Newsletter No.2 2013

Dear Colleagues,

Welcome! to the August WHTA newsletter. Just to clarify, this is only the second of the four newsletters that will be sent out this year. Normally, I would space the newsletters over the whole 12months but unfortunately the first six months simply got away from me with commitments to conferences, setting up the new mini-tutes for members, the WHTA online service, courses etc. Therefore the 4 newsletters are all occurring in the second six months of the year (will be June, ***August***, October, December).

Over the last few months WHTA has continued to grow and I am forever humbled by the support you all give. I really have had an immensely rewarding time over the last few years gradually meeting more and more of you, and look forward to meeting those of you I haven't already met. The increase in membership has definitely meant that I can now start to venture into new services that will hopefully not only support members in their professional development, but also increase awareness of our role amongst women, doctors, nurses etc.

I often start newsletters with an update on WHTA including new services we are providing, but I have decided to change the format and put the update at the end so you all get to the clinical information straight away. Therefore, this is just a short introductory letter.

I do hope that you find this newsletter interesting and that hopefully there is something in it for everyone to enhance clinical practice.

Have a lovely day,

Taryn

PS. Whilst I have a husband (Colin), and two boys (Ethan and Joshua), recently people have also asked about my animals. I thought I would introduce you to them.

Jetc (Dog) with Maggie and Julie (Chickens)

Cuppa (as in Cuppa Tea) and Frosty

Contents pp

CLINICAL TIP
Assessing Changes in Faecal Incontinence

In clinical practice it is vital that we have objective measures that can monitor changes in our patient's symptoms. Assessments are most useful when they are easy to use, relevant to the patient's presenting problem and have good reliability when assessing on multiple time points.

Three commonly used scoring systems to monitor change in Faecal Incontinence include:

1. **St Mark's Incontinence Score (SMIS)** **0 - 24**
2. **Wexner Continence Grading System (Wexner)** **0 - 20**
3. **Revised Faecal Incontinence Scale (RFIS) - *NEW THIS YEAR*!** **0 - 20**

1. St Mark's Incontinence Score ('SMIS' or 'Vaizey Score') - SCORE = 0 – 24

This Scoring System was first published in 1999 by the Colorectal Department of St Mark's Hospital (UK). This is the unit also famous for the St Mark's pudendal nerve terminal motor latency electrode.

As the paper was published by the lead author "Vaizey", it is also known as the "Vaizey Score".

The lowest score that can be given is 0 (complete continence), with the highest score being 24 (completely incontinent).

Type of Incontinence	NEVER Never	RARELY <1/month	SOMETIMES >1/month but <1/week	USUALLY >1/week but <1/day	Always >1/day
PART ONE					
Incont of Solid Stool	0	1	2	3	4
Incont of Liquid Stool	0	1	2	3	4
Incont of Gas	0	1	2	3	4
Lifestyle Alteration	0	1	2	3	4
				No	**Yes**
PART TWO	Needing to wear a pad of plug			0	2
	Taking constipating medicines			0	2
	Lack of ability to defer defecation for 15minutes			0	4

Reference: Vaizey, Carapeti, Cahill and Kamm 1999, Prospective comparison of faecal incontinence grading systems, Gut, vol 44, 77-80.

2. Wexner Score SCORE = 0 – 20

The Wexner Score has been around longer than the St Mark's Score. However, it has been criticised by some as it does not include faecal urgency.

Type of Incontinence	NEVER Never	RARELY <1/month	SOMETIMES >1/month but <1/week	USUALLY >1/week but <1/day	Always >1/day
Solid	0	1	2	3	4
Liquid	0	1	2	3	4
Gas	0	1	2	3	4
Wears Pad	0	1	2	3	4
Lifestyle Alteration	0	1	2	3	4

Ref: Jorge and Wexner 1993: Etiology and management of fecal incontinence. Dis Colon Rectum, vol 36, 77-97.

3. Revised Faecal Incontinence Score (RFIS) – 0 - 20

This is a new fecal incontinence score only released this year. The questionnaire is copyrighted to the University of Wollongong with a license to the University of Melbourne and the Commonwealth of Australia.

QUESTIONS:

1. Do you leak, have accidents or lose control with solid stool?
2. Do you leak, have accidents or lose control with liquid stool?
3. Do you leak stool if you don't get to the toilet in time?
4. Does stool leak so that you have to change your underwear?
5. Does bowel or stool leakage cause you to alter your lifestyle?

- Each Question scored from 0 (never) to 4 (always)
  - Never = 0
  - Rarely ie less than once in the past 4 weeks = 1
  - Sometimes ie less than once per week = 2
  - Often or usually ie less than once per day, more than once per week = 3
  - Always ie once or more per day = 4

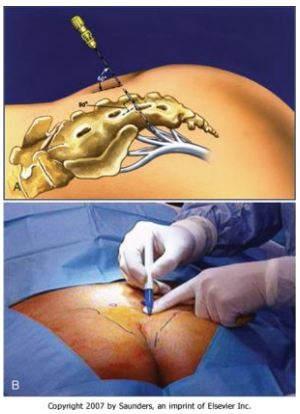
FINAL NOTE

Each of the above three scoring systems are easy to use, validated scoring systems that can be used in the clinic to monitor change in faecal incontinence symptoms over time. They are also commonly used in research papers analysing the effectiveness of faecal incontinence treatments.

