

Newsletter No.1 2014

Dear Colleagues,

Welcome! to the first of the four official newsletters for 2014 WHTA Members. It is lovely to have so many continuing members from last year, and to also welcome so many new members who have recently joined WHTA for the first time.

For those of you who are new to WHTA, it may seem unusual that I am just sending the first newsletter for 2014 (unfortunately this probably isn't unexpected for previous members ☺). Whilst I always hope to get the first issue out earlier in the year, things unfortunately always seem to get in the way (partly the writer's block I often seem to get in the first few months of each year, and then additionally I had an overseas holiday in May). I therefore apologise for the delay but do assure you that as with last year - in which the first newsletter was also about this time - there will be the promised four full newsletters by 31st January 2015 (the last day of the current membership year).

A QUICK OVERVIEW OF THIS NEWSLETTER.....

THE CLINICAL FOCUS TOPIC THIS MONTH - STAGE 1 PELVIC ORGAN PROLAPSE (starts page 3)

For this newsletter, the major clinical focus topic is Stage 1 Prolapse. There are two sections:

- "Stage 1 Prolapse – are we over diagnosing?"
- "Should the POP-Q be revised with regard to Stage 1?"

These topics are currently the focus of much debate in urogynaecology circles. What has previously been defined as Stage I Prolapse seems to occur so frequently in the general population (even occurring in young nulliparous women), that many are questioning whether this small amount of vaginal wall descent should be regarded as prolapse at all. Increasingly, there is now suggestion that this should simply be regarded as within the spectrum of normal anatomical variation that occurs between people. There is also discussion as to whether uterine descent to -2 should be regarded equally to anterior or posterior wall descent to -2, and whether the whole POP-Q staging system should be revised.

This is an interesting debate, and one that I hope will provide you with food for thought as you read the article and consider your own thoughts on this matter regarding your clinical practice.

THIS MONTH'S PRODUCT REVIEW – Electrical Stimulation Units..... which ones to buy?

Recently I have had a number of emails asking for advice regarding the purchase of electrical stimulation units. In essence there are probably three main Neurotrac Electrical Stimulation units on the market that I believe are all perfectly suitable for providing external and / or internal

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electrical stimulation treatments depending on what you want to use it for: the Neurotrac Pelvitone, the Neurotrac Continence and the standard Neurotrac TENS. To assist with decision making though, I have included an explanation of the differences between the three machines.

CLINICAL TIPS SECTION

As with all newsletters, this section is designed to provide a few quick clinical tips that I hope will be easy to implement in your clinical practice. This month the focus is on important considerations when asking about coital incontinence and stool type during defecation. In addition, I will explain what I do when it's difficult to visualise the urethral meatus when assessing for GH + PB.

PROFESSIONAL LINKS & CONFERENCES

Regularly linking with professional colleagues is an extremely useful way to not only enhance our own individual professional development, but to also facilitate and promote the physiotherapy profession as a whole. Included in this newsletter is therefore the details of a few interesting conferences that are being held over the next 6months (all related to women's health or pelvic floor dysfunction), as well as suggestions of some relevant social media sites that allow networking between WH physios.

RESEARCH SUMMARIES

Toward the end you will find the Research Summary section. For those of you who are new to WHTA, you will find that this section can vary quite substantially from newsletter to newsletter. In some newsletters I tend to focus on just 4 or 5 recently published papers, in which case I give quite a detailed summary from the full text and add quite a lengthy commentary of my own opinion of the paper. Other times I use the newsletter to provide a very quick summary of a large number of papers that have recently been published.

With this being the first newsletter of the year, I have decided that for this issue I will do the latter. There has actually been quite a lot of research published in the last few months, so you will find approximately 40 articles briefly summarised with direct links provided to the pubmed listing.

Finally..... THE WHTA UPDATE

WHTA has obviously grown substantially over the last few years and I thank you all for your support. With that growth however, has also come an amazing opportunity to network together for the promotion of our profession and facilitation of opportunities to share the enormous knowledge base held by the collective of the membership. As you read about our plans, I hope you will find this all very exciting!

Anyway..... I do hope you find the newsletter useful. Please feel free to let me know if there is a specific topic that you would like me to write about in a future newsletter and I will do my best to cover it!

Have a lovely day,

Taryn

Clinical Focus Topic:

Stage 1 Prolapse: is it an over-diagnosis?

