked a lot about childbirth and that impact on pelvic floor. I'd like to hear about other issues that might impact someone's pelvic floor health.

Dr. Olga Ramm:

Yes, so there's this kind of whole other pathophysiology of pelvic floor dysfunction outside of direct injury to nerves and muscles, which kind of is the tone of the pelvic floor. So the pelvic floor muscles, as you saw in the model, make up kind of the entirety of that genital hiatus, and sometimes they can become tense or hypertonic, so to speak, and that can show up in all kinds of unpleasant symptoms. For people, it is a really large contributor to chronic pelvic pain and to conditions such as bladder pain, kind of formerly called interstitial cystitis to dysfunctional dyssynergic defecation and constipation, to pain with intercourse and even endometriosis.

Pain is so multifactorial, but this pain cascade then causes kind of central sensitization, making it even more difficult to treat. There's a lot of people who get referred for chronic UTIs, urgency, frequency, and then their cultures come up negative. And when we do a thorough pelvic floor exam, we realize that yeah, a lot of their pain is generated by the pelvic floor itself, not necessarily by the organs within it. That's not to say that it is always the inciting factor, but it's very difficult for muscles to stay relaxed and loose when something's hurting. So someone may have had a really severe UTI years ago and that caused their pelvic floor to become tight and that's spurned this kind of pain spiral that goes on and on.

And I think what's really been fascinating to me is taking a look at what are some of the things that feed into these disorders? Because oftentimes, they're this no man's land, they can't be treated surgically. We don't have a great track record of treating them pharmacologically. So that's kind of like the limits of where allopathic medicine can reach. And it's frustrating when you're trying to make someone better to not have the tools in the armamentarium. And one of the things that our group looked at was, because we just kind of organically noticed it through talking to people, this correlation between chronic pelvic pain conditions and adversity in life, which I think you had brought up, people who have experienced trauma, how did they do in the birthing space? And I think outside of the birthing space, there is an imprint that happens. And what's interesting is that it doesn't even have to be trauma with a capital T, as they call it.

Again, we have an imperfect by proxy measure of adversity, which is the adverse childhood events scale. And it's a 10 item questionnaire that goes through things like abuse, verbal, physical or sexual neglect and household instability. And I think for a long time, people in sexual health have had this sense that, "Oh, yeah, sexual abuse survivors are going to be more prone toward having pelvic pain conditions." But what the data is showing us, which I think is kind of fascinating is that you are just as likely to have this chronic pain condition, including chronic pelvic pain if you were unhoused or if you've felt unloved or if you showed up to school in unkempt clothing that made you feel embarrassed or ashamed. And all of these things are additive. I mean, it really is fascinating, almost like a linear relationship between the number of adverse events that you report and the prevalence of chronic pelvic pain.

Tammy Kremer:

I so appreciate this part of the conversation. It's something that I personally have, women in my life who have gone through years and years of trying to get care in order to alleviate vaginal pain. Like you said, pain with intercourse, pain with urination, and trying to find the providers who can actually meet their needs has been so difficult. And I know there are some really great ones at UCSF. We have Tami Rowen, someone I'm familiar with who does a lot of work on this, who actually helped someone in my life. And it's just something that people don't really know where to go to talk about this.

So it's really helpful to hear what the research is showing and what we do know. It makes me want to shout it from the rooftops. It makes me think about the book called, The Body Keeps the Score, that really goes into the ways that the body holds memory and trauma. I also think about kind of historical trauma, intergenerational trauma, and various ways that show up. That's something that impacted me

when I had pelvic pain in my own life and I kind of worked through what areas might have made my body contract, and that was one of the pieces too. So yeah, I appreciate this kind of broader view.

Dr. Olga Ramm:

It really is kind of a fascinating space between allopathic medicine, mental health, kind of this sort of metaphysical spiritual world. What I oftentimes hear from patients is that when they get referred to therapy, it's oftentimes talk therapy or cognitive behavioral therapy, which definitely is helpful in having them gain insight into why they are where they are or why they move through the world the way they do.

And patients often say, "I appreciate knowing why I find myself on the ledge and having an armamentarium of things in my toolkit to cope with it, but sometimes I just get tired of being on the ledge." And so I think it's really interesting to think about more bottom up focused therapy processes that kind of look at trauma reintegration, not from like, let's hash out why this happened to you, but exactly as you're saying, why is it that this is showing up in your life and what's the neuro biochemical or whatever other footprint that your cells are carrying and how do we get rid of that?

Tammy Kremer:

Yeah. What a wonderful question to ask in terms of actually getting to what's going on and also normalizing like, yes, like you said, therapy can be helpful, but when you tell someone to go take a bath and light a candle and go to yoga and go to therapy when they're dealing with these issues as their only intervention, it can be incredibly demoralizing and make people feel wrong for their own condition in their body and make people feel kind of ashamed for their own kind of biological experience, especially when we know that now we have other ways of getting in there and supporting folks. We've talked a lot about women, which is great. Where would you refer someone today if a male bodied person came in with some symptoms like this?

Dr. Olga Ramm:

So I think I would send them to the Chronic Pelvic Pain Society of North America. That's one place that's kind of relatively gender inclusive, because as I mentioned, most of the resources I know are women focused. Yeah.