CLINICAL FOCUS TOPIC #1

Transcutaneous Sacral Stimulation for FI

BACKGROUND – Implanted Sacral Stimulation for Faecal Incontinence



Implanted Sacral Stimulation (Interstim™, Medtronic Inc.) has now had numerous randomised controlled trials validating its effectiveness for the treatment of faecal incontinence. Patients can undergo a two-step procedure of a trial implant through the S3 foramen, followed by a permanent implant with a generator inserted in the upper buttock.

The mechanism underpinning the improvement in symptoms is still not fully understood, but may involve a combination of neuromuscular facilitation of the anal sphincter complex, combined with a normalisation of antegrade and retrograde peristaltic waves through the colon.

Whatever the mechanism however…. The question many physiotherapists are asking is whether Transcutaneous Stimulation may be an effective treatment without the associated risks of an implanted lead and generator.

In Newsletter # 1 of 2012 (can be found in Dropbox) I reviewed some of the recent research on Transcutaneous Tibial Nerve Stimulation – behind the medial malleolus – for faecal incontinence. Both implanted sacral stimulation and Tibial Nerve stimulation are thought to work via the S3 nerve root / dermatome (respectively).

So ……. **Can direct SACRAL TENS over S3 assist with faecal incontinence?**

FOCUS TOPIC - *Transcutaneous* Sacral Nerve Stimulation for Faecal Incontinence.

To date there have only been three research trials looking at Sacral TENS for faecal incontinence *(to my knowledge*).

1. **Chew, Sundaraj and Adams 2011**, Sacral transcutaneous electrical nerve stimulation in the treatment of idiopathic faecal, incontinence. *Colorectal Disease,* vol 13, pp. 567 – 571

2. **Leung and Francombe 2013**, Preliminary Results of Sacral Transcutaneous Electrical Nerve Stimulation for Fecal Incontinence, *Diseases of the Colon and Rectum,* vol 56, no. 3.

3. **Thomas, Norton, Nicholls and Vaizey 2013**, A pilot study of transcutaneous sacral nerve stimulation for faecal incontinence. *Colorectal Disease,* Aug, epub ahead of print.

SUMMARY OF TRIALS ON SACRAL STIMULATION FOR FECAL INCONTINENCE

	Chew et al 2011	Leung et al 2013	Thomas et al 2013
Number of Participants	**n = 17**	**n = 20**	**n = 10**
TENS Pads – Location	**2 square electrodes** 3cm x 3cm At S3:	**2 square electrodes** 3cm x 3cm **At S3: 3-4cm apart**	**4 rectangular electrodes** 10cm x 5cm **Over whole sacral area**
TENS Settings	**10Hz** **200ms** **Continuous** **Intensity** Tingling sensation	**10Hz** **250ms** **Continuous** **Intensity** Tingling 10-30mA	**14Hz** **210ms** **Continuous** **Intensity** Sub-sensory
Length of TENS sessions	**2hours per day**	**2hrs morn. & afternoon** (day 1 & 2) **3hours morn. & afternoon** (day 3 & 4) **8hours per day** (day 5 Onwards)	**12hours per day**
Duration of Rx	**3.5 months**	**1 month** Cease at 1month if not improving Continue - but gradually wean down time if significant improvement	**1 month**
	RESULTS		
	FI Episodes per week **Pre** / **Post**	**St Mark's / Vaizey FI Score** **Pre** / **Post**	**FI Episodes per week** **Pre** / **Post**
	19.7 / **12.1** (3/12 post Rx)	**12.7** / **5.8**	**9.5** / **3**
	FI Severity Index	**Wexner Score**	**Time able to Defer**
	40.9 / 3/12post Rx: **28.3**, Long Term: **24.8**	**7.9** / **4.0** (50% improved)	**1min** / **4.5min**

Taryn's Comments:

METHODS

At present we only have 3 published trials on the use of transcutaneous sacral nerve stimulation for faecal incontinence. Unfortunately, all three trials are of small numbers and **none of the trials had a control group.** Therefore the possibility of a placebo effect needs to be considered. The good news is that each of the authors (particularly Thomas et al 2013) have indicated that they now intend to undertake larger randomized controlled trials.

However, if we take the current research on face value……..

Interestingly, all studies used long term stimulation:

- Chew et al - 2hours per day
- Leung et al - 8hours per day and
- Thomas et al - 12 hours per day

In addition, all the studies used a **10-15Hz frequency** with a **200-250ms pulse width**.