INTRODUCTION – *the ethical dilemma of 'to give, or not to give' a diagnosis.*

As health professionals we are constantly faced with all manner of ethical dilemma when interacting with our patients. One of the more common of these is the dilemma we face when deciding whether to inform a person of an 'anatomical variation' we '*incidentally find*' during their physical examination.

There is no doubt that when given accurately and appropriately, the identification of a specific "diagnosis" can be extremely empowering for a patient who is in search of answers. It can be the first vital step in assisting the person to become educated about their body, understand their symptoms, and make appropriate life-changes to maximise their health. In contrast though, receiving a label or diagnosis can also have quite significant negative impacts, especially in terms of a person's self-image or psychological well-being.

Whilst the ability to diagnose is therefore important, equally important is the ability to not over-diagnose in the presence of what might simply be *normal human variation*. A question we should therefore always consider when making an assessment is 'Could this simply be an example of normal human variation rather than something that needs to be suggested to the patient as a condition or disease?'

An example of this could be the asymptomatic woman attending a day 1 postnatal education class who is found to have a 1-2cm rectus diastasis when examining her abdomen. Then there is the woman presenting purely with urinary incontinence, but who is found to have evidence of mild Stage I posterior vaginal wall descent when you perform her vaginal examination. In reality, neither of these 'anatomical variations' may be causing any significant symptoms. The women themselves may not even be aware of them except for the fact that you are now considering telling them!

The dilemma we all worry about though, is whether not providing the patient with information on their current physical status denies them their right to be fully informed and make informed life choices. In contrast however, over-diagnosing in the presence of what may be regarded by some as '*normal human variation*' could result in unnecessary psychological distress. Even if the diagnosis may seem minor to us as physiotherapists, simply using a term like 'diastasis' or 'prolapse' can be quite distressing to the patient who is receiving this information about their own body and then going home and looking up the term on Google!.

This is currently the topic of quite significant debate within the Urogynaecology setting, with many arguing whether the current definition of "Stage I Prolapse" is in fact an over-diagnosis of what may be normal human anatomy. To enter into this debate however, we must first consider our perception of "normal".

CONSIDERATION #1: THE CONCEPT OF 'NORMAL' – *are we being influenced by unrealistic textbooks??*

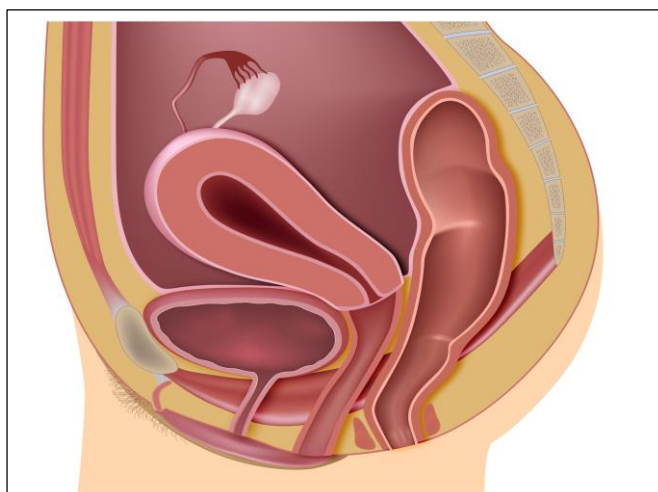
We are all aware that modern society's perception of 'normal female anatomy' is increasingly being influenced by the daily exposure to images in magazines and advertising that are being "*photo-shopped*". Magazines are now filled with images of women where wrinkles have been removed, stretch marks removed, cleavage enlarged, eyes brightened, hair colour enhanced and thighs trimmed down. Unfortunately this seems to be resulting in an ever increasing

incidence of low self-esteem amongst women who can no longer keep up with the barbie-doll like porcelain doll image which is being portrayed as “normal”.

