Newsletter No.4 2012

Dear Colleagues,

NOTE:

As for all online versions of past Newsletters – the bulk of the opening letter has been removed.

However, I have left in the Results of a WHTA Survey we performed which may be of interest regarding whether WHTA should providing education and training to other professional groups.

At the end of the Newsletter are two Appendices which outline the anonymous written responses to this survey. It is very interesting reading and I thank all who contributed.

Contents pp

Topic 2: Results of Survey regarding "WHTA Education for Nurses"

As most of you would be aware, in the middle of August I sent an email to all WHTA members asking for your support in completing an anonymous survey regarding professional development of Continence Nurses Advisors by WHTA. This questionnaire was sent out as I had been asked by a number of you who work with CNA's about whether I would be happy to provide this. As I mentioned in my email to you all, this did raise a number of ethical issues. I therefore asked for your opinions before making any decisions about whether I provide this service in the future.

(for those of you who only joined WHTA recently I have copied the email into the first Appendix at the end of the newsletter so that you can read the issues involved).

May I begin by saying thank you to the 37 physiotherapists who responded!! That was an amazing response rate and I feel very honoured that so many of you took the time to respond. It has been very interesting reading your thoughts and it has definitely helped in deciding the future path I will take on this issue.

For those of you who are interested……. The numeric results were:

Question One:

As a physiotherapist, have you attended a course on pelvic floor dysfunction that was attended by both registered nurses and physiotherapists?

- Yes — 17 people
- No — 20 people

Question Two:

If Yes….. what was your opinion of having a multidisciplinary course?

- Excellent, it was really beneficial — N = 0
- Good, it was a benefit — N = 6
- Ok, Neither good nor bad — N = 6
- Negative, it reduced the quality of the course — N = 3
- Negative, we were giving physio skills to nurses — N = 2

Question Three:

In terms of the possibility of WHTA running professional development courses for physiotherapists and registered nurses, do you think WHTA should:

- Only run courses for physiotherapists — N = 4
- Run courses that can always be attended by both — N = 0
- Run courses for both, sometimes together — N = 18
- Run courses for RN's, but always separate to PT courses — N = 15

QUESTION THREE: Written Comments

I have attached all the written comments given for Question three at the end of the newsletter as an appendix. They are quite long, but I think they provide some very useful insight into other physiotherapist's experiences, and the implications of this issue. I would encourage you to read through them as they provide an extremely insightful summary of the work experiences of various physiotherapists around the country in this area – ranging from very positive to not so positive.

So what is my decision on this issue ?? (after considering all the written comments specifically)

- From 2013 I do plan to offer courses to
  - Continence Nurses in the area of **Overactive Bladder, Urgency, Frequency and Nocturia.**
  - Registered Midwives in the area of **Pelvic Floor, Birth Related PF Trauma, Postnatal Bladder Function etc**

- These courses will be run **separate** to courses I run for Physiotherapists and will have a different content focus

- Courses for Continence Nurse Advisors and Midwives will have a number of aims:

1. Increase understanding of the complex anatomy and physiology of the pelvic floor related conditions / LUTS

2. Explanation/ Instruction on Advanced Assessment skills that are relevant to RN's and RM's
   - eg explaining of sensation bladder diaries both for OAB and postpartum, urodynamics etc,
   - explaining to midwives the role of basic PF assessments during pregnancy to identify women with weak or inco-ordinate PF, explaining the role of endoanal ultrasounds after anal sphincter injuries, role of ultrasound and MRI in diagnosing avulsion

3. Explanation of Treatments that I feel are universal to Nursing and Physiotherapy
   - eg advice re fluid intake, behavior / lifestyle modification / urge suppression strategies, bladder drills,

4. Explanation of the scope of practice of physiotherapy in the area of pelvic floor and how to identify which patients would benefit from a referral to a physiotherapist.

5. Explanation of times where physiotherapists often need to refer to Continence Nurse Advisors
   - eg high post void residuals needing self catheterisation training, skin care management in patients with severe urinary incontinence, advice re pads / protective garments etc.

By doing this I think we can contribute to the good will cause amongst health professionals of the sharing of knowledge, whilst also maintaining our scope of practice as unique. In addition, I think this could then also be a way of ultimately promoting / differentiating our role as physiotherapists, and increasing awareness of when we as physiotherapists can be a valuable first line or additional approach for women with these conditions.

PART TWO
Clinical Information Section

MAIN Clinical Focus	**Assessing Bladder Sensation and Urgency in the Subjective History**
Handy Tips in the Clinic	**Vaginal e-stim** **- times when I use it!**
In the News	**Johnson & Johnson stop sale of Vaginal Mesh!!**
Publication Review	**EAU makes Clinical Guidelines Available in full Text**
Research tweets	**Past couple of months**

Clinical Focus Topic URGENCY

As many of you know, the LUT complaint of "***Urinary Urgency***" is probably one of my favourite areas to treat in the clinic and also one of my favourite areas to teach about in the training room. I find the challenge of determining the true anatomical cause behind the symptom makes it an intellectually stimulating field to work, and I also believe that physiotherapists have an enormous range of skills that are useful in treating this distressing LUT symptom.

What do we know about Urinary Urgency??

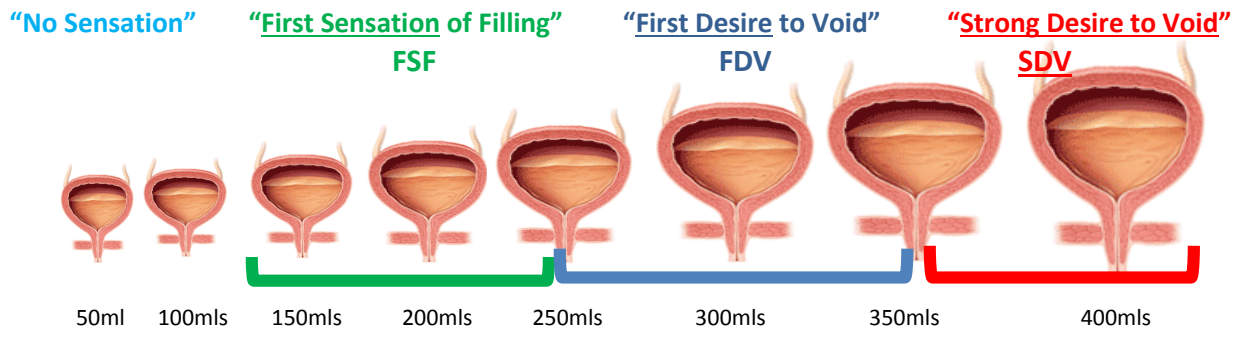
1. **Urinary Urgency is a *SENSATION!!!*** (as a opposed to a motor dysfunction)

   Comment: *Urgency is something a person feels. By definition we are therefore talking about an alteration to the normal sensory experience of the bladder filling. In different people it has a different cause, and may or may not be linked to altered motor function of the lower urinary tract.*

2. **Experiencing a sensation of urinary urgency is different to experiencing a 'Strong Desire/Urge to Void'.**

   Comment: *A 'strong desire/urge to void' is a normal sensation that we expect a person to feel when the bladder is very full. In fact, it is one of the three official bladder sensations (as per IUGA / ICS) that a person is meant to experience during the filling phase of bladder function. It is generally perceived as a strong pressure in the lower abdomen that may be a little uncomfortable, but does not cause a fear about leakage. People don't necessarily like the feeling associated with an extremely full bladder, but it is not an abnormal sensation to have. Most importantly, whilst a strong urge to void gives a strong instinctive desire to go to the bathroom, people experiencing this sensation should feel they can defer for a little while if they have to (eg waiting for a test).*

NORMAL BLADDER SENSATION DURING THE STORAGE PHASE (ICS / IUGA)



it is NORMAL to feel a strong desire to void at some point!

A strong urge to void is only regarded as abnormal if the person experiences it at volumes less than about 350mls. Even in this scenario it is still different to a sensation of urgency. A strong urge to void at 200mls is simply increased bladder sensation, not necessarily urgency.

