(PFM) is healthy and functional, it is voluminous and has a good capacity for contraction and relaxation. However, when there is a weakness in the functioning of this musculature, several dysfunctions can occur and influence the female sexual function. Sexual dysfunctions (SD) are classified into female orgasm disorder; female sexual arousal disorder; genito-pelvic disorder/penetration; and substance-induced sexual dysfunction. SD and MAP usually impact women, generating activity and participation limitations.

Objectives: To identify PFM disorders in young nulliparous women and correlate them with sexual function.

Methods: A descriptive, observational, cross-sectional study with a quantitative approach was carried out. The sampling process was of the convenience type, being selected women aged between 18 and 30 years, nulliparous, who had never been pregnant, had already experienced the first sexual intercourse and who were not menstruating on the day of the evaluation. The evaluation was carried out through the application of questionnaires (socio-clinical questionnaire, Pelvic Floor Distress Inventory, Female Sexual Function Index, International Consultation on Incontinence Questionnaire-Short Form, Jorge & Wexner Anal Incontinence Scale) and, later, by the physical assessment of perineal body tone, external anal sphincter tone and PFM strength using the Perfect scheme. Data were analyzed according to the distribution of sample normality, comparing the groups with and without pelvic floor dysfunction according to the occurrence of urogenital dysfunction using the t test for independent samples. The Statistical Program for Social Science program (version 23) was used, considering a significance level of 5%.

Results: Participants were 45 young nulliparous women with a median age of 21 years. Most participants (75.5%) had an active sex life with a steady partner. Regarding pelvic floor disorders, 24.44% had bladder dysfunction (urinary incontinence), 31.11% had SD (pain and low lubrication) and 15.55% had coloproctological changes (intestinal constipation). Most of the sample had muscle weakness (with a median of 3 degrees) and normotonia in the perineal body (n=33) and external anal sphincter (n=38). Participants with SD had worse values for the pain/discomfort and lubrication domains in the Female Sexual Function Index instrument. In the comparative analysis between SD and other PFM dysfunctions, it was verified that the group with SD had more vaginal (p=0.04) (trigger points and fissures) and intestinal (p=0.02) dysfunctions (intestinal constipation). There was a correlation between SD, vaginal (R=0.04) and intestinal (R=0.04) dysfunctions.

Conclusion: There was a predominance of urinary dysfunction among PFM disorders and the prevalence of SD was high, taking into account that these are young nulliparous women. Women with sexual dysfunction have worse intestinal and vaginal functions with a correlation also between the same dysfunctions.

Implications: In scientific terms, this study presents relevant data by presenting high frequencies of pelvic floor dysfunctions and correlations with SD in young and nulliparous women. In clinical terms, this study presents relevant data by presenting high frequencies of pelvic floor dysfunctions and correlations with SD in young and nulliparous women. The importance of the functional assessment of the PFM and how the sexual function of the PFM can be assessed by the physiotherapist is highlighted.

Keywords: Women’s health, Pelvic diaphragm, Sexuality

Conflict of interest: The authors declare no conflict of interest.

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