RESULTS

Whilst the results presented show an improvement, they don't seem to show a high rate of cure. With that said, the treatment duration was fairly short (1-3months) and Thomas et al indicated in their discussion that 2 out of 10 patients were actually completely continent after 1 month.

What makes the results more impressive though is that all the studies had an inclusion criteria that the patients had previously failed medical therapy and physiotherapy with biofeedback. These were therefore a "hard to cure" cohort.

Another interesting finding is that of Chew et al 2011. Whilst the initial therapy was only 3.5 months, patients either maintained their improvement or improved further in the 12-18months after treatment finished.

FINAL SUMMARY

The research on Transcutaneous Sacral stimulation for faecal incontinence is obviously in its early days. However, as it is basically a "risk-free" treatment (assuming standard TENS contra-indications have been checked), I would think it is worth trying in this cohort of patients in whom other therapies have failed.

Long term it would also be interesting to find out whether sacral TENS has any predictive value in determining which patients may improve with implanted sacral stimulation. If it was found to be predictive, this may then hopefully reduce the need for trial implantation of Interstim in patients likely to be unresponsive to this type of management.

Clinical Focus Topic #2 *Vaginal Flatus*

BACKGROUND INFORMATION

Vaginal wind is an embarrassing yet underreported symptom in the scientific literature. The first publication on the topic was Krissi, Medina and Stanton (2003) who described vaginal wind as symptomatic vaginal "noise, occurring during physical activity and unrelated to vaginal manipulation, such as vaginal examination or intercourse".

Krissi et al (2003) go on to suggest that the mechanism of vaginal wind may be the creation of a "valve-like structure at the introitus, together with a real, rather than potential vaginal space".

This definition is consistent with my experience of women presenting with this distressing symptom in clinical practice. In particular, most women have tended to be particularly symptomatic during exercise programs that require inverted manoeuvres (eg Pilates, yoga, gymnastics). The typical history seems to involve a sensation of air entering the vaginal canal during inverted postures, then releasing on return to upright.

For the women who present to my clinic, the symptom often causes significant distress, and regularly results in women avoiding exercises and social situations where the "vaginal noise" most commonly occurs.

PATIENT CHARACTERISTICS / INCIDENCE OF VAGINAL WIND

Although extremely distressing, there appears little written on this topic in the scientific literature. A search of the literature only resulted in four publications.

Krissi H, Medina C and Stanton 2003 - "PRE-MENOPAUSAL WOMEN"

Vaginal wind – a new pelvic symptom. ***International Urogynaecology Journal,*** **2003, vol 14, pp399-402**

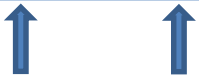
Presented the patient characteristics, symptoms, physical examination results and treatment outcomes of 6 pre-menopausal women presenting to a uro-gynaecology clinic with a primary complain of vaginal wind.

Patient Characteristics

General

- *All six women were* ***pre-menopausal*** *at the* ***time of onset*** *of symptoms.*
- *4 out of 5 women had a* ***normal BMI****, one was underweight and one overweight.*

Patient Number	*1*	*2*	*3*	*4*	*5*	*6*
Age at onset	***21***	***26***	***27***	***34***	***37***	***52***
BMI	***15.2***	***32.2***	***23.1***	***24.7***	***20.4***	***23.3***



Obstetric Histories

- *5 out of 6 women were **parous**, 1 was nulliparous*
- *4 (out of 5) indicated **their first vaginal birth** as the **precipitating factor** for onset of symptoms.*
- *All births were average birth weights,*
- *There was a relatively normal / expected distribution of vaginal vs instrumental births*
- *All parous women had experienced either a **perineal tear or episiotomy**.*

Patient Number	*1*	*2*	*3*	*4*	*5*	*6*
Parity	***1***	***1***	***1***	***3***	***1***	***0***
Largest Weight	***3300***	***3250***	***3550***	***3100***	***3450***	***-***
Mode of Delivery	***NVD***	***Forceps***	***Forceps***	***NVD***	***NVD***	***-***
Episiotomy / Tear	***Tear***	***Episiotomy***	***Episiotomy***	***Tear***	***Episiotomy***	***-***

Prolapse

*There appeared to be a very high rate of rectocele amongst the 6 women (66%), with even the nulliparous female demonstrating **posterior vaginal wall prolapse**.*

Patient Number	*1*	*2*	*3*	*4*	*5*	*6*
PROLAPSE	***Rectocele***	***Rectocele*** ***Enterocele*** ***Cystocele***	***Rectocele*** ***Cystocele***			***Rectocele***

Pelvic Floor Function

Considering the women were virtually all parous, there was a very high average pelvic floor strength with all women grading 3-5 on a Modified Oxford Scale ("Normal - Strong" on International Continence Society Grading). It could be hypothesised that strong pelvic floor musculature may in fact have an increased ability to "trap" vaginal wind which is then later expelled during forceful manoeuvres??