3. **The sensation of urgency is defined by the International Continence Society & International Urogyneacology Association Terminology Report (Haylen et al 2010) as a "compelling, difficult to defer desire to pass urine**"

Comment: *The difference with a sensation of urgency is that the person no longer feels they can defer voiding. They feel they have no choice but to go to the bathroom. Even if deferring is deemed necessary (eg waiting with a full bladder to have an ultrasound), they will decide to pass urine anyway (even if this means missing their appointment) rather than try to defer.*

4. **People who suffer from bouts of urinary urgency do not necessarily experience it every time they void.**

Comment: *A person may void 12 times per day, but on only 1-2 occasions each day experience a sensation that they MUST stop in the middle of doing something and rush to the toilet (urgency). There is therefore a difference between assessing someone's urinary frequency each day, and assessing the number of episodes of urgency they experience each day.*

5. **People who don't have urinary frequency can still suffer from Urinary Urgency**

Comment: *Just because a person only voids 4-5 times per day doesn't mean they don't suffer the distressing symptom of urinary urgency. They may void 4-5 times each day, but once every two days get a sudden, intense 'urgency' that comes out of nowhere and makes them scared they aren't going to make it to the toilet in time.*

6. **People with urinary frequency don't necessarily have urgency**

Comment: *Whilst people with urinary urgency will often void frequently in an attempt to avoid it happening, there are numerous causes of urinary frequency other than urgency. Small bladder capacity (low compliance bladder) and high post void residuals are both examples of LUT dysfunction that will cause urinary frequency without ever necessarily giving a patient a sensation of urgency (they are likely to just get a strong urge to void and then pass a small volume of urine).*

7. **Experiencing a bout of urinary urgency does not necessarily relate to a certain bladder volume**

Comment: *There is now thought to be two different types of urinary urgency (Blaivas et al 2009). A sensation of urgency that occurs because a person has reached their maximum bladder capacity (Type 1 Urgency), and a sensation of Urgency that seems to be unrelated to bladder volume (Type 2 Urgency). Type 2 urgency tends to be an all-or-nothing sensation similar to switching on a light switch. People can go from "No sensation of their bladder filling" to "A sensation of urgently having to race to the toilet" with no sensation in between. Whilst other people (those with Type 1 urgency) will say that they only get to that point of urgency after having had to delay a mild urge to void (ie they had smaller urge earlier but there bladder then*

reached capacity and it felt quite urgent). In addition, Type 1 urgency is usually associated with a feeling that their bladder is actually full. In Type 2 Urgency people will often acknowledge that their bladder doesn't necessarily feel full, yet they still feel a desperate urge to rush to the toilet / fear that they will leak if they don't rush to the toilet. It is now suggested that these two types of urgency could be from completely different pathophysiological mechanisms.

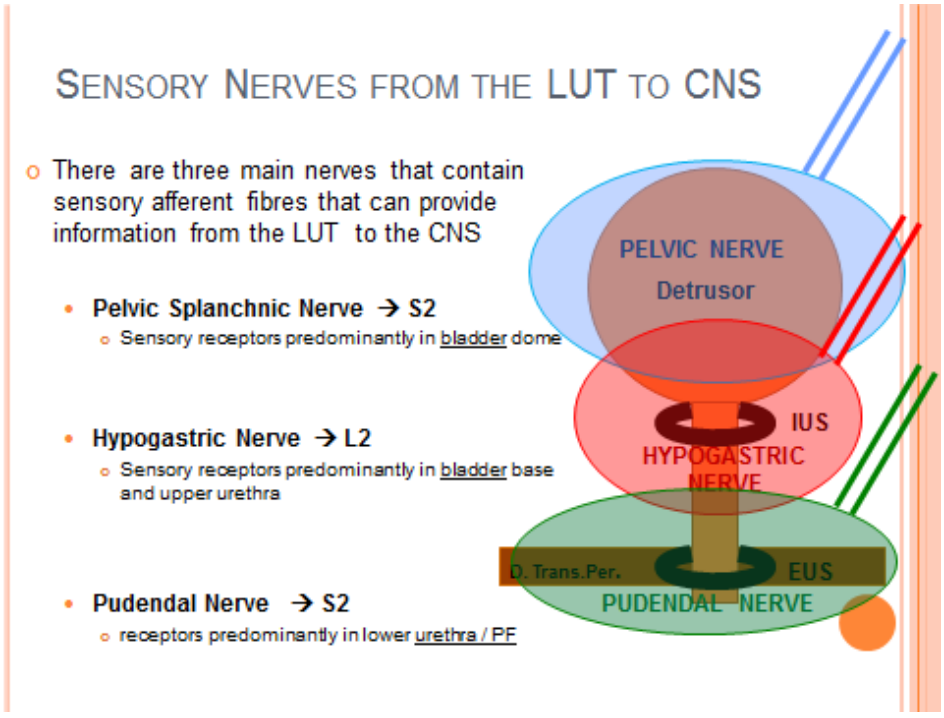
8. **The symptom of urinary urgency is different to urinary incontinence**

Comment: As physiotherapists who treat various forms of urinary incontinence we tend to be very good at focusing on 'incontinence episodes' and not focusing on urgency episodes. However, some people experience urgency 3-4 times per day but never leak. Other people get urgency only 1 per day but leak every-time it happens. Whilst historically OAB-Dry has been thought of as a more mild form of Urgency, it is now questioned whether they are completely different mechanisms. A person with OAB-Dry may experience a stronger sensation of urgency, but have no motor issue causing leakage, whilst a person with OAB-Wet may have a milder urgency (milder sensory dysfunction) but an additional motor dysfunction causing the leakage.

What causes a sensation of Urinary Urgency??

More and more research seems to be indicating that the sensation of 'urinary urgency' can probably be caused by multiple different dysfunctions. If we accept that urgency is an abnormal sensation, then we assume that there is abnormal sensory processing someone within the nervous system. This could be anywhere from the starting point of the lower urinary tract structures all the way up to and including sensory processing in the brain.

Even at the level of the lower urinary tract there are numerous sensory innervations that could be dysfunctional.



As all three of these nerves have sensory fibres that innervate the LUT, potentially any of them could send an abnormal signal to the cortex that is interpreted as urgency.

Therefore, possible causes of urinary urgency include (theories in the literature)

Bladder Causes *(via Pelvic Splanchnic & Hypogastric Nerve facilitated urgency Sensation)*

- Segmental Detrusor Overactivity → stretch of adjacent bladder wall sections
- Abnormal autonomic sensory nerve receptor density / activation
- Urothelial damage → abnormal sensory receptor / nerve ending exposure
- Urothelial dysfunction → abnormal release of neurotransmitters into bladder wall

Urethral Cause Theories *(Hypogastric and Pudendal Nerve facilitated urgency Sensation)*

- Poor bladder neck support → urethral opening → urethral sensation
- Urethral Sphincter instability → spontaneous relaxation of the urethral sphincters during storage

Pelvic Floor Muscle Cause Theories *(Pudendal Nerve facilitated urgency Sensation)*

- Pelvic Floor Overactivity / Trigger points
- Pelvic Floor Underactivity → poor detrusor inhibition

Cortical Cause Theories

- Altered cortical processing of LUT sensation when it arrives at the cerebral cortex.

*Note: most of these theories are in the process of research testing to prove their validity.

Assessing Urgency in the Subjective History - Do we do it thoroughly enough???

Whilst understanding the varying anatomical dysfunctions behind urgency is obviously extremely important to determine the best treatment, before we even get to treatment planning the first step must be to accurately ***identify whether urgency*** is really one of the patient's problems.

When supervising students in the area of pelvic floor dysfunction I often find they perform a lot of questioning in the history around fluid intake each day, number of voids per day and number of voids per night. They will also ask a lot of questions about incontinence episodes, volume leaked on each episode etc. However, specific questioning on bladder **sensation** and **urgency** seems to often be a bit limited. The problem is that for some people, the sensation of urgency 3-4 times a day sometimes bothers them more than their stress incontinence even though they may not leak.

Obviously there are lots of different approaches to taking a pelvic floor subjective history. Every person needs to work out what style of questioning works for them. Every time I take a history my questioning changes slightly depending on the person and information they have given. Outlined below is purely one example of what I may ask a person when doing the section of the subjective history on Bladder Function:

TARYN'S VERSION OF BLADDER FUNCTION QUESTIONING

Ok, to work out exactly what is going on, I just need to start by asking you a few questions about your day to day bladder function.....

1 Fluid Intake Questions

First of all, could you tell me roughly how much fluid you usually drink in a day?

