(PB4015) FEASIBILITY AND CLINICAL OUTCOMES OF PELVIC FLOOR THERAPY IN FEMALE ALLOGENEIC HCT RECIPIENTS WITH CHRONIC GENITAL GVHD

Topic: 23. Stem cell transplantation - Clinical

Portia Smallbone*[1], Nichole Samms[1], George Chen[1], Jin Im[1], Richard E. Champlin[1], Elizabeth J. Shpall[1], Amin Majid Alousi[1]

[1]*MD Anderson Cancer Center, Houston, United States of America;*

Background

Chronic dyspareunia is common post allogeneic stem cell transplantation (HCT). Chronic genital graft-versus-host disease (vGVHD) is an underrecognized complication, associated with dyspareunia, vaginal stenosis, introital narrowing, and significant impairment of sexual and emotional quality of life. While medical management including corticosteroid therapy is standard, the role of dedicated pelvic floor therapy (PFT) in genital cGVHD remains poorly defined.

Aims

To evaluate the feasibility and clinical outcomes of pelvic floor therapy in female HCT recipients, including those with vGVHD.

Methods

We performed a retrospective chart review of adult female HCT recipients referred for pelvic therapy between 2018-2025. Clinical characteristics, NIH cGVHD staging criteria, therapy engagement, pain scores and functional outcomes were evaluated. PFT consisted of 40-60 minutes sessions including education, manual myofascial release, pelvic floor muscle exercises, and structured home dilator therapy.

Results

29 patients post-HCT received pelvic therapy. Dyspareunia was the predominant presenting symptom (90%), with 50% reporting dryness and 20% reporting additional pain symptoms or non-vulvar symptoms. 10 patients had confirmed chronic vaginal GVHD, 13 demonstrated documented pelvic floor hypertonicity, while 6 were referred for incontinence.
Among patients with vGVHD, all patients had concurrent cGVHD at referral (median NIH score 6.5 (range; 1-9)). Multi-organ involvement was common, most frequently oral (60%), ocular (60%) and fascial (50%). Median age at HCT was 51 years (range 30–57), and median time from HCT to pelvic therapy initiation was 23.1 months (range; 6.1-115.7m). All but one patient received prophylaxis with post-transplant cyclophosphamide, mycophenolate and tacrolimus.
Most patients were receiving established GVHD-directed therapy at referral: 60% were on concurrent systemic immunosuppression (tacrolimus, ruxolitinib, or belumosudil), 60% were using topical corticosteroids, and 70% topical estrogen therapy. Two patients required escalation of systemic therapy (oral corticosteroids and ruxolitinib) for progression of extra-genital GVHD during follow-up. Four patients had clitoral phimosis or labial resorption, and three patients required surgical management (lysis of adhesions or reconstruction) during disease course. 30% were sexually active at time of referral, with 2 patients commencing sexual activity by completion of PFT.
Median number of PFT sessions completed was 2.5 (range 1-24), with 40% completing prolonged therapy (13-24 sessions). Baseline median pain score was 7/10 (range 2-10), improving to 3.5/10 at 6 months in patients with available follow-up. All patients completing prolonged therapy reported ≥50% subjective improvement, with reduction in median pain score.
Documented barriers to completion (n=8) included surgical intervention (n=3), geographical or logistical constraints (n=3) and pain limiting adherence (n=2); no specific barrier was documented in the remaining cases.

Summary/Conclusion

Pelvic floor therapy is feasible in female HCT recipients, including those with chronic vGVHD. Clinically meaningful reductions in pain scores were observed, particularly among patients with prolonged engagement. These findings support integration of structured pelvic floor therapy into multidisciplinary management of vGVHD and warrant prospective evaluation.