Patient Number	*1*	*2*	*3*	*4*	*5*	*6*
PELVIC FLOOR STRENGTH (MOS)	***3***	***5***	***5***	***3***	***3***	***4***

****

Marijke et al (2009)

Vaginal noise: prevalence, bother and risk factors in a general female population aged 45-85 years. International Urogynaecology Journal, vol 20, pp 905 – 911

A cross-sectional study on the general population.

Questionnaires sent to 2,921 women (aged 45-85years)

→ responded by 1,397 women.

➔ N = 800 selected for VE with POP-Q and PF Assessment.

RESULTS

- Vaginal Noise was experienced by 12.8% of the respondents
- 72.8% of those symptomatic of vaginal noise experienced a "little bother"
- Average parity was 2 (P0 = 8.6%, P1 = 15.4%, P2 = 48.3%, P3 = 27.7%)

Comparison of Women with and Without Symptomatic Vaginal Noise (VN)

- SEXUAL ACTIVITY STATUS – not associated
  - No difference in rates of VN in Sexually Active (13.3%) and Non-Sexually Active (12.2%)

- PELVIC FLOOR FUNCTION – not associated
  - No differences found in Pelvic Floor Strength, Ability to achieve urethral lift or ability to perform the "Knack" between those with and without symptomatic Vaginal Noise.

- PROLAPSE – **associated**
  - Significantly greater number of women in the vaginal noise group demonstrated Pelvic Organ Prolapse on vaginal examination (20.9% vs 10.3%)

- INCONTINENCE – **associated**
  - Significantly greater number of women in the vaginal noise group suffered Urge Urinary Incontinence (43% vs 27%), Stress Urinary Incontinence (69% vs 52%), Faecal Incontinence – liquid stool (22% vs 11%) and Faecal Incontinence – solid stool (9.2% vs 2.6%)

TREATMENT OF VAGINAL WIND – 3 Publications

1. **Krissi H, Medina C and Stanton 2003 - "PRE-MENOPAUSAL WOMEN"**
   Vaginal wind – a new pelvic symptom. ***International Urogynaecology Journal,*** **vol 14, pp399-402**
   All women were first offered pelvic floor exercises. Some women were then offered either a modified Bard Pessary (similar to a contiform), prolapse surgery or a Fenton's procedure.

PELVIC FLOOR MUSCLE TRAINING / PHYSIOTHERAPY

None of the women had improvement in the symptom of vaginal wind with PFMT / physiotherapy.

Patient # →	*1*	*2*	*3*	*4*	*5*	*6*
PELVIC FLOOR EXERCISES	***No improvement***	***No Improvement***	***No Improvement***	***No Improvement***	***No Improvement***	***No Improvement***

MODIFIED BARD PESSARY (similar to contiform)

2 Women Declined Pessary, 4 trialled the pessary

- *2/4 had minimal improvement*
- *2/4 were completely cured with the pessary*

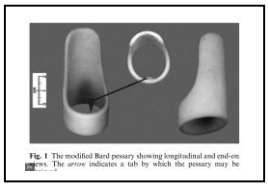


Fig. 1 The modified Bard pessary showing longitudinal and end-on views. The arrow indicates a tab by which the pessary may be

Patient # →	*1*	*2*	*3*	*4*	*5*	*6*
Bard Pessary	***Cured – Completely Asymptomatic***	*Declined Pessary*	***Minimal Improvement***	***Cured – Completely Asymptomatic***	*Declined Pessary*	***Minimal Improvement***

2. **Hsu, Sylvia 2007**
   Vaginal wind – a treatment option. ***International Urogynaecology Journal,*** **vol 18, p703**

Presented a case of a 43yo Chinese woman who complained of vaginal wind symptoms since the age of 31 – a month after her second delivery. Both children had been born by caesarean section. Very Distressed.

Pelvic Floor Muscle training failed to resolve the symptom.

However…… ***Wearing of a Tampon fully resolved the symptom*** *by preventing air entering the vaginal cavity.*

3. **Jeffery, Franco and Fynes 2008**
   Vaginal wind – the cube pessary as a solution. ***International Urogynaecology Journal,*** **vol 19, p1457**

Presented a case of a 55yo woman who complained of vaginal wind. Episodes occurred a few times a day. Vaginal Examination did not demonstrate any prolapse.

- *Pelvic Floor Muscle training failed to resolve the symptom.*
- *Anterior Colporrhaphy (Anterior Repair) failed to resolve the symptom*
- *Ring Pessary was failed to resolve the symptoms*

However…… ***Wearing of a Cube Pessary fully resolved the symptom*** *by preventing air entering the vaginal cavity.*

TARYN'S SUMMARY

1. **Vaginal wind appears to occur in about 10-15% of women, affecting both pre-and post-menopausal women**
2. **The majority of women appear to only perceive a "little bother", however for some women the symptom is more severe and is very distressing.**
3. **Vaginal Wind does not appear to be related to pelvic floor muscle weakness and does not appear to respond to pelvic floor muscle exercises**
4. **Vaginal Wind does appear related to pelvic organ prolapse, however can occur in the absence of POP**
5. **Vaginal Wind appears most successfully treated by a vaginal support / space occupying device**
   a. **Contiform / Bard Pessary**
   b. **Cube Pessary**
   c. **Tampon**

IN THE NEWS
What research has recently been published?