→ Water: _____ → Tea: _____ → Coffee

→ Alcohol: _____ → Other: _____

2 Urinary Frequency / Nocturia Questions

And how often would you usually pass urine through the day? _____

Every hour? Every 3hours? _____

Does this bother you? YES / NO

Do you need to get up to pass urine through the night? Y / N

How many times: _____

Between what hours of the night is this – what time do you go to sleep?_____ Get up? _____

3 Urge to Void / Bladder Sensation / Urinary Urgency Questions

When you first get an urge to pass urine, how long can you normally hold on before going to the toilet? _____

Do you ever get an urge to void that is so strong you have to suddenly stop what you are doing and race to the toilet, or can you hold on if you need to?? eg would you ever have to leave your shopping at the cash register and race to the toilet? Yes / No

IF YES to Urgency:

How often would you get that feeling of really strong urgency where you feel you have to race to the toilet??

_____ per day / week / month

In most people, the first urge to go to the toilet is mild, then the urge gradually builds as their bladder fills. In some people though, the urge to void can change from nothing to desperate in an instant? Does that sudden, desperate urge without warning every happen to you? Type 1 / Type 2 Urgency / Both

How often? Frequency Type 1 Urgency?_____ Frequency of Type 2 Urgency? _____

When that sudden urgency occurs, does it feel like your bladder is full, or is it a different feeling?_____

Is there anything that you have realised commonly triggers that feeling of urgency coming on? eg hearing running water, approaching home etc _____

When this strong urgency feeling occurs, do you ever not make it and leak before getting there?

Yes / No How often? _____ per day / week / month _____ (amount) eg 20c, 50c, outer clothes, down leg

At other times, when it's not such a strong urgency feeling, and it's just a mild feeling that you bladder is starting to fill, if I asked you to wait, how long can you usually hold on from when you have first felt the urge to void? _____ min

Clinical Tip – *'e-stim' When do I use it?*

There is no doubt that the use of electrical modalities as a treatment (eg therapeutic ultrasound, TENS, interferential, muscular stimulation) is one that tends to divide physiotherapists across Australia. There appears to be an unspoken judgment that electrical modalities are only used by private practitioners who want to simply put people on a machine for 30min and make money without having to do any hands on treatment.

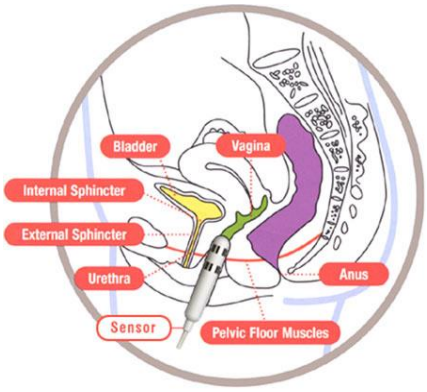
Whilst I am sure this scenario was true for a certain period in physiotherapy history, personally, I find very few examples of this today. Unfortunately though, it seems many people are now reluctant to use electrical modalities for fear of being branded as one of these "lazy practitioners".

The other difficulty is that different research papers on electrical modalities tend to always have different protocols regarding length of treatment, settings that should be used, frequency of sessions etc. This means that you virtually never get enough research on one type of protocol to be sure it is the best method to use. It is not surprising then that systematic reviews generally coming out saying "there is currently insufficient data".

It is understandable therefore that I regularly get questions from WHTA members about the use of e-stim, ranging from "Do you use e-stim?", "When do you choose to use e-stim?", "What settings do you use?", "How long before you notice a difference?"

So I thought I would just give you my opinion of what I find works. It is based as much as I can on the research, but it is also largely just my own clinical experience with patients as well.

Vaginal E-Stim: When do I use it?



There are six main scenarios where I will use vaginal e-stim in the clinical setting;

SCENARIO ONE: ***To ELICIT a Pelvic Floor Contraction***

We've all had them….. the patient who you just can't get a pelvic floor contraction. You have asked them to try to stop the flow, you have tried so many verbal descriptions and visual metaphors you think you could write a literary piece better than Shakespeare, you have tried proprioceptive feedback of pressing on the pelvic floor during a VE, you have tried RTUS for visual feedback, you have tried eliciting a co-contraction via TA and any other muscle group you can think of…… and STILL NO CONTRACTION!!

This is the group I am most likely to use vaginal electrical stimulation treatment on very early in the process of treating them.

Settings:	Frequency:	35-50Hz (usually ~40Hz),
	Intermittent:	3-4seconds on : 6-8sec off time
	Duration:	Minimum of 5minutes, often up to 20minutes.
	How often	Preferably at least 3 times per week.

Clinical Tips

The degree of activation of the muscle depends on its activation capability

a. If it is simply a co-ordination issue (ie on palpation the muscle has lots of bulk as though it should be strong), you should feel the probe move with activation of the muscle on the first session. In these cases, you often only need one or two sessions for them to work out what they are meant to be feeling, and they start doing it voluntarily without stim.

b. If it is an extremely weak, atrophic muscle, the person may feel the stim but you can't feel the probe move. It may be only activating the slightest flicker in the muscle. If used regularly I find the muscle should have developed enough strength to create a palpable voluntary flicker (Grade 1 - 2) within 3 weeks.

SCENARIO TWO: *To EXTEND the Length of a Contraction*

Sometimes I have someone attend the clinic who can contract their pelvic floor very strongly (Grade 4) but only for 1-2seconds and then it disappears completely. I try numerous strategies to get them to hold longer but they just can't. I assess them with a Peritron Perineometer and they squeeze up to 45cmH20 initially, and then immediately drop to 21cmH20, 12cmH20, 5cmH20 over just 1-2seconds. We start by just trying a 2-3 sec contraction but they can't hold it.

In this scenario I often use e-stim again. I am not doing this for strength, I am purely doing it to draw out the contraction.

Settings	Frequency:	35-50Hz (usually ~40Hz),
	Intermittent:	Starting with a minimum of 5 sec on time, and then each week increasing
	Duration:	Minimum of 5minutes, often up to 20minutes.
	How often	Preferably at least 3 times per week.

Clinical Tips

1. Make sure they are squeezing with the machine
2. The goal is to get them to start feeling the muscle squeeze for a longer duration

SCENARIO THREE: ***To INCREASE RESTING TONE / REDUCE HIATUS***

Ok… now I want to state this up front…… I have absolutely no research to back me up on this. But my clinical experience having used an objective measure of pelvic floor (Peritron Perineometer) with nearly all my incontinence and prolapse patients for over a decade is that Pelvic Floor exercises are excellent at increasing squeeze pressure, but they are only ok at increasing resting tone.

I can have a patient whose fortnightly results with PFMT are (I see most patients fortnightly):

Session One	Resting Tone = 18cmH20	Max Squeeze = 12cmH20 (MOS Gd 1-2)
Session Two	Resting Tone = 19cmH20	Max Squeeze = 18cmH20 (MOS Gd 2)
Session Three	Resting Tone = 19cmH20	Max Squeeze = 23cmH20 (MOS Gd 2)
Session Four	Resting Tone = 20cmH20	Max Squeeze = 29cmH20 (MOS Gd 2-3)
Session Five	Resting Tone = 20cmH20	Max Squeeze = 31cmH20 (MOS Gd 3)

By the end of session five I am becoming fairly happy with the *Strength* of their squeeze, but their resting tone is still quite low. If this person is a runner I really want to increase their resting tone.

This is a person I will do e-stim on. I tend to find really **high intensity e-stim** is one of the easiest ways to get resting tone up. They also come back saying that the vagina feels tighter.

What do I mean by high intensity??

Settings	Frequency:	35-50Hz (usually ~40Hz),
	Intermittent:	6-8 sec on time, 3-4sec off
	Duration:	20-25 min
	How often	At least 3 times per week, preferably everyday

Clinical Tips

1. This is an intense program. The ratio is 2:1.
2. Make sure they are squeezing with the machine for at least the first few minutes.
3. If doing this daily, or twice per day warn them to watch for signs of pain. If they develop any pain they need to reduce back to only using every second day.

In the example above it is not uncommon that I will have someone come back after 3 weeks of doing this e-stim everyday and their results are then:

Session Six	Resting Tone = 28cmH20	Max Squeeze = 31cmH20 (MOS Gd 3)

SCENARIO FOUR: ***To INCREASE the SPEED of the Contraction***

Sometimes I have someone who can perform a reasonably strong Pelvic Floor contraction but the speed of the

contraction is really sluggish. It takes some people 2-3 seconds to get to maximum squeeze. This isn't particularly helpful if they are trying to squeeze quickly before a cough or sneeze. Obviously I simply try getting them to practice voluntarily doing a faster squeeze initially, but if it stays really sluggish and slow I will also use e-stim.

To get this to work you need to use a customizable program on your machine as you will want to specifically set the "Ramp Time". (Ramp time = the time the machine takes to increase to maximum set intensity)

Both the Pericalm and the Neurotrac Pelvitone and Neurtrac Continence allow you to set the ramp time when using a Customisable program.