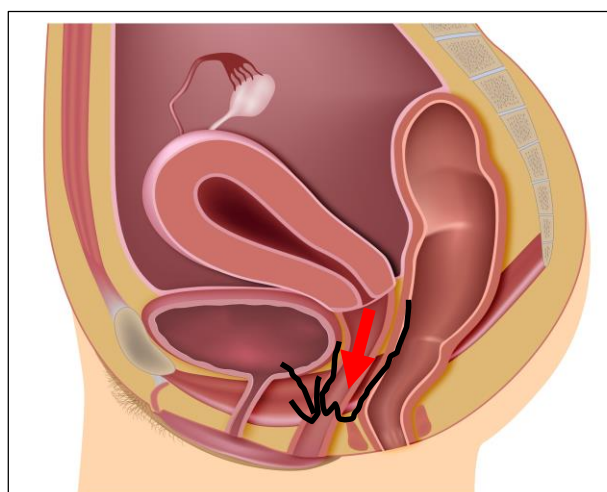
In more recent years, this photo-shop phenomenon has seemed to extend even further into the female genitalia. The use of photo-shop to ‘enhance’, ‘trim-down’ or ‘even-up’ the female labia on images contained within pornographic websites seems to have already begun altering the perception of what is ‘normal female genitalia’ amongst both young men and women. Consequently, we are now seeing a dramatic rise in labiaplasty rates by young women distressed about their ‘abnormal genital appearance’. For example, between 2000 and 2011 the number of genital cosmetic surgeries in Victoria grew from 640 per year to 1,565 per year, with close to 100 of these in the 15-24 year age bracket! (*Data from Women's Health Victoria 2013 Issue Paper.*)

But whilst health professionals seem to feel quite within their right to criticise the advertising industry and pornographic industry for this exposure of women to unrealistic body images, are we as health professionals (*including myself!*) guilty of the same thing?

Every day in my clinic (like I am sure many of you also do), I use diagrams to explain pelvic floor anatomy to my patients. I tend to begin with a diagram of what I purport to be “Normal”, then draw all over the image to explain the variation I have observed during the vaginal examination.



An example diagram that health professionals would often use to demonstrate “normal” pelvic anatomy.



A typical example of drawing on a diagram to represent Stage 1 Prolapse.

The question we must ask ourselves though, is whether the image on the left truly represents ‘Normal’ anatomy? Could it actually be an unrealistic ideal that actually rarely occurs in real life, and that the image on the right is in fact normal in a large percentage of the female population? If this is the case, suggesting that only the image on the left is ‘normal’ may result in a large number of women undergoing unnecessary surgery to correct their normal ‘prolapse’.

So, could the previously defined stage 1 POP actually be a normal occurrence in the female population?

It is important to realise that for many years, the only clinical assessments of pelvic organ/vaginal wall position were being performed on symptomatic, parous women presenting to Urogynaecology clinics. In the absence of exposure to asymptomatic, nulliparous women, health professionals were able to continue to believe that ‘normal’ was equivalent

to that which is represented in diagrams within textbooks (similar to the diagram I gave previously). Recently however, studies on asymptomatic, nulliparous women have begun to significantly challenge our perception of what we should regard as normal, forcing us to re-think the unrealistic ideals we may be suggesting to our patients.

Buschbaum et al 2006 (Obstetrics & Gynaecology, vol 108, no. 6) compared 101 full biologic sister pairs – in which one sister was nulliparous and one sister was parous (with at least one vaginal delivery). Unfortunately the cohort only included subjects of white racial background, however the overall research methodology was good with the examiners blinded to the subjects' parity and sibling status.

Whilst the goal of this study was to look at the familial link for prolapse (which is not the focus of this discussion), the study does also provide us with some interesting statistics on the normal degree of organ descent found in 'normal' postmenopausal nulliparous women.

Data from the Nulliparous, Postmenopausal Women (n = 101):

BUSCHBAUM et al 2006	Anterior Wall	Apical (Uterine/Vault)	Posterior Wall
Stage 0	47%	83%	61%
Stage 1	43% Anterior	17% Apical	27% Posterior
Stage 2	9% POP	0% POP	12% POP
Stage 3	1% = 53%	0% = 17%	0% = 39%
Stage 2	0%	0%	0%

Interestingly, we can see that in terms of the anterior vaginal wall, ***less than half the nulliparous, postmenopausal women actually demonstrated ideal support (ie Stage 0)***, with 43% demonstrating Stage I Anterior wall POP if utilising the current POP-Q criteria, and some demonstrating stage 2 or 3 descent.

It is important to remember that all women in this study were of a white racial background, making this not necessarily generalizable to the multicultural population we commonly encounter in our clinics. In addition, all women were post-menopausal, therefore we cannot necessarily assume this is representative of the pelvic organ support we would find in our younger women.

So what is the rate of POP in our younger women?

Two studies have published results in young nulliparous women. Unfortunately both involved women who were either currently involved in regular high impact activity (military women), or women who were about to participate in high intensity activity (college students about to start a summer military 'boot-camp').