Outlined below are some major points from research recently published online. Most of these articles are prior to official publication in their respective journals – but have been released ahead of print online. The dates are therefore often the online publication date.

****

Obesity and Stress Urinary Incontinence

Osborn et al August 2013: Journal of Urology.

Undertook a review of the literature finding that

- Obesity leads to weakening of the pelvic floor muscles and loss of muscle innervation
- Weight loss though lifestyle modification or bariatric surgery improves symptoms of SUI
- However Obese and non-obese women can both improve with SUI surgery.

LINK: http://www.ncbi.nlm.nih.gov/pubmed/23972338

****

What Predicts Improvement in Sexual Function after Pelvic Floor Surgery? A follow up study

Lonnee-Hoffman et al August 2013: Acta Obstet Gynecol Scand

Found that whilst some women improve and a few deteriorate, on average, women undergoing either POP or SUI surgery appear to have improved sexual function post-op. However, the authors also found that improvement in sexual function only reached statistical significance for SUI surgery group.

The main predictors of improvement in sexual function after SUI surgery were good health pre-op and the presence of coital incontinence as a symptoms pre-operatively.

LINK: http://www.ncbi.nlm.nih.gov/pubmed/23962181

****

Familial Predisposition to Pelvic Floor Dysfunction: prolapse and incontinence surgery among family members and its relationship with age or parity in a Swedish population

Andrada and Persson August 2013: European Journal of Obstet Gynecol Reprod Biol

Found that women who had a sister or mother who had undergone an incontinence or prolapse operation were at increased risk of requiring surgery themselves.

- Sister having had incontinence / prolapse surgery: 4.69x risk
- Mother having had incontinence / prolapse surgery: 2.17x risk

With regards to sisters, the Odds Ratio for risk reduced the older the age of the sister at the time of her surgery. (ie the higher the risk the younger she was when needing surgery)

LINK: http://www.ncbi.nlm.nih.gov/pubmed/23928477

****

Can hiatal ballooning be determined by two-dimensional translabial ultrasound?

Pineda, Shek, Wong and Dietz August 2013, Aust NZ Obstet Gynaecol

This research group has previously published data on both 3D translabial ultrasound and the use of external GH + PB measures to assess hiatal ballooning. They have now published data specifically for the cut-off when using 2D translabial ultrasound.

	NORMAL	MILD	MODERATE	MARKED	SEVERE
GH +PB	<7cm	7-8cm	8-9cm	9-10cm	>10cm
2D AP Diameter	<6	6-6.5cm	6.5-7cm	7-7.5cm	>7.5cm

LINK: http://www.ncbi.nlm.nih.gov/pubmed/23909797

****

Architectural design of the pelvic floor is consistent with muscle functional subspecialisation

Tuttle et al August 2013, International Urogyn Journal

Analysed 10 human cadavers and separated coccygeus, iliococcygeus and pubovisceral muscle. Found that the pelvic floor muscles were thinner than expected based on data from imaging studies. Cross sectional area was small compared with other human muscles and not significantly different between the muscles. Coccygeus had the shortest fibres, with the authors suggesting this is important in a primary role as a stabiliser, whilst pubovisceral muscle had the longest fibres making it preferable for large movements.

LINK: http://www.ncbi.nlm.nih.gov/pubmed/23903821

****

Electrical stimulation and biofeedback for the treatment of fecal incontinence: a systematic review

Vonthein et al July 2013, epub ahead of print, International J Colorectal Disease

Reviewed 13 randomised trials of either Biofeedback (BF) alone, Electrical Stimulation alone (ES) or BF + ES

Primary Results:

- Twice as many patients became continent when BF was used compared to control
- Twice as many patient became continent when BF + ES was used compared to BP alone
- When amplitude-modulated medium frequency stimulation (pre-modulated interferential) was used in combination with biofeedback 50% of patients were continent after 6months.

LINK: http://www.ncbi.nlm.nih.gov/pubmed/23900652

****

There is not yet strong evidence that exercise regimens other than pelvic floor muscle training can reduce stress urinary incontinence in women: a systematic review.

Bo and Herbert June 2013, J Physiotherapy

Reviewed 7 randomised controlled trials on exercise programs other than PFMT for the management of SUI. Included three on abdominal training, two on the Paula Method and two on Pilates. The authors found that there is currently no convincing evidence for the effect of these regimes.