Settings	Frequency:	35-50Hz (usually ~40Hz),
	Intermittent:	3 sec on time, 3sec off
	Ramp Time:	0.6 – 0.7sec
	Duration:	20-25 min

Clinical Tips

0.6 – 0.7 seconds ramp time is quite a quick ramp time. Warn the patient that when it goes onto the On Cycle it will climb to its max stimulation intensity very quickly. The Patient will feel it as a very sudden contraction.

Note: in reverse, if I have someone in scenario One (no pelvic floor contraction) who is postmenopausal, atrophic and is very sensitive I will slow the ramp time right down. People who are sensitive and find the sensation of electrical stim uncomfortable usually cope better with a slow ramp time. I would then set the ramp time to 2.0 – 2.5sec.

SCENARIO FIVE: *For Urgency, Frequency and Nocturia (not related to Nocturnal Polyuria)*

If I have someone who has urgency, frequency and nocturia who has plateaued despite using manual therapy, behaviour retraining, bladder retraining/bladder drills, lifestyle modification etc. I will then implement vaginal e-stim.

The research on settings for urgency, frequency, detrusor overactivity etc is quite variable. They tend to range from 10-20Hz. Personally, I have often had better success closer to 20Hz.

Settings	Frequency:	trial 10Hz for 2 weeks
		If no change, change to 15Hz for 2 weeks
		If no change, trial 20Hz for 2 weeks
	Continuous Stimulation	
	Duration:	30-45minutes
		3—4 times per week

Clinical Tip I tend to find that the first sign of improvement is a reduction in nocturia. People come in saying "I slept all through the night for the first time in years". Depending on how severe they were to start with, I often find this happens within 3-4 weeks of using the machine.

SCENARIO SIX: ***In severe PF pain patients with allodynia / extreme sensitisation***

Again – I need to state that this is not from research. It is just my clinical experience. Some of my pain patients have the unusual combination of extreme vaginal pain to touch despite only mild hypertonia. They are the patients than can accommodate a single finger examination quite easily from a tension point of view, but the pain trigger occurs if you move your finger over the vaginal mucosa or with gentle tension on the muscle.

NOTE: The patients I am referring to are very specific!!!

- They have minimal pain on a single finger examination if you keep your finger still.
- They have excruciating pain any time you are moving your examining finger
- The pain is not related to pressure onto the muscle belly of levators or superficial pelvic floor, it is more related to the mechanoreceptor stimulation of a moving examining finger.

These patients seem to respond really well to low frequency vaginal e-stim for pain.

Settings
Frequency: 3Hz
Continuous Stimulation
Duration: Start with 5minutes each night
If tolerating well, increase to 10min after 1 week.
If tolerating well, increase to 15min after another week
If tolerating well, increase to 20min after another week.

Clinical Tip There is not a consistent response to this. Some patient respond really well and there pain is down to a manageable level for VE's within 3-4 weeks, other people feel it irritates their pain. You start with a small duration and simply see how they go.

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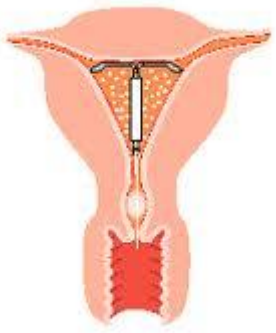
One other consideration: E-stim with a Mirena IUD



Traditionally, having an IUD insitu was a contra-indication to having vaginal e-stim. This however was largely due to the fact that most women a decade or two ago were having the old "Copper IUD" and people had concern regarding close proximity of a metal.

These days most women who want an intra-uterine device option choose the **Mirena IUS** (intra-uterine system) .

note – the Mirena is regarded as an "Intra-Uterine System" rather than just an Intra-Uterine device because it has a localised hormonal release mechanism.

I regularly receive enquiries as to whether I do e-stim with someone who has a Mirena.

Mirena and Vaginal E-Stim – do I use it??

The short answer to this is Yes, the device is entirely plastic (including the strings) and is situated up inside the vagina away from where the probe will be active. It shouldn't really have any way to conduct..... **BUT!!!!!!!**

The difficult part about this is that we don't have any research to guide us.

So what do I do???

I let them make an informed decision having been given truthful information.

I explain the following points to my patients!!! (ie I specifically state each of the following)

- We still have IUD listed as a contra-indication for e-stim in the information booklets that come with the machine
- This was largely due to the old metal IUDs and risk of conductivity
- The Mirena is plastic so in theory should be fine.
- However <u>WE DO NOT HAVE ANY RESEARCH TO PROVE IT IS SAFE.</u>
- I have had at least 20patients with a Mirena use e-stim and never had a problem, but there is always a chance.
- If they notice any pain, discomfort or altered sensation they must cease using the machine immediately.

Note – Paragard IUD

Whilst not commonly being used in women in Australia, the Paragard IUD (non-hormonal and also known as the "Copper T") is available and has copper around its centre. Women choose this if they want a non-hormonally releasing device. It does often make periods heavier (as opposed to the Mirena which makes then lighter or non-existent). Officially this is contra-indicated for vaginal e-stim.

In the News – Johnson & Johnson cease sale of vaginal mesh!!

Acknowledgement: Thank you to Melanie Bennett who alerted me to this announcement.

For those of you who have attended the Advanced Pelvic Floor – Prolapse and Stress Incontinence course you will remember me talking at length about the issue of vaginally placed mesh and risk of erosion / pain after placement. As a result of complications associated with vaginal placed mesh there have been thousands of formal incident reports and the FDA in the USA has issued two public health warnings.

This has then led to an enormous number of law firms advertising to recruit women to class actions against the major companies producing vaginal mesh (Johnson and Johnson's sub business Ethicon, Boston Scientific, American Medical Systems etc).

Please find below just two of the many articles that have been printed on this announcement:

Article 1:

Link: http://www.bloomberg.com/news/2012-06-04/j-j-tells-judge-it-will-stop-selling-vaginal-mesh-implant.html

J&J Tells Judge It Will Stop Sales of Vaginal Implants

By Alex Nussbaum and Jef Feeley - Jun 6, 2012 6:12 AM GMT+1000

Johnson & Johnson (JNJ)'s Ethicon unit told a federal judge in West Virginia it intends to stop selling four vaginal mesh implants after being sued by more than 600 women who say the products caused internal injuries.

Johnson & Johnson said it has requested approval from the Food and Drug Administration to stop "commercializing" the devices, in a letter filed yesterday with U.S. District Judge Joseph R. Goodwin in Charleston, West Virginia, who is overseeing the litigation. An Ethicon spokesman said in an e- mail that the unit would halt sales of the devices worldwide.

The FDA in March said New Brunswick, New Jersey-based J&J had sold one of the implants, the Gynecare Prolift, for three years without proper regulatory approval. That followed the agency's order in January that J&J and 30 other makers of vaginal mesh implants study organ damage and other health complications blamed on the products, which are used to treat incontinence and shore up weakened pelvic muscles.

Ethicon has asked the FDA for 120 days to end sales so it can "notify its customers and provide those hospitals and surgeons with sufficient time to select alternative treatment options for their patients," the J&J subsidiary said in its letter. "Ethicon will also discontinue or revise, as appropriate, all marketing materials during this time."

The FDA hadn't responded to the request, according to the letter. The move covers the Prolift, Prolift+ M, TVT Secur and Prosima surgical meshes. Ethicon said it's asked the agency to let it continue selling a fifth product, the Gyencare Gynemesh, with a change to the labeling that restricts its use.

Hundreds of Lawsuits

Hundreds of women say the meshes, threaded into place through incisions in the vagina, have eroded and shrank over time, causing pain and injuries. Patients have filed suits against J&J, C.R. Bard Inc. (BCR) of Murray Hill, New Jersey; and Endo Health Solutions Inc. of Chadds Ford, Pennsylvania, along with other manufacturers.

"We are happy to see that Ethicon finally decided to do the right thing and stop selling these products," Bryan Aylstock, a Pensacola, Florida-based lawyer for mesh patients who are suing J&J, said in a telephone interview.

Ethicon is discontinuing sales of the products worldwide, Matthew Johnson, a company spokesman, said in an e-mail. It's not recalling meshes already sold or implanted and its decision isn't based on any safety concerns, he said.

'Carefully Considering'

"We came to this decision after carefully considering numerous factors" including "the commercial viability of these products in competitive and declining worldwide markets, the complexities of the regulatory environments in which we operate, and the availability of other treatment options for women," Johnson said.