Tammy Kremer:

Okay. Thanks for that reference. That's helpful. So in terms of sexual health providers, what kind of things would you want a sexual health provider to know? And I'm thinking today about folks who might be doing some really basic care, providing some initial counseling and contraception or providing testing who they might have a patient come in and say, "By the way, I have this thing going on." What would you like them to know about when to refer someone to care?

Dr. Olga Ramm:

Well, I think that the most important thing is that patients oftentimes don't bring it up, unless they are directly asked because there is, for better or worse, I think there's just a lot of embarrassment and shame, and kind of self-body image stuff that weaves in and out of our decisions around what to share with our healthcare providers. And I think it's pretty easy to just say, "Oh, in the course of the last couple of months, have you experienced..." And then list off the symptoms of the three most common pelvic floor disorders, right? Leakage, unwanted urinary leakage or bowel accidents or do you feel like something is off, like there's a bulge coming out of your vagina? And if they say yes, you can say, "Does

it bother you? And how much does it bother you?" If there's like an affirmative answer to both of those, that warrants a referral, I think.

Tammy Kremer:

So we're coming to a close here. I want to bring you back in, Nicole. What are some things that you would like to share that if you could talk to your friends or a sister or a cousin, what would you like people to know about what you went through in order to help them kind of assess their own health?

Nicole Curutchet:

I really think it's a stigma about talking about your body and talking about that stuff. I remember when I went back to work, for me to be out as long as I was out, people were like, "Whoa, something must have really happened." And some of the female colleagues that I had, I chose to share what was happening with some of them. And I did that because there's not a lot of info out there. And when you would talk about it, I can say 70% of the people that I told what was going on, they're like, "What?" And because I told one of my friends what was going on with me, I kid you not, not even six weeks after I had my surgery, she had a prolapse bladder.

Tammy Kremer:

Wow.

Nicole Curutchet:

It just happened to her. And she goes, "Is this what that felt like?" I'm like, "Yeah." So sure enough, she had to go in, she had to get the surgery. She was open enough to talk to me about it, right? And so, it's okay. I mean, I just learned so much from you just about the different types of pelvic floor issues, right? So you're never going to know until you start talking. And this is our bodies and it's the truth, and we don't want people to suffer, so why not talk about it? That's the whole purpose of me being here.

Tammy Kremer:

Let's talk about it.

Nicole Curutchet:

Let's talk about it.

Tammy Kremer:

Yep, yep.

Nicole Curutchet:

Right?

Tammy Kremer:

And Dr. Ramm, anything that I didn't ask you that you want to share with our listeners?

Dr. Olga Ramm:

I often tell people this, I appreciate you making the drive from Santa Clara and there are a limited number of board certified pelvic reconstructive surgeons, even in a metropolitan area like the Bay Area. And so, sometimes patients will choose to go to their local gynecologist or local urologist and not do the due diligence. And I often tell people, "oh, you've probably driven further than this to get a good deal on your furniture. So you might as well do that same kind of research and make sure that this person has board certification in the surgical subspecialty that you need before you make the decision." Historically, there's a wide variety of surgeries that have been done for some of these conditions and there's also a very wide range of successful outcomes. So it's really important to have that data presented to you and to have it be driven not only by evidence, but by your own individual goals.

Tammy Kremer:

So to close, I always like to ask our guests, what's one thing you hope we can create by coming together for sexual health? Dr. Ramm, do you want to go first?

Dr. Olga Ramm:

Yeah. I hope that beyond an awareness, we can create a space where all the different layers of the medical system, but also of society at large, feel comfortable talking about... I mean, I think the term sexual health oftentimes is marginalized from health with a capital H, but it is such an integral part of it, and it's also such an integral part of how we relate to ourselves, to our partners, and then to the outer world. And so, if we feel good within and we feel good in our partnership, we show up in a much more positive way to the world.

Tammy Kremer:

Thank you. Nicole.

Nicole Curutchet:

I have to say, doing this with you, I was thinking in the back of my head of how cool is this, that a patient gets to have a relationship with a surgeon like this, right? We put surgeons on this pedestal, and rightfully so. I mean, really, you help us, you take the pain away, but at the end of the day, you're a normal human being and the good ones have compassion, have empathy, and I wish there were more relationships between a patient and a surgeon like this because I really think it would help to have an open conversation. So I wish it just makes surgeons or doctors aware that sometimes, patients are afraid to talk and be honest, and I hope that's what could come out of this as well, besides awareness.

Tammy Kremer:

Yeah. Thank you. Well, thank you both so much for everything you shared today, coming from your own personal story and the work that you've dedicated your career to. I know I have learned a lot, and I'm sure our listeners and our viewers will as well. So just thank you again.

Nicole Curutchet:

Thanks for having us.

Dr. Olga Ramm:

Thank you. Thanks for making the time to hear what we have to say.

Tammy Kremer:

Absolutely. Thanks for listening and please follow and rate us wherever you get your podcasts to help more people find us. And hey, how about sharing this with a friend or a colleague you'd like to talk with about sexual health? Check out the show notes for the resources mentioned in this episode and the transcript of the show. Connect with us on Instagram at Coming Together Pod, on X @CaliforniaPTC, and at comingtogetherpod.com. This podcast is produced by me, Tammy Kremer, with our co-producer and editor, Isaiah Ashburn, brought to you by the California Prevention Training Center. We're based at the University of California, San Francisco, and would like to acknowledge the Ramaytush Ohlone people, the traditional custodians of the land that UCSF sits upon. Thank you for coming together for sexual health.