LINK: http://www.ncbi.nlm.nih.gov/pubmed/23896331

****

Levator haematoma at the attachment zone as an early marker for levator ani muscle avulsion.

Delft, Thakar, Shobeiri and Sultan July 2013, epub ahead of print.

Note – *Background info from Taryn*: Many people are now questioning why degree of perineal trauma appears to be the only type of pelvic floor trauma documented at the time of birth. The difficulty for clinicians / obstetricians has been finding a valid, reliable method to diagnose avulsion in the presence of bleeding, oedema etc at the time of birth.

The authors initially assessed 269 nullips at 36/40

- ➔ n = 114 were followed up within 4/7 of birth
- ➔ n = 199 were followed up at 3/12 postpartum.

Results

- No Antenatal Avulsions were found
- 27/114 (24%) demonstrated well delineate, hypo echoic areas consistent with haematoma post birth.
- In total, 38 haematomas were found within the 27 cases: 11 bilateral, 16 unilateral)
- N = 22 Haematomas were located away from the levator ani attachment zone, n = 16 at the attachment zone.
  - Haematomas located away from the Levator Ani attachment to the pubis resolved.
  - All haematomas located at the attachment zone manifested as pubococcygeus avulsions at 3/12 PP.
- An additional 20 avulsions were identified at 3/12 postpartum
  - 13/20 had not been scanned at 4/7 postpartum
  - 7/20 had been scanned with no haematoma evident, but avulsion present at 3/12

CONCLUSION

Hematomas at the site of the LAM attachment to the pubic bone always result in avulsion diagnosed three months postpartum. However, one third of avulsions are not preceded by a haematoma.

LINK: http://www.ncbi.nlm.nih.gov/pubmed/23893754

****

Does the presence of a high-grade internal rectal prolapse affect the outcome of pelvic floor retraining in patient with faecal incontinence or obstructed defecation?

Adusumilli et al 2013, Colorectal Disease, epub ahead of print

N = 120 consecutive patients were recruited to the study

- ➔ n = 56 with obstructed defecation,

➔ n = 64 with faecal incontinence

All pts with Faecal Incontinence were assessed with the Faecal Incontinence Severity Index (FISI)
All pts with Obstructed Defecation were assessed with the Patient Assessment of Constipation Symptoms (PAC-SYM)

	PFMT For Faecal Incontinence	PFMT for Obstructed Defecation
Patients without High Rectal Prolapse	FISI score improved from 36 to 27 $p < 0.01$	PAC-SYM improved signif from 24 to 19 $p = 0.01$
Patients with High Rectal Prolapse	FISI Score NO IMPROVEMENT 32 to 32	PAC-SYM Score NO IMPROVEMENT 26 to 25

CONCLUSION:
Pelvic floor retraining may be useful in patients with faecal incontinence and defecation disorders without high-grade internal rectal prolapse. Those with high grade internal rectal prolapse should be considered for surgery from the outset. LINK: http://www.ncbi.nlm.nih.gov/pubmed/23890098

****

A Comparison of Demographic and Psychosexual Characteristics of Women with Primary versus Secondary Provoked Vestibulodynia. **Brotto et al July 2013, epub ahead of print**, Clin J Pain
Reviewed n = 132 premenopausal women (n = 42 primary, n = 90 secondary) with provoked vestibulodynia (PVD).
There was no difference on any psychological measure between primary and secondary PVD.
Women with secondary PVD had:

- Significantly more clitoral hood pain
- Higher overall vestibular pain
- More overall sexual dysfunction
- Proportionately more intercourse occasions that were painful.

Women with primary PVD:

- Had more dysmenorrhea
- Were more likely to report that their partners were unaware of their pain

LINK: http://www.ncbi.nlm.nih.gov/pubmed/23887337

****

Long Term Outcomes of Perineal Rehabilitation
Torella et al July 2013, epub ahead of print, Minerva Ginecol
TARYN'S NOTE: *Whilst many studies have obviously been conducted of PFMT for POP and SUI, I find this study quite interesting as it distinguishes two groups of patients, those with mild symptoms, versus those who have failed surgery.*

Studied Two Groups of Women:

- Group A (n = 27): With mild symptoms of prolapse and SUI
- Group B (n= 22): SUI Symptomatic patients post TVT-O surgery

Results: - All were followed up at 5 years (60months)

	Group A: Mild	Group B: SUI Symptoms Post TVT-O
Prolapse Symptoms	65% - Cured / Much Improved 18.5% - No change 22.4% - Worse	
SUI Symptoms	59.3% - Cured 40.7% - Much Improved	55.5% - Cured 44% - Much improved

LINK: http://www.ncbi.nlm.nih.gov/pubmed/23881392

****

The Personal Impact of Pelvic Floor Symptoms and their Relationship to Age

Dua et al 2013, International Urogyn Journal epub, ahead of print.