"We continue to have confidence in the safety and efficacy of these products," he said.

Sales will be ended on a region-by-region basis, with the entire process to be completed by the first quarter of 2013, Johnson said. The Gynemesh will remain on the market only for abdominal implantations, he said.

An FDA spokeswoman, Erica Jefferson, said in an e-mail that she couldn't comment on Johnson & Johnson's plan regarding the vaginal mesh implants.

An agency report last year found a fivefold jump in deaths, injuries or malfunctions tied to vaginal mesh for organs that slump, or "prolapse," because of weakened support. Two months later, an advisory panel urged the FDA to reclassify the devices as "high-risk" products needing human testing.

Endo 'Committed'

Endo (ENDP) will continue selling incontinence and prolapse mesh, the company's senior vice-president for corporate affairs, Blaine Davis, said today in a telephone interview. While publicity about the products' safety has hurt sales, Endo sees the devices as a "very beneficial treatment option" when doctors choose the right patients, he said.

The company, which sold about $85.5 million in women's health meshes in the past fiscal year, is putting more money into training doctors about how to use the products and plans to conduct studies to prove their safety, he said. The scope of the studies is being discussed with the FDA, Davis said.

"As a company, we're very committed to these categories," he said. "We are actually investing behind these products."

Scott Lowry, a C.R. Bard spokesman, didn't return messages today seeking comment.

Prolift Approval

J&J, the world's biggest seller of health-care products, fell less than 1 percent to $62.21 at the close of New York trading. C.R. Bard rose 1 percent to $96.41. Endo, which sells mesh through its American Medical Systems unit, fell less than 1 percent to $30.81.

Ethicon introduced its Gynecare Prolift mesh in March 2005, touting it in an annual report as an "innovative and effective surgical option" for weakened muscles. The FDA said it learned of the Prolift only in 2007, when J&J sought approval for a related product.

The company said it could market the Prolift without approval because it was so similar to the already approved Gynecare Gynemesh, Morgan Liscinsky, an FDA spokeswoman, said in March. "FDA disagreed with this assertion," concluding distribution began "without appropriate" clearance, she said.

The FDA cleared the Prolift in May 2008.

The case is In Re Ethicon Inc. Pelvic Repair System Product Liability Litigation, MDL No. 2327, U.S. District Court for the Southern District of West Virginia (Charleston).

Pfizer Inc (PFE), based in New York, is the world's biggest health-care company by sales.

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Another Article

http://news.yahoo.com/transvaginal-mesh-lawyers-discuss-johnson-johnson-decision-stop-221613867.html

Transvaginal Mesh Lawyers Discuss Johnson & Johnson's Decision to Stop Sale of Vaginal Mesh Implants

Tue, Jun 5, 2012

Attorneys with Georgia's Blasingame, Burch, Garrard & Ashley, P.C., say that Johnson & Johnson's Ethicon unit should stop the sale of its vaginal mesh products immediately instead of by the first quarter of 2013.

Henry G. Garrard III, a Georgia lawyer who is a national leader in defective transvaginal mesh litigation, said today that he was pleased by Johnson & Johnson's recently announced decision to cease the sale of four of its vaginal mesh implants.

Garrard currently is serving as Coordinating Co-Lead Counsel of ongoing transvaginal mesh lawsuits in the U.S. District Court for the Southern District of West Virginia, and his law firm partner, Josh B. Wages, is a member of the Plaintiffs' Steering Committee.

The cases involve hundreds of women from across the U.S. who allege to have suffered physical and emotional injuries from defective vaginal mesh implants manufactured and sold by Johnson's Ethicon unit (MDL No. 2327) as well as C.R. Bard, Inc. (MDL No. 2187), American Medical Systems, Inc. (MDL No. 2325) and Boston Scientific Corp. (MDL No. 2326).

According to Bloomberg News, in a June 4 letter filed with the federal judge overseeing the litigation, Chief Judge Joseph R. Goodwin, Johnson & Johnson said it had advised the U.S. Food and Drug Administration (FDA) that it would "stop commercializing" four of its vaginal mesh implant systems: The Gynecare TVT Secur, Prosima, Prolift and Prolift+M.

The company asked the FDA for 120 days to end the sale of the transvaginal mesh products so it could notify customers and provide hospitals and surgeons with sufficient time to select alternative treatment options, Bloomberg

News reported. A company spokesperson told the news outlet that the sales would cease on a regional basis and be completed by early 2013.

According to Bloomberg News, Johnson & Johnson's Ethicon unit has asked the FDA to permit the company to continue selling its Gynecare Gynemesh product for use as abdominal implants.

Although Garrard said Johnson & Johnson's decision to discontinue the sale of the named vaginal implants was a positive development, he said that waiting until 2013 to complete the process was "unacceptable."

"We believe these devices should be taken off the market immediately," Garrard said.

Added Wages, "Despite Johnson & Johnson's announcement concerning its future plans, we will continue to press ahead with the complaints filed by our clients alleging that these products caused them to suffer significant harm."

Garrard, Wages and their firm currently are preparing for the first bellwether trial in litigation against C.R. Bard, Inc., the manufacturer of the Avaulta BioSynthetic, Avaulta Plus and Avaulta Solo support systems. Judge Goodwin set the first Bard trial date for February 5, 2013, according to court documents.

Johnson & Johnson's announcement comes exactly four months after the FDA ordered manufacturers of vaginal mesh products used for the treatment of pelvic organ prolapse (POP) and stress urinary incontinence (SUI) to conduct post-market surveillance studies of their devices. These studies are also commonly referred to as "522 studies."

In a July 2011 report, the FDA said it had received 3,979 reports of injury, death and malfunction involving "urogynecologic surgical mesh products" between 2005 and 2010. Most of those reports had been received between 2008 and 2010, when the number of reports involving mesh used for POP repairs "increased by more than 5-fold compared to the number of reports received in the previous 3 years," according to the agency.

The FDA found that "serious complications," including mesh erosion and vaginal shrinkage, linked to surgical mesh for transvaginal repair of POP "are not rare," and that it was not clear that transvaginal POP repair with mesh was any more effective than non-mesh repair.

In September 2011, an FDA advisory panel recommended that transvaginal mesh products be placed into the FDA's highest risk category for medical devices, or Class III, which would require human testing before new mesh products are allowed to be sold.

The panel also recommended that the post-market studies be conducted for mesh products that are currently on the market.

About Blasingame, Burch, Garrard & Ashley, P.C.

Blasingame, Burch, Garrard & Ashley, P.C., is an Athens, Georgia-based law firm that has been widely recognized for its ethics, skill and professionalism by Martindale-Hubbell®, The Best Lawyers in America, American College of Trial Lawyers, Super Lawyers and Law & Politics Media/Atlanta Magazine. Since 2006, the firm's defective medical device and product liability lawyers have pursued claims involving defective transvaginal mesh products, including handling attorney referrals from co-counsel across the country. For more information, call the firm at (866) 354-3544 or use its online contact form. Josh B. Wages Blasingame, Burch, Garrard & Ashley, P.C

POINTS OF NOTE FOR PHYSIOTHERAPISTS;

- **It is only Johnson and Johnson at the moment ceasing sale of vaginal mesh. Other suppliers are planning to continue for the time being**
- **The cessation of sale only refers to vaginal surgeries placing mesh. It does not apply to abdominally placed prolapse mesh.**
- **There are obviously hundreds of thousands of women who already have mesh placed vaginally that will be attending clinics for decades to come.**
- **We still need to be alert to the presence of mesh in the vaginal wall when seeing women with pain, or when considering use of a vaginal pessary, e-stim or manual therapy release work.**

Publication Review – EAU Guidelines

ABOUT THE European Association of Urology www.uroweb.org

NOTE: Description below is Directly from their website:

"Our mission: To raise the level of urological care throughout Europe and beyond.

The EAU represents the leading authority within Europe on urological practice, research and education. Over 16,000 medical professionals have joined its ranks and help to create forward-looking solutions for continuous improvement, professional growth and knowledge sharing.

The EAU delivers training, stimulates research and broadcasts information. The EAU's scientific publications encourage discussion and its expert recommendations guide urologists in their every-day practice.

Are you a practising urologist, a resident, a researcher? Whatever your interests are, the EAU is here to meet your needs. You are invited to explore all facets of a dynamic professionally managed organisation representing Europe's urological professionals"

RELEVANCE TO PHYSIOTHERAPY??