1. O'Boyle et al 2002 – Active Duty Women

O'Boyle et al in 2002, published the prolapse assessment results of 42 active duty nulliparous women (within the American Military). All women were between the ages of 19 and 29 with n = 21 being *pregnant* nulliparous, and n = 21 being *non-pregnant* nulliparous.

Whilst the focus of the study was actually to compare the pregnant to the non-pregnant military women (which is beyond the scope of this review), the data from the 21 non-pregnant women provide us with the ability to look at normal pelvic organ support status in a cohort of young, nulliparous, active women.

2. Larsen and Yavorek 2007 – College Students

Larsen and Yavorek also assessed young, nulliparous women, but these were college students about to attend a training program at a United States military academy over their summer break. N = 116 women completed the study, having an assessment both pre and post the summer training program, with a subgroup of n = 37 undergoing additional paratrooper training (jumping out of a plane). Whilst the goal of this study was to assess the impact of summer military training and paratrooper training on pelvic organ support (which is also beyond the scope of this review), the pre-training results do provide us with another cohort of young, nulliparous women to review their baseline pelvic organ prolapse status.

RESULTS DATA	O'BOYLE et al 2002		LARSEN & YAVOREK 2007	
PROLAPSE STAGE	Young Nulliparous (non-pregnant) N = 21, avg age = 22.2		Young Nulliparous (non-pregnant) N = 116, avg age = 20.7	
Stage 0	43%	Total	52%	Total
Stage 1	57%	POP	46%	POP
Stage 2	0%	= 57%	2%	= 48%
Stage 3	0%	(military)	0%	(college)

Unfortunately, you can see from the table that the prolapse stage is not split by compartment. This unfortunately was a limitation of both these studies. In neither publication did the Authors publish prolapse stage by compartment. Rather, they simply listed the worst prolapse stage in any of the compartments. Therefore it is impossible to determine whether these stages were predominantly anterior / posterior wall prolapses or apical prolapse.

A second limitation of these studies is the fact that all these women were either involved in training with the American Military, or had a desire to attend summer military training. This therefore does not necessarily represent the POP status of sedentary women of the same age.

CONSIDERATIONS FROM THE ABOVE DATA

When looking at these high rates of Stage 1 Prolapse in asymptomatic, nulliparous women, we do start to question whether this should in fact be regarded as prolapse at all. Interestingly, in an article titled "POP-Q 2.0: it's time has come" published in the International Urogynaecology Journal this year (vol 25, pp 447-449), Harmanli suggests that the current POP-Q criteria of Stage 1 as a form of prolapse may in fact be a gross over-diagnosis, with its inclusion making POP a diagnosis in up to 76% of parous women:

"The POP-Q system was arbitrarily derived and has limited clinical relevance: there has to be something inherently wrong about a classification system that designates only 24% of the general adult female population as completely normal (stage 0), when only about 6% of community-dwelling women express that they have any symptoms attributable to this condition"

Dietz and Mann in their 2014 article also in the International Urogynaecology Journal (vol 25, p 451) hold a similar view:

"Stages 0-4 [of the POP-Q] were defined based on expert opinion, not on an objective evaluation of the association between examination findings and symptoms. It has since become clear that stage 1 prolapse of the anterior and posterior vaginal wall are so common as to likely be part of the normal range.....It seems to make little sense to define something as stage 1 or 2 of a disease process that is very common, benign, and not predictive of symptoms or progression".

Interestingly, both these authors make the point that stage 1 prolapse is not only extremely common, but it is also usually asymptomatic. Dietz and Mann also suggest that Stage 1 Prolapse is not predictive of prolapse progression, or more symptomatic prolapse in the future. If this is true, it does seem unusual to label someone with a diagnosis when it may have no impact on quality of life, health, or survival.

CONSIDERATION #2: Does Stage 1 Pelvic Organ / Vaginal wall descent pose a problem?

Interestingly, if the research is to be believed, for most people it does appear that Stage 1 'Prolapse' is usually asymptomatic and doesn't necessarily progress.

Buschbaum et al (2006) who reviewed the 101 post-menopausal sister pairs found that none of the women with Stage 1 Prolapse (in either the nulliparous or parous cohorts) were symptomatic. They go on to state: *"this supports the idea that stage 1 support is a normal finding and should not be considered prolapse"*.

In terms of progression, Tegerstedt et al in 2005 (IJU vol 16) analysed the incidence of symptomatic POP across age cohorts and found that this may be an unsubstantiated concern, particularly in post-menopausal women. In their study of 5,489 women they found that the incidence of symptomatic prolapse does increase with age during younger adulthood, but levelled off after age 50.