Questionnaire administered and stratified by age. Found that older women were significantly less bothered by mild to moderate urinary, bowel and vaginal symptoms than younger women. There was no difference on the impact of severe symptoms when stratified by age. Women were least bothered by constipation and most bothered by faecal incontinence.

LINK: http://www.ncbi.nlm.nih.gov/pubmed/23877750

****

Electrical Stimulation in Chronic Functional Constipation: Five Years' experience in patients refractory to biofeedback therapy with rectal hyposensitivity

Jung et al 2013 July, J Neurogastroenterology, vol 19, no. 3, 366-373

N = 147 women with functional constipation refractory to biofeedback therapy completed all treatment sessions of anal electrical stimulation.

This study used an anal plug electrode with a variable frequency of 2-110Hz, pulse width of 360-960usec, and an amplitude of 30-35V.

The overall response rate to treatment was 59.2%. However subgroup analysis showed:

- Response rate of 64.8% in women with functional constipation without rectal hyposensitivity
- Response rate of 50.8% in women with functional constipation with rectal hyposensitivity.

THIS ARTICLE IS AVAILABLE AS FREE FULL TEXT – LINK: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3714415/

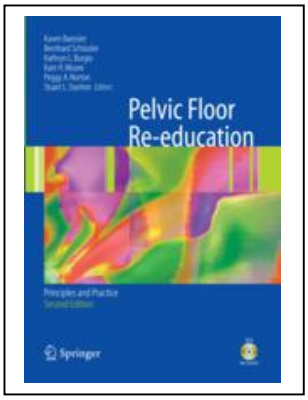
****

CASE REPORT: Advanced Uterine Prolapse during Pregnancy – pre and post natal management

Pizzoferrato et al 2013 July-Aug, epub ahead of print. Gynecol Obstet Fertil.

The Authors present a case report of a 39 year old multiparous woman referred for management of stage 3/4 uterine prolapse at 13/40. The authors suggest that management requires local antiseptics, rest and manual re-integration or reduction of the prolapse using a pessary to prevent ulceration of the cervix.

Books Reviews x 2 *(1 Good, 1 Bad!)*



TITLE: **Pelvic Floor Re-Education – principles and practice**
2nd Edition, 2009

EDITORS: **Baessler, Schussler, Burgio, Moore, Norton, Stanton**

PUBLISHER: **Springer**

PRICE: **$82.50 in Hard Copy via Amazon**

Taryn's Rating

DIFFICULTY: Intermediate – Advanced

VIEWPOINT: Good balance of Conservative / Physiotherapy & Medical

QUALITY: ★★★★ **HIGH, VERY IMPRESSED**

RECOMMENDED: Strongly Recommended
The information is detailed enough to advanced physiotherapists knowledge on a range of topics, yet concise enough to provide easy reading.

Chapters note – I have only given the subsections for the first three chapters to give an idea of the books content

1. **Function and Dysfunction of the Pelvic Floor and Viscera**
   - Functional Anatomy of the Pelvic Floor and Lower Urinary Tract
   - Neural Control of Pelvic Floor Muscles
   - The Effects of Pregnancy and Childbirth on the Pelvic Floor
   - Muscle Function and Ageing
   - Urinary Incontinence and Voiding Dysfunction
   - Pelvic Organ Prolapse
   - Anal Incontinence, Constipation, and Obstructed Defecation
   - Overactive Pelvic Floor and Related Pain

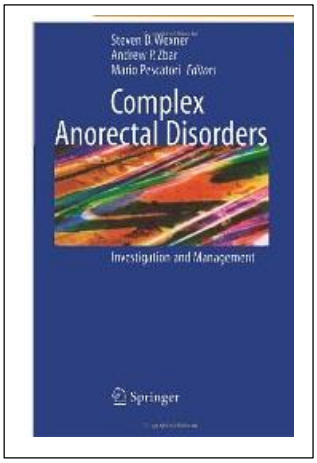
2. **Evaluation of the Pelvic Floor**
   - Clinical Evaluation of Pelvic Floor Muscles
   - Examination of the Patient with Pelvic Organ Prolapse
   - Urodynamics
   - Applying Urodynamic Findings to Clinical Practice
   - Anorectal Physiology
   - Ultrasound Imaging
   - Magnetic Resonance Imaging
   - Electrophysiology
   - Outcome Measures in Pelvic Floor Rehabilitation
   -

3. **Techniques of Pelvic Floor Rehabilitation and Muscle Training**
4. **Treatment: Condition-Specific Assessment and Approaches**
5. **What to do if Physiotherapy Fails**

TITLE: **Complex Anorectal Disorders**
?1st Edition, 2005

EDITORS **Wexner, Zbar, Pescatori**
PUBLISHER: **Springer**

PRICE: **$120.12 in Hard Copy via Amazon**
$111.20 Kindle Electronic Edition



Taryn's Rating

DIFFICULTY: Intermediate – Advanced

VIEWPOINT: Medical

QUALITY: ★☆☆☆ **DISAPPOINTING**

RECOMMENDED: **Not Recommended**

After finding Pelvic Floor Re-Education (by the same publisher) such a useful, easy to read reference book, I was hoping that this would be the same. The editors are extremely well known in the field. Unfortunately I was quite disappointed. The writing style seems to use a lot of words yet give very little clear, useful information. There is also very little use of diagrams / illustrations.