The EAU is actually very open regarding it's sharing of knowledge. It regularly updates all its clinical guidelines and in doing so reviews the research on the conservative, medical and surgical management of a broad range of urological conditions. After doing so, it then publishes guidelines based on the best available evidence at the time and makes the full text freely available!! In addition, most of the guidelines are available in multiple languages and there is also usually as summary article that has been published in the associated peer reviewed journal.

FULL VERSION VS POCKET VERSION of EACH GUIDELINE?

Once the research has been reviewed, there are two versions of each document published:

- **Full Version:** these are usually over 100 pages of paragraph style / full sentence writing summarizing the research trials methodology, results, and overall conclusions

- **Pocket Version:** these are only about 20-30 pages and are the summarized recommendations only written in dot points. Each statement is an action point.

  eg *"Voiding diaries should be used in urinary incontinence to evaluate co-existing storage and voiding dysfunction in clinical practice and research"*

  eg *" A diary duration of between 3 and 7 days is recommended"*

Example Guidelines relevant to Physiotherapy

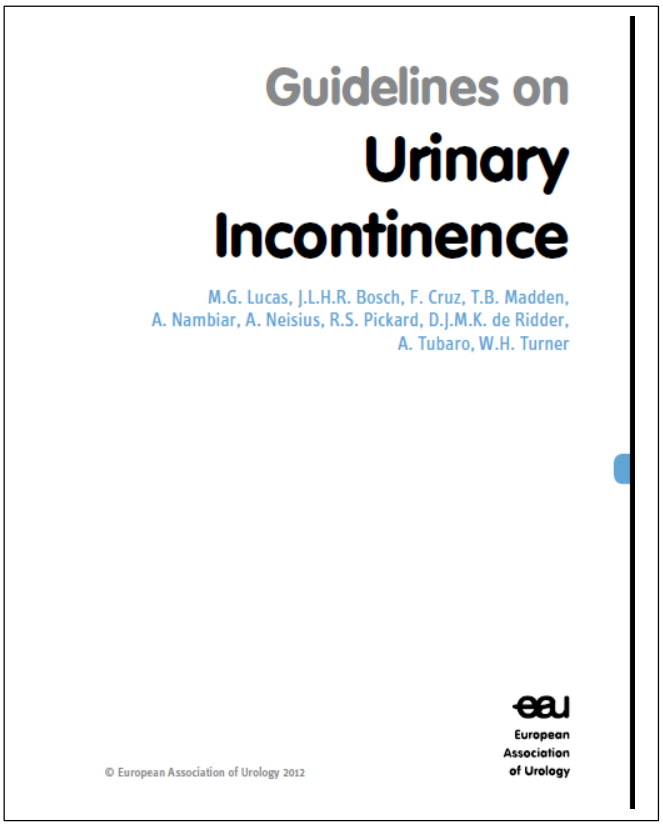
1. 2012 EAU Guidelines on Urinary Incontinence
2. 2012 EAU Guidelines on Paediatric urology
3. 2012 EAU Guidelines on Pain Management
4. 2012 EAU Guidelines on Chronic Pelvic Pain
5. 2011 EAU Guidelines on Neurogenic Lower Urinary Tract Dysfunction

EXAMPLE CONTENTS

2012 EAU Guidelines on Urinary Incontinence

http://www.uroweb.org/gls/pockets/english/16_Urinary_Incontinence.pdf …

Full Version



1. INTRODUCTION

1. ASSESSMENT AND DIAGNOSIS

    2.1 History and physical examination
    2.2 Patient questionnaires
    2.3 Voiding dairies
    2.4 Urinalysis and urinary tract infection
    2.5 Post-voiding residual volume
    2.6 Urodynamics
    2.7 Pad testing
    2.8 Imaging

2. CONSERVATIVE TREATMENT

    3.1 Simple clinical interventions
        3.1.1 Underlying disease/cognitive impairment
        3.1.2 Adjustment of medication
        3.1.3 Constipation
        3.1.4 Containment

    3.2 Lifestyle interventions
        3.2.1 Caffeine reduction
        3.2.2 Physical exercise
        3.2.3 Fluid intake
        3.2.4 Obesity and weight loss
        3.2.5 Smoking

    3.3 Behavioural therapy/scheduled voiding

    3.4 Physical therapies

        3.4.1 Pelvic floor muscle training (PFMT)
            3.4.1.1 Methods used to augment PFMT
            3.4.1.4 Efficacy of PFMT in SUI, UUI and MUI in women
            3.4.1.5 Efficacy of PFMT in childbearing women
            3.4.1.6 Efficacy of PFMT in men with SUI following radical prostatectomy
            3.4.1.7 Preventive value of PFMT in childbearing women and post-RP men

        3.4.2 Electrical stimulation (surface electrodes)

        3.4.3 Magnetic stimulation

        3.4.4 Posterior (percutaneous) tibial nerve stimulation

Copy of Tweets at WHTA_Physio

Please find below the WHTA Research tweets listed in the last few months since the last newsletter. Previous research tweets can be found either on the twitter home page or in previous newsletters.

CHILDBEARING YEAR

MUSCULOSKELETAL

Aldabe et al 2012 Systematic Review once again shows virtually no r'ship between relaxin & preg pelvic girdle pain BUT http://www.springerlink.com/content/gk32h26342m337w3

Vollestad et al June 2012 Relaxin related to Lig laxity and positive ASLR, just not related to pregnancy related pelvic girdle pain http://www.manualtherapyjournal.com/article/S1356-689X(12)00004-5/abstract

EXERCISE IN PREGNANCY

Robledo-Calonia et al 2012 3 months of aerobic exercise program in pregnancy reduces depressive symptoms in nullips http://ajp.physiotherapy.asn.au/AJP/vol_58/1/Robledo%20Colonia.pdf

POSTNATAL

Driving after Caesarean Section Sedgely et al 2012 ANZJOG Review of advice given to women regarding when it is safe to drive after caesarean section http://onlinelibrary.wiley.com/doi/10.1111/j.1479-828X.2012.01435.x/abstract;jsessionid=FEDAC190B3D3CA273221DA000AEAAEB9.d04t03?deniedAccessCustomisedMessage=&userIsAuthenticated=false

PELVIC FLOOR / GYNAECOLOGY

PELVIC FLOOR ANATOMY

Morris et al 2012 Comparison of effect of age on levator ani & obturator internus muscle x-section areas & volumes in nulliparous women. http://1.usa.gov/Oo26mS

Brown et al 2012 Find that the bony pelvis size of women with PF dysfunction is smaller than controls http://www.springerlink.com/content/m412g77l758640h6/

PELVIC FLOOR ASSESSMENT

Resende et al 2012 PF EMG Ax correlates with MOS Ax, Max PFC in nullips = 90uV and Gd 4, in Pregnancy = 30uV and Gd 2 http://www.springerlink.com/content/cp24r281l2w7g551/

PELVIC FLOOR MUSCLE TRAINING

Pereira et al 2012 Addition of vaginal cones to 2/week PFMT does not appear to improve long term outcomes for UI http://onlinelibrary.wiley.com/doi/10.1002/nau.22271/abstract

Stafne et al 2012 1/week group PFMT w Physio + 2/week home PFMT between 20/40 and 36/40 prevents UI in late pregnancy http://onlinelibrary.wiley.com/doi/10.1111/j.1471-0528.2012.03426.x/abstract?deniedAccessCustomisedMessage=&userIsAuthenticated=true

PELVIC ORGAN PROLAPSE

Elenskaia et al 2012 find that prolapse grade worsens between 14wks to 5yrs after vaginal birth http://www.ncbi.nlm.nih.gov/pubmed/22955252?dopt=Citation ...