AGE	Prevalence of SYMPTOMATIC Prolapse
30-39	4.1%
40-49	6.2%
50-59	11.8%
60-69	12.2%
70-79	11.0%

Analysing their data, Tegerstedt et al 2005 suggest that

'once a woman reaches the age of 50-60, the risk of developing new symptomatic prolapse is very small..... Asymptomatic stage 1 POP at the time of menopause is very unlikely to develop into clinically significant symptomatic disease'.

The interesting information from this study is that the number of women with any degree of symptomatic prolapse did not seem to increase after age 50. This statistic may seem difficult to believe for those of us who see an increasing number of women present for treatment of prolapse with increasing age. However, to make sense of this it is important to realise that there is a difference between analysing the risk that a symptomatic woman's prolapse may become more symptomatic, to the risk of developing a new symptomatic prolapse.

Let's Consider and Example

Amongst a random sample of n = 1000 50year old women in 2010 it is found that 100 of them have symptomatic stage II prolapse with an average bothersome score of 3-4/10. This would mean that the incidence of symptomatic prolapse at age 50 is ~10%. However, even though 10% of these women have symptomatic prolapse, possibly only 1-2% will consider surgery as their 'bother' is fairly low.

Let's than pretend it is ten years later.... It is now found that amongst the same cohort of n = 1000 60 year old women there are still 100 women with symptomatic prolapse but it is now more bothersome for them (bothersome score 7/10) and objectively assessed as Stage III. There is still the same incidence of symptomatic prolapse ie 10% of the cohort has symptomatic prolapse, but we are likely to see more of them in clinic due to its increased severity.

This Tegerstedt study was looking at the change in incidence of symptomatic prolapse. Incidence only changes if asymptomatic women become symptomatic (this is most likely to occur if a woman with stage 0 or 1 develops stage 2 or 3 prolapse and becomes symptomatic). Therefore, the fact that the incidence didn't change after age 50 doesn't mean that women who already have symptomatic prolapse don't progressively get worse, it simply implies that there were very few new cases of symptomatic prolapse amongst the previously asymptomatic women above age 50.

The authors therefore suggested that for women with observed Stage 1 Prolapse at age 50, this could simply be 'normal' for them, and is not necessarily the start of a progressive disorder.

Interestingly, if we re-look at the three previous studies on the incidence of prolapse in nulliparous women.....and then compare these incidences with the rates of Stage 1 prolapse amongst the older women in the Buschbaum et al 2006 study, we see that the rate of Stage 1 prolapse is not significantly different between the young nulliparous cohorts and the older nulliparous cohorts (using anterior compartment figures).

PROLAPSE STAGE	EARLY ADULthood		LATER ADULthood	
	O'BOYLE et al 2002	LARSEN & YAVOREK 2007	BUSCHBAUM et al 2006 (anterior data)	BUSCHBAUM et al 2006 (anterior data)
	Nulliparous avg age = 22.2	Nulliparous avg age = 20.7	Nulliparous avg age = 60.5yrs	Parous avg age = 60.2
Stage 0	43%	52%	43%	15.8%
Stage 1	57% Stage 1	46% Stage 1	49% Stage 1	42.6% Stage 1
Stage 2	0% = 57%	2% = 48%	1% = 49%	29.7% = 43%
Stage 3	0%	0%	0%	7.9%
Stage 4	0%	0%	0%	4%

This seems consistent with the thought that there may be a certain percentage of nulliparous women (~50%) who simply have stage 1 positioning of their pelvic organs / vaginal wall throughout their entire life, without it ever progressing.

STAGE 1 PROLAPSE – does that mean it never progresses???

Obviously no..... In fact, the most difficult group to predict is the parous women. In terms of the increased incidence of stage II, III and IV prolapse we see in the older parous women (final column in the table above), we cannot know whether this reflects the women who were originally Stage 1 not changing, and the Stage 0 women changing to Stage II-IV, or if there is a generalised worsening for all women where Stage 0 → Stage 1, Stage 1 → Stage 2 etc

Obviously, to determine this we will need long term studies following the same cohort of women over decades!!!

STAGE 1 PROLAPSE – should we therefore no longer use the word 'Prolapse' for this type of descent?