Very disappointing considering the high price tag!

Chapters note – I have only given the subsections of chapters two and three to give an idea of the books content

SECTION ONE: ANORECTAL TESTING

1. **Anorectal Anatomy: the Contribution of New Technology**
2. **Anorectal Physiology**
   - History, Clinical Examination and Basic Physiology
   - Rectoanal Inhibition
   - Vectorvolume Manometry
   - Clinical Rectal Compliance Measurement
   - Impendence Planimetry
3. **Anorectal Imaging**
   - Evacuation Proctography
   - Defecography: A Swedish Perspective
   - Ultrasound in Coloproctologic Practice
   - Three Dimensional Endoanal Ultrasound in Proctological Practice
   - MRI in Colorectal Surgery
4. **Sphincter Pharmacology and Pharmacotherapy**
5. **Anal and Perianal Pathology**

SECTION TWO: CLINICAL ANORECTAL ASSESSMENT

6. **Assessment of the Constipated Patient**
7. **Assessing the Patient with Fecal Incontinence**
8. **Urogynaecological Assessment and Perspectives in Patients presenting with Evacuatory Dysfunction**

Update on WHTA

Well….. if you have read this far you are doing well! I really do hope that you found some useful information in this month's Newsletter. I would now just like to finish with an update on WHTA and Member services.

1. WEBSITE UPDATE

As I am sure you are all aware, in recent months we have undertaken an overhaul of the WHTA website. This has enabled us to branch into a whole new look and also add some new features. If you are experiencing any difficulty with sections of the website please let us know.

2. WHTA PHYSIOTHERAPIST LOCATOR – ADVERTISING YOUR SERVICES!!

We have now added a physiotherapy locator tool to the website. This is the first stage of a long term advertising plan that we are devising to assist GPs, Specialists and women themselves find physiotherapists with a special interest in women's health.

Despite the fact that we haven't started advertising the tool, I have had two pieces of feedback from other health professionals indicating they have used the tool to refer patients. I also am already using the tool to refer my regional patients.

IF YOU HAVEN'T ALREADY APPLIED FOR LISTING, I WOULD ENCOURAGE YOU TO DO SO!!

The listings are organized by state, and then have sub-listing per area. There are pre-requisites to be listed.

URINARY INCONTINENCE LISTING:	**Advanced Stress Incontinence OR Advanced OAB Course** Note: "WHTA 5 Days Women's Health Course" participants can also list for up to 18months after completing the course. After that time, completion of an advanced course will be needed to maintain listing
PROLAPSE LISTING:	**Advanced Prolapse Course** Currently I am also allowing people to list if they have completed the Objective Testing Course PLUS Advanced Exercise and Sport Course. This may change next year.
CHRONIC PAIN LISTING	**Advanced Pelvic Floor – Genitourinary & Anorectal Pain Course**

In addition, practitioners must be current members of WHTA and also have completed a minimum of 4hour education with WHTA in the last 12months. This can be made up of face-to-face courses or webinars.

3. ADVERTISING PRODUCTS

Once we have a sufficient number of physiotherapists on the WHTA Physiotherapy Locator I will start organizing a range of promotional products that can be sent to Gynaes, Urologists, GPs, Child and Family Health Clinics etc. This will include.

- Calendars
- Pens
- Magnets
- Stress Balls
- Post-Cards

I also hope that if we have enough members next year to make it viable, then we can also **develop an App** for the **Physiotherapist Locator**.

4. WHTA ONLINE

I have now run 5 webinars on Nocturia. I am hoping that those of you who attended found them useful. There have been a few glitches to iron out but is seems to be getting smoother.

The big dilemma I have had is with regards to notes. The issue is not WHTA members. The issue is that the webinars are open to physiotherapists who are not members of WHTA, whom I do not know. When people do not know you directly there is a greater tendency to share intellectual property that is actually copyright. The difficulty I have is that if I post the electronic copy of the notes for the webinar, physiotherapists can forward them to their colleagues and post them on the net. Ultimately, my intellectual property is the only thing that makes WHTA financially viable.

THEREFORE, NOTES FOR FUTURE WEBINARS

What I have decided is that all future webinars will have notes available on the educational site for download prior to the event, but they will be an edited version. eg the diagram may be in the notes but you will need to add the labels as you watch the webinar. The bulk of the information will be on the slide but there may be a few key points that you need to add as you participate.

I hope you can understand the sensitive nature of this issue.

Anyway…… I think that is basically all for now.

I hope you have enjoyed the newsletter and I look forward to hopefully seeing you or talking to you all soon!

Taryn