

OVERVIEW

The WHTA Advanced Pelvic Floor: Pelvic Organ Prolapse and Stress Urinary Incontinence Level 3 course is a 4-day theory plus 2-3hour practical course aimed at pelvic floor physiotherapists with significant clinical experience in the field. It is designed to extend the clinician into advanced clinical reasoning and treatment selection, as well as provide practical training in pessary management.

NOTE: physiotherapists attending the practical of this course must already

- be trained in vaginal examination / basic assessment of pelvic organ prolapse
- have performed a MINIMUM of 20 vaginal examinations independently in clinical practice.

COURSE DURATION

30hours online (4 days) plus 2-3hour VE / Pessary Practical

Day One: Advanced Assessment and Diagnosis of Pelvic Organ Prolapse

The Prolapse component includes:

1. Advanced Anatomy / Pathophysiology of Pelvic Organ Prolapse

Detailed anatomy of POP including muscular and fascial factors

- understanding the three 'levels of pelvic organ support' (as described by DeLancey)
- understanding complex fascial anatomy of the pelvis and its role in pelvic organ support, including the structure and function of the arcus tendinous fascia pelvis, paracolpium, parametrium, pubocervical fascia, rectovaginal fascia, perineal body and uterine ligaments.
- understanding muscular factors that do, and do not contribute to pelvic organ prolapse (review of the evidence for PFM strength, levator hiatus size, genital hiatus size, distensibility, resting tone in POP).

2. Advanced Assessment Skills for POP

- detailed education and training in POP-Q (Aa, Ba, C, D, Ap, Bp, GH, PB and TVL)
- using the POP-Q measures to differentiate:
 - o uterine prolapse from cervical elongation with normal uterus support
 - o anterior and posterior wall prolapse secondary to apical support dysfunction as opposed to a true anterior / posterior vaginal wall dysfunction
 - o POP that is 'likely vs unlikely' to progress over time
 - o women who are likely vs unlikely to develop POP in the future
 - o whether POP symptoms are likely to be related to anatomical descent vs urogenital atrophy, central sensitisation and hypervigilance.

Day Two: Advanced Training in Management Options for Pelvic Organ Prolapse

3. Conservative Management of POP

- PFMT/LIFESTYLE ADVICE: detailed review of the research on the role and limitations of PFMT and lifestyle advice for the anatomical and symptom management of POP
- PESSARIES: education and training on the use of support pessaries for POP
 - o types of pelvic organ support pessaries (silicone vs other, varying shapes etc)
 - o assessment / sizing / prescription of pelvic organ support pessaries
 - o pessary selection based on anatomical findings
 - o insertion and removal techniques
 - o contraindications / precautions / risk management
 - o follow up requirements, working in a multidisciplinary team
 - o sterilisation / implementation of a pessary service in clinical practice

Note:

the above pessary training is provided during the 4-day theoretical component of the course.

PRACTICAL

During the 2-3hour practical each participant performs an assessment for sizing, insertion and removal of a ring and cube pessary

4. Pelvic Organ Prolapse Surgeries

Detailed education and training on the most common surgical procedures for POP.

Discussion includes education on each procedure, risks, benefits, success and failure rates, as well as the impact of various surgical procedures on the ability to offer pessary and other conservative management post-op (eg which surgeries → pessary being contraindicated).

Surgeries specifically discussed (including video explanation) include:

- o anterior/posterior colporrhaphy with and without mesh
- o hysterectomy and hysteropexy
- o sacrocolpopexy and sacrospinous ligament fixation

Understanding transvaginal mesh complications, surgical and conservative management implications and medicolegal considerations

Physiotherapists who have completed the above POP course (including practical) are then eligible to attend a WHTA advanced pessary practical workshop once they have independently managed at least 10 POP patients with a pessary in clinical practice.

Day Three and Four - Stress Urinary Incontinence

The SUI component of the course is designed to challenge the experienced pelvic floor physiotherapist to consider the multifactorial nature of SUI – 'not all SUI is the same'. It covers:

1. Understanding SUI due to Urethral Hypermobility vs Intrinsic Sphincter Deficiency (ISD)
2. Advanced Assessment of SUI to differentiate Urethral Hypermobility from ISD components
3. Advanced treatment design based on the underlying mechanism to optimise SUI outcome

DAY 3: ASSESSMENT AND DIAGNOSIS

- Multivariable nature of SUI including
 - DeLancey's "hammock" hypothesis and the importance of urethral stabilisation to enable urethral pressure augmentation during increases in IAP;
 - levator ani and fascial factors contributing to urethral hypermobility
 - internal/external urethral sphincter, urethral vascularity and hormonal factors contributing to intrinsic sphincter deficiency (ISD)
 - when SUI isn't SUI eg cough induced detrusor overactivity
- Advanced assessment techniques to differentiate SUI due to urethral hypermobility vs ISD.
 - urethral Pressure Profiles / MUCP / VLPP
 - symptom assessment / Stamey Grade assessment / specific symptoms of ISD
 - combining ultrasound & digital examination to distinguish muscular vs fascial causes of SUI
 - MRI and what it has revealed about the mechanism of SUI in majority of women

DAY 4: TREATMENT

- Optimising Pelvic Floor Muscle Training for SUI
 - an in-depth review of the role, mechanism and success rates of PFMT
 - the importance of 'supervision': group supervision vs individual supervision vs home training
 - how urethral hypermobility vs ISD may change the design of PFMT
- Other conservative management for SUI
 - weight loss, hormone replacement, over the counter mechanical supports
 - addition of biofeedback, weighted vaginal cones, e-stim
 - pessaries for SUI (ring with knob, continence dish etc)
- Medical / Surgical options for SUI
 - suburethral slings (TVT / TOT / minislings); suspension procedures
 - urethral Bulking agents
 - do medications play a role?
 - what does the future hold? Stem cell injection to regrow the urethral sphincter