As a result of all this debate, Tooze-Hobson and Swift (2014) published a paper earlier this year in the IUJ titled "POP-Q Stage I Prolapse: is it time to alter our terminology?". In their paper they state their dilemma with the current POP-Q descriptors:

'we currently have a prolapse classification system that defines even small movement in the vaginal position as at least a stage I prolapse, regardless of symptoms'.

It seems that the debate now has multiple components, with various questions needing to be answered:

- Should we actually change the POP-Q staging criteria and redefine Stage 1 and Stage 2?
- Should we simply change our terminology to eliminate the inferred implications that come with a term like 'Prolapse'. eg should we talk about Stage 0 and Stage 1 'Support', and reserve the term prolapse for Stage 2 and beyond?
- Should we eliminate the stages completely, and simply describe the position relative to the hymen so as to eliminate the misinterpretation altogether of stages eg simply use anterior wall -2, cervix -4, posterior wall +1?

This leads me to the next section of this newsletter.....

Clinical Focus Topic:

Should the POP-Q now be revised?

It was in 1996 that the Pelvic Organ Prolapse Quantification system (POP-Q) was first published as the newly recommended assessment tool for the evaluation of Pelvic Organ Prolapse (Bump et al 1996). Its introduction was quite significant, as it was the first time it was suggested that 6 different points throughout the vaginal canal should be analysed to accurately assess vaginal wall and apical compartment descent. Its development resulted from an 'exchange of ideas' and subcommittee meetings of experts between 1993 and 1996, utilising the most up to date research available at the time as well as the experts' own clinical experience.

Now, close to 20 years since its first publication, there is question regarding whether our ongoing knowledge and research on pelvic organ prolapse should facilitate an updating of the POP-Q assessment criteria.

People are already unofficially changing.....

The confusion surrounding the clinical relevance / non-relevance of Stage I pelvic organ prolapse (discussed in the previous section) has now led to many researchers already changing their definition of 'normal' or 'cured' when publishing data about prolapse occurrence or success rates of surgical POP procedures. An example of this is Buschbaum et al (2006), who state in the methodology section of their research project:

"We considered stages 0 and 1 as normal support, and combined these stages in our analysis under 'no prolapse'."

This has obviously brought about significant debate. On one hand it seems reasonable that Stage 1 descent be considered normal. On the other hand though, are we really comfortable suggesting that a woman whose cervix is sitting 2cm inside the vaginal entrance after a uterine suspension surgery should always be satisfied?

Dietz and Mann 2014 (IJU, vol 25, no. 4) believe that any debate attempting to create uniform agreement as to whether Stage I POP (as defined by the POP-Q) is abnormal or not is oversimplifying the situation. In their article in the IJU this year, Dietz and Mann suggest that a cervix at -2 is completely different to an anterior wall (Aa) point at -2, and therefore we may need to completely reconsider the current POP-Q assessment approach.

The importance with which this topic is being regarded within the gynaecology specialty is no better demonstrated than by the fact that the International Urogynaecology Association chose to publish 4 separate articles directly related to this topic in its April edition of the IJU earlier this year (vol 25, issue no.4). These included

AUTHOR(S)

ARTICLE TITLE

- | | |
|---------------------------|---|
| 1. Riss and Dwyer | POP-Q classification system: looking back and looking forward |
| 2. Bump | POP-Q system: two decades of progress and debate |
| 3. Toozs-Hobson and Swift | POP-Q stage 1 prolapse: is it time to alter our terminology? |
| 4. Hammanli | POP-Q 2.0: its time has come! |

To fully understand these discussions though, we must first have a good understanding of the POP-Q and what it being debated.....

(Note: the very next section below is provided for our up and coming new women's health physios ☺ who may be less familiar with the intricacies of the POP-Q ☺, feel free to skip to the following section if you are one of the 'old-girls' and very confident with the POP-Q already!!).

UNDERSTANDING THE CURRENT POP-Q: Points and Stages

THE POINTS: Aa, Ba, C, D, Ap, Bp

The POP-Q utilises the individual assessment of 6 different points along the vaginal walls and apical compartment to gain an overall picture of vaginal wall and apical compartment positions.

There are two points assessed for the Anterior Wall (Aa and Ba), two points for the Posterior Wall (Ap, Bp) and two points for the apical compartment (C for cervix, D for Pouch of Douglas / Posterior Fornix).