Rostaminia 2012 Bilateral Levator ani avulsion re-attached to anterior arcus tendineus in 3yr postnatal woman, 3/12 post op still attached , and reduced levator hiatus from 17.8cm2 to 12.5cm2 http://www.springerlink.com/content/5707k406701677j1/?MUD=MP

STRESS INCONTINENCE

Ko et al 2010 find that 4 weeks of 30min/day treadmill running in rats significantly improves abdominal leak point pressures (ie should reduce SUI) - link to abstract which also has link to free full text (btw.... I know it's only in rats... But logic in full text is interesting) http://www.ncbi.nlm.nih.gov/pubmed?term=treadmill%20exercise%20rats%20leak%20point

OVERACTIVE BLADDER

Meng et al 2012 Full text article on the anatomy and physiology of OAB - complex anatomy. http://onlinelibrary.wiley.com/doi/10.1111/j.1757-5672.2011.00122.x/pdf

Townsend MK 2012 Long term caffeine intake was not associated with progression of urinary incontinence but study design was not able to examine acute effects of caffeine intake. http://www.urotoday.com/UroToday/Urinary-Incontinence/caffeine-intake-and-risk-of-urinary-incontinence-progression-among-women-abstract.html

PELVIC FLOOR PAIN

Educational Cartoon: This is a great cartoon to explain chronic pain to patients!
http://www.youtube.com/watch?v=4b8oB757DKc&sns=tw … via @**youtube**

Gentilcore-Saulnier et al 2010 Provoked Vestibulodynia associated with abnormally high EMG of Superficial Pelvic Floor muscles only, not increased EMG of deep Pelvic Floor (levator ani)
http://onlinelibrary.wiley.com/doi/10.1111/j.1743-6109.2009.01642.x/abstract

Pastore and Katzman 2012 Recognising myofascial pelvic pain in women with pelvic pain
http://bit.ly/TsCEgo

Rosenbaum &Padoa 2012 Link to FULL TEXT article 'Managing Pregnancy and Delivery in women with Sexual Pain Disorders' http://tallirosenbaum.com/sites/default/files/j.1743-6109.2012.02811.x.pdf

Pagano & Wong 2012 56% of pt's with provoked vestibulodynia respond to amitrypt in topical cream form, with 10% having pain free intercourse. Whilst 44% had no benefit, for 56% it avoids systemic side effects of oral version & concern re anti-depressants
http://journals.lww.com/jlgtd/Abstract/publishahead/Use_of_Amitriptyline_Cream_in_the_Management_of.99918.aspx

Lorenzo-Gomez 2012 Uromune sublingual vaccine significantly better at preventing recurrent UTI than prophylactic antibiotics http://www.springerlink.com/content/u2xvn64550057523/

DEFECATION

Sakakibara et al 2010 FULL TEXT Influence of Body Position on Defecation in Humans
http://bit.ly/QnM27b

PELVIC FLOOR SURGERY (SUI &/OR POP SURGERY)

J&J have announced that it will stop sales of it's vaginally placed mesh worldwide
http://www.bloomberg.com/news/2012-06-04/j-j-tells-judge-it-will-stop-selling-vaginal-mesh-implant.html …

Another link relating to J&Js announcement to cease the sale of transvaginally placed mesh.
http://news.yahoo.com/transvaginal-mesh-lawyers-discuss-johnson-johnson-decision-stop-221613867.html …

Rostaminia 2012 Bilateral Levator ani avulsion re-attached to anterior arcus tendineus in 3yr postnatal woman, 3/12 post op still attached , and reduced levator hiatus from 17.8cm2 to 12.5cm2
http://www.springerlink.com/content/5707k406701677j1/?MUD=MP

OTHER

Animation Site for Explaining How Muscles Work - Only briefly looked at this site but example animation explaining actions of mm during sit up seems very cute for pts http://www.muscleandmotion.com/Strength_Exercises.aspx …

APA campaigns for medicare funded physiotherpy treatment for incontinence. Q now is which physiotherapists would be eligible to provide this? http://physiotherapy.asn.au/AsiCommon/Controls/Shared/FormsAuthentication/Login.aspx?WebsiteKey=0253d77a-1e36-4220-ad17-2f5ba4da1ad6&LoginMessage=Your+session+has+timed+out.+Please+try+your+operation+again.

Appendix 1: Email from Taryn to WHTA members re Courses for Nurses Questionnaire

Email - 18th August 2012 From Taryn to WHTA MEMBERS

Dear WHTA Members,

I am quickly writing to you all with a request. I would like your opinion on an ethical dilemma I have.

Recently I have been involved in a number of discussions at various meetings regarding professional development of both physios and nurses. This has then coincided with a number of you contacting me in the last week asking if I would be willing to provide a professional development course to groups such as Nurse Continence Advisors / Clinical Nurse Consultants.

This obviously raises an ethical dilemma for me. Is it ethically important to train anyone available to work in this field so that women can receive the best care possible? alternatively, is it ethically important to maintain the professional scope of practice within physiotherapy.

I would therefore like your opinion to help me make a decision regarding this matter. The link straight to an anonymous questionnaire is at the bottom of the email. However, if you would like to first hear my current personal opinion I am more than happy to put this forward first. Please remember though that it is just an opinion and it is open to change based on your responses to the questions.... that is why I am asking!!

In terms of my feelings on this matter (acknowledging that I have also completed all but 3 subjects of a Bachelor of Nursing back in 2004-2006 after completing my physio degree).....

Personally, I think I feel that professional development courses need to be considered quite differently to conferences. At conferences people are just giving summaries of recent research, they aren't usually teaching practical clinical skills / treatments as such. I think conferences are great to be multidisciplinary to network etc.

In terms of small group (<20 people) professional development courses, the first thing is that I think it is lovely that RNs would like to learn from physios. I think that level of respect is something we should all be very humbled by and appreciative of. However, I my gut feeling is that whilst I am happy to teach both physios and nurses .....

I think Advanced Skill Professional Development courses (as opposed to conferences) should generally be run separate (ie a course specifically for PTs, a separate course for RNs with variations on what is taught)

1. *Personally, I feel that Nursing and Physio are two different professions with very unique skill sets. In the same way that Physios shouldn't be learning how to insert and remove catheters, teach self-catheterisation or do dressings for skin breakdown, I don't think RNs should be trying to learn advanced PFMT prescription, trigger point release work, advance strength training and co-ordination principles or manual therapy for pelvic floor dysfunction. Conversely, there are a whole range of things that are obviously for both professions, eg bladder retraining theory.*

2. *There are therefore large parts of a course that I am happy to teach to both (anatomy and physiology, understanding LUT testing such as urodynamics etc), but when we get to treatment I think there is a delineation that should be maintained. I believe Talking about the different treatment options is great (so that different professions know all the options available), but I wouldn't teach nurses how to do pelvic floor release work or trigger point work*

3. *If i taught the groups together I think I would naturally pull back on some of the practical skills that I believe are very much Physio skills. There are lots of things I would teach to both, but some skills I think are meant to stay with physio.*

Pragmatically though... there are some big advantages of WHTA providing courses for nurses etc.....

1. *We can make sure we maintain consistency for women on options for treatment.*

2. *Financial Viability and Reduced Course Fees: Obviously, if I was to run an OAB or Stress Incontinence course for nurses, there are large parts of the courses that would be the same for both groups (anatomy & physiology etc). Most of the course fees go to covering the time I spend developing courses where I am not officially getting paid. The more people who attend the one course the more cost effective I can make the per participant fee. In addition, if I provide courses to both RNs and PTs I have more chance of sustaining WHTA and having it financially viable whilst keeping course fees as low as possible.*

Anyway, as I said I am very open to opinions. I would like to hear them before I make a decision about offering training for nurses.

btw..... if people ask....the one thing I feel I do need to stay solid on is that membership to WHTA is not open for other professions, it is a physio membership. The newsletters are very much about clinical skills between physios, and the discounts for courses are specifically to support physiotherapists.

So that was MY email to WHTA Members

Please find a copy of the Responses from WHTA Members in the Next Appendix

Appendix: Comments from Survey

I agree that some of the theory could be presented to both, but we are 2 separate professions and do have at present reasonable clear roles in managing patients with pelvic floor dysfunction. I think if we cross pollinate this skill mix too much the physio role is in danger of being lost. There are already nurses working in gynae clinics and the advantages a physio can add with their knowledge of muscle and connective tissue and the associated treatment techniques (that we use in all areas of the body, but can apply to the pelvic floor with excellent theoretical background) will be overlooked if nurses can say they are educated on pelvic floor muscle treatments. Don't forget staffing decisions are often made by administrators who can be out of touch with clinical practice.

Where I previously worked the RN's wanted to make a new curriculum for all parent education course classes. After I supplied my content they removed my contract and I was left without a job, they now have a half page short note version of my pelvic floor exercises which is handed out to participants, They are told "do these or you will get incontinent after your baby" it is not clearly written nor contains any directive anatomy and I doubt even the most educated woman would be able to follow the directions effectively. I have sited the document from a class participant and put her on the right path. Keep your initial gut feelings, keep physio skills to physio so RNs don't over run us. But a physiology Anatomy course and advertising the ability of physios would be beneficial to advocate our work

I agree with you in that PTs and RNs have differing skill sets. I have worked with RNs in cardiac rehab, and while I realise it's different to women's health, the feedback the nurses give is that they are not qualified to prescribe exercises and were a little nervous about it if I could not attend. The best results were always achieved when the PT and RN worked together because of their different skills. Also, I believe that in treating pelvic floor dysfunction you have to look at the whole person. Sometimes it may be a straight case of PF strengthening, for example, but a lot of the time other factors need to be looked at eg. postural muscles/TA. I would rather see us working together with our differing skills to get the best result.