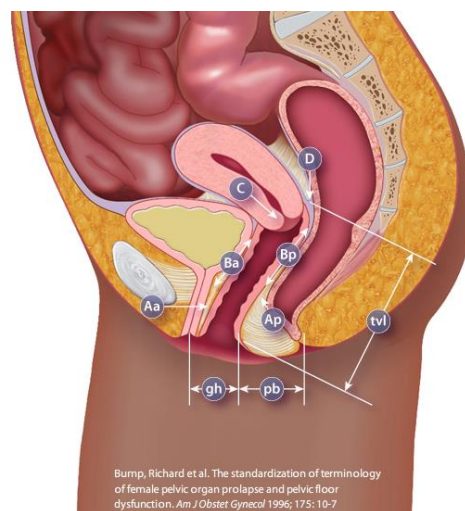


Image from the POP-Q app by Boston Scientific, available via iTunes.

ANTERIOR WALL POINTS:

- Point 'Aa': A point located 3cm along the anterior vaginal wall: corresponds to the urethrovesical junction/bladder neck. Expected to sit at **-3** in a woman with normal anatomy, on maximal descent can distend to +3
- Point 'Ba': An arbitrary point that simply reflects the point of the anterior wall that distends the greatest. (as point Aa is limited to +3 descent, point Ba allows for assessment of a greater degree of anterior wall prolapse)

POSTERIOR WALL POINTS:

- Point 'Ap': A point 3cm along the posterior vaginal wall. Expected to sit at **-3** in a woman with normal anatomy, on maximal descent can therefore distend to +3
- Point 'Bp': An arbitrary point simply used to define the maximal point of descent of the posterior vaginal wall relative to the hymen.

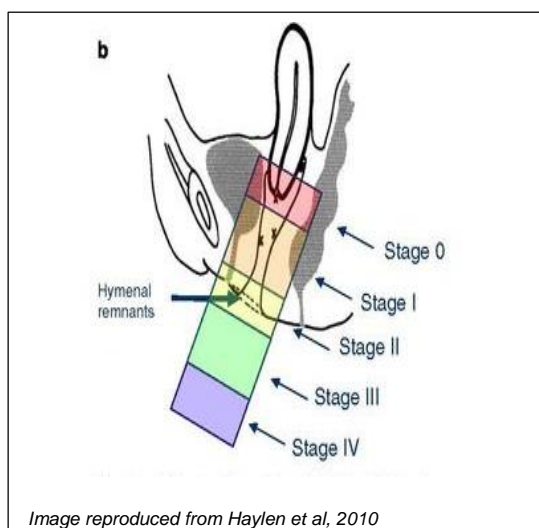
APICAL POINTS:

- Point 'C': The **C**ervix (or vaginal cuff in a woman who has had a hysterectomy) Expected to sit **8-10cm** above the hymen (ie -8 to -10), on maximal descent can distend to +10 to +12
- Point 'D': The Posterior Fornix (behind the cervix), representing the Pouch of **D**ouglas. Expected to be located a few cm higher than the cervix at **-10 to -12**, can fully evert to +10.

The position of each point was designed to be assessed relative to the level of the hymenal remnants, with maintenance of position above the hymen being assessed with negative values and descent beyond the hymen being given positive values. eg if the cervix (designated as point C) remains 6 cm above the hymen in a patient performing a Valsalva it would be given a score of C = -6, however if the cervix descends to 2cm outside the vagina on Valsalva it would be scored as C = +2. (note: all assessments are performed on full Valsalva).

THE STAGES:

With the publication of the POP-Q not only came a new approach by assessing the 6 different points, but also a new criteria for the overall staging of pelvic organ prolapse. Stage 1 was now regarded as descent of any of the points to a position no further than -1 (1cm inside vagina) with Stage 2 prolapse defined as descent of any of the points to a position between -1 and +1. Interestingly though, these criteria for stage 2 prolapse were the same whether we were talking about movement of the Aa point or the C point.



CRITERIA FOR POP STAGES RELATIVE TO HYMEN

Stage 0: No prolapse is demonstrated. (Aa: -3, Ap: -3, C: -9)

Stage I: Most distal portion of the prolapse is more than 1cm above the level of the hymen. (<-1)

Stage II: Most distal portion of the prolapse is 1 cm or less proximal to or distal to the plane of the hymen. (-1 to +1)

Stage III: The most distal portion of the prolapse is more than 1cm below the plane of the hymen. (>+1)

Stage IV: Complete eversion / procidentia

The Confusion Around Stage 1: Should we alter the POP-Q?

Utilising the expected points above, we can already see a discrepancy in defining Stage 2 prolapse equally in all compartments. For the anterior and posterior compartments Point Aa and Ap only need to descend 2 cm to reach -1 (1cm inside the hymen) and classify as Stage 2, whilst the uterus would need to descend 7-8cm before it would reach a -1 position.

Is a 1cm movement of the Aa point from -3 to -2, really the same as a 7-8cm movement of the Uterus to -2?

To address this issue, Dietz and Mann researched the issue of whether apical prolapse becomes symptomatic at a different level to when anterior or posterior wall descent becomes asymptomatic.....

Diets HP and Mann KP 2014, What is clinically relevant prolapse? An attempt at defining cutoffs for the clinical assessment of pelvic organ descent. *International Urogynaecology Journal*, vol 25, no. 4, pp 451 – 455.

Purpose of Research Study

To investigate the relationship between symptoms of prolapse and the ICS Pelvic Organ Prolapse Quantification measurements in order to establish optimal cut-offs for predicting prolapse symptoms.

Methods

N = 764 data sets were reviewed comparing the degree of maximal descent of the anterior compartment (Ba), posterior compartment (Bp) or Cervix/Vaginal Cuff (C) to the presence or absence of prolapse symptoms.

Patient age, BMI, previous hysterectomy or incontinence/prolapse surgery, as well as vaginal parity were tested to control for confounding effects on the relationship between POP-Q measurements and symptoms of prolapse.

Results:

Correlation analysis between the level of descent and the commencement of prolapse symptoms found that most patients became symptomatic of prolapse at a different stage for the apical compartment than for the anterior or posterior compartments.

	Cut-Off Level at which Descent is most likely to become Symptomatic	Sensitivity	Specificity
Anterior Compartment (Ba)	-0.5	69%	71%
Posterior Compartment (Bp)	-0.5	63%	62%
Apical Compartment (C)	-4	67%	64%

In other words, any descent of the cervix to a position lower than -4 was found to be likely to cause symptoms in a woman. This makes a cervix sitting at -2 (traditionally classified as stage 1) likely to be symptomatic. In contrast, an anterior wall descending to -1 (mild stage 2) is commonly asymptomatic.

Conclusion of the Authors:

'Our findings suggest that the ICS POP-Q staging system requires revision. Prolapse of the anterior and posterior vaginal wall of <-1 should probably be regarded as normal. On the other hand, stage 1 uterine prolapse as currently defined seems highly relevant.'

SUMMARY: THE THREE IMPORTANT TAKE HOME MESSAGES FROM THIS MONTH'S FOCUS TOPIC

1. It is important to reassure women that stage 1 descent occurs in at least 50% of all women, and this rate applies even to those who haven't had children!
2. Having Stage 1 POP does not necessarily mean that it will get worse. We need to look at other risk factors if we want to determine risk of worsening prolapse (eg family history of POP surgery, levator hiatus size, BMI etc)
3. Apical compartment prolapse should be considered differently to anterior and posterior wall prolapse as women are likely to become symptomatic at -4 position (stage 1), whereas anterior and posterior is often not until -0.5.

PRODUCT REVIEW

E-Stimulation Units.....

Regularly I am asked questions regarding the electrical stimulation units that I use in my clinic. There are numerous units on the market and the reality is that they all probably do a *fairly similar* thing. With that said, there are some differences, so I have outlined below some of the considerations I make when deciding on a unit:

1. COMPANY / BRAND




Personally, I tend to use the **Neurotrac Brand** for my e-stimulation units, mainly because they also make two basic EMG biofeedback units (either the "Neurotrac Simplex" & the "Neurotrac Peritone") that are reasonably priced and can be used with an internal probe for PF assessment.

By having the same brand for both my electrical stimulation and EMG biofeedback units, it ensures that if a patient buys an electrode and lead for their electrical stimulation treatment it can also be used for an EMG assessment (and vice versa) as the lead will be the same for both machines.

2. COST OF UNIT

Neurotrac actually make an enormous range of different electrical stimulation units, however this also means there is then an enormous price range due to the variation in capabilities of each of the different units. As I get most of my patients to buy their own unit for home use, I aim to choose the cheapest unit that is capable of performing all the specifications they need for their particular condition, whilst aiming for them to not have to pay for something they don't need.

The three Neurotrac units I usually choose between are:

NAME	Neurotrac Pelvitone	Neurotrac Continece	Neurotrac TENS
Appearance			
Average Cost Online (if patients buy personally online)*	\$180 - \$200	\