I can understand your point of view about teaching nurses but I have a big dilemma about continence nurse advisers doing our job. I think they do a great job as you say as part of a team with catheters, pad advice etc. Just personally what has happened to me I think will start happening across the board. I have worked out of a urology office for many years. [sentence here removed to maintain confidentiality} The doctor recently sent me a letter stating he needed use of the space and so I have moved next door. I used to see all the doctor's patients. Since I moved - and in no way on bad terms - I have not had a single referral. I have learnt that the nurse that he employs to help with performing urodynamics is now the "urology nurse" in the practice and teaching pelvic floor muscle exercises and bladder training!!! I am in no way threatened at the moment because I am very confident in what I can offer patients and know that in no way can she do a better job than me at the moment. But if she were sent to your wonderful courses then I would not be so sure. If we start teaching RNs all our skills then pelvic floor physiotherapy will become redundant and doctors will employ a nurse to do what we do. I think we need to protect what we have and encourage younger physio's to get involved.

I agree with your thoughts Taryn, too often people are acting outside their scope of knowledge. I feel by having nurses etc being able to perform some of the skills we do underminds our profession at times.

Taryn, it's your business - you could run separate courses for RNs, but if it was for both, I think it might send the message that they can do the same things as we do. Run separately, you can make the point that some generic things can overlap but that there is a line at which PT referral is required. Imagine the uproar if the nurses offered a course to us so that we can now assist in theatre (my urologists would be happy for me to do this actually) or do wound dressings or stoma care. The Nurses Union would be in uproar.

I believe that we need to protect our skills and knowledge as a physiotherapy profession and that courses should be specific to physiotherapists. I do however believe that inservices or small presentations with general overview of what we offer is fantastic to promote our services and to promote referral processes.

I agree that there is some overlap between the professions however we do need to maintain our professional base with regard to pelvic floor rehabilitation / manual treatment techniques.

Fine with running courses for both but completely agree that we need to keep separate our skills and not let them 'merge'. There will be components (anatomy, background info) that will cross over and other parts of courses that should remain seperate. I have once done a course run by physios which allowed other 'trainers' to attend and it was a nightmare. The skill set was so varied that the course ended up being a complete waste of my time. I think ensuring all attending have similar levels of qualifications is absolutely essential.

I agree that it is great to work together BUT very important for skill sets and knowledge basis for each profession to remain delineated. Knowing when to refer to the other profession (eg I refer on to my local community nurse who is an expert in catheterisation when appropriate and she refers appropriate pts to me) We don't have knowledge they do and vica versa. i would find a course presented to both together probably not worth doing as the level of skill taught would have to be lower. Likewise a nurse would not want to go to one teaching wound care to us as it would have to much lower level skill aim.

Possibly could run an appropriate course where general information is covered first (for example on day one) for physios and nurses, then separate after that (day two for physios only) with physios only being taught specific physio clinical skills and techniques. This could then help reduce the cost for attendees and reduce the time required from you to present the course compared to if it was done completely separately.

Funny you should ask this question Taryn!! In my government job I have been running the continence clinic and the nurses basically just identify clients, order pads then refer to me for further assessment. As I am resigning soon and going to private practice, I am in a situation as to what I should teach the nurses to keep the service running and beneficial to clients, as there is not going to be a physio available to continue the role! A lot of the education and subjective can be delivered by both I feel. However, when it comes to the more specific PFM training, internal assessments and individual advice based on this I feel that physios are better placed and trained. Of course there are some grey areas. One eg - we are trying to get funding for the government for a RTUS to detect PFM activation without the need for an internal (as no-one interested in being trained!). Both the PTs and the RN were interested in being trained in the use of the US. Would potentially be ok if the client was straight forward and not a motor moron when it came to muscle training. However, for more lateral ways to activate the PFMs then Physios would be best! Hope this helps. I would love feedback too in regards to which clients would be best to refer to a physio, rather than just RN involvement, so to guide the future management of clients in my soon to be ex govt job! Cheers.

I completely agree with your opinion that we do need to maintain certain skills that are uniquely physiotherapy skills and advance our profession. However I appreciate that increasing nurses understanding of anatomy and physiology , bladder training etc. would be beneficial.

How about having an opportunity for the RNs to do the basic courses but not the advanced courses. How would that work with pracs?? I don't think RNs should be claiming to do PF assessments, but they could give a basic explanation of PF exercises accurately.

Depending on the topic, I would be happy to go to a course with RNs but would feel uncomfortable about them learning in depth PFM assessment and treatment. So I would like physio only courses as well.

It is great for RNs to have an understanding of what physios do , and vice versa, and courses that have a component that are run together gives RNs and physios a chance to communicate on shared topics, and to network.

I completely agree with your summary. I think the clinical application skills should be kept to the physio profession, although nurses could really benefit from up to date information on anatomy, physiology and treatment options available to promote this area.

Those sections which both need to know can be done together and then separate for individual parts so quality of course maintained.

Can overlap on general knowledge areas, but be seperate for each professions needs. Easy to say - hard to do. Probably easiest to just run different professions education seperately.

PT''s and nurses have to have an understanding of the roles and skills of other members of the team so that we can both refer as needed. Of course some common knowledge is necessary. However, teaching skills that build upon physio skills that take years to hone (palpation, muscle training, exercise prescription) blurs professional boundaries and may in fact compromise the effectiveness of such treatments...and I doubt that nurses would be impressed with us wanting to learn to catheterise!

Most definitely have them separated - it would be easier to follow as participants as well,

I feel that running separate courses would be best, with some areas of combining, as we don't do nurse combined courses for musculoskeletal - i.e. how to treat back pain. I do believe in getting the same information out for continium of care for patients and the multidisciplinary team to be involved with care. But feel we need to keep physio skills within our own profession.

I think the basic courses are fine to be attended by nurses since they do treat these patients and it will place them in a good position to continue to do so. However, we do need to protect our specific physio skills and be a bit protective of it.

I can see benefit in providing information to RN's as well as physio's, but I do think that it would be good if these RN's were working in the area of womans health.

I feel very similar to you. You could NOT teach a RN in one weekend how to do advanced PFMT / release work etc. They do not have the Physiotherapy background to enable this.

....Or run courses for RNs separate to PTs Should you choose to do RN courses i think you should make it clear to them the professional boundaries that you mentioned in your email I have worked with many nurses that always seem unsatisfied by their scope of practice and therefore look to encroach on the work of other professions.

I believe that physios have the training which gives them the skill to assess muscle strength appropriately, guide the patient in the correct technique and best of all, the training to do the best pelvic floor assessment; nursing does not give this. I believe the lines should be very clearly kept. I have had a Nurse Continence Advisor give advice which a physio would not necessarily have given.

I think it is an important side of your business to develop - courses such as OAB and Stress Incontinence for nurses. But perhaps they could be separate and not include the pelvic floor assessment/treatment aspect but concentrate on lifestyle advice, education, bladder retraining, etc. Surely this would benefit all - patients included.

I guess it depends on how you structure the info towards each, like you said. Maybe half a day of info together and the second half for physios with practical? (depending on course). I think your fees are already very reasonable, and almost a bit undervalued (as in most courses are WAY more than you charge!). So I don't think you need to find ways to make your courses more affordable, as long as you can keep WHTA going!!!!

Physios go to uni for 4 years and get a physiotherapy degree allowing them to practise physiotherapy. In order to gain rego and keep it up to date, and also treat patients, the degree is necessary. The same goes for nurses. We are not nurses, hence we don't dress wounds, insert catheters, or give needles or meds... we may know how to, and this may be beneficial to our clinical practice as physios. Nurses are not physios, so they are not qualified with the skill set we are in order to treat conditions relative to physio.

I think we should look at the multidisciplinary continence teams that currently exist, and in my opinion, work well. Both nurses and physios see the same type of patients, but cross refer if needed. I know I am speaking for the public sector only, and am sure the private sector would operate differently, given that clients are often difficult to 'pass on' for financial reasons.

I dont have a problem attending a course with Nurses, so long as they don't attend advanced courses having not attended any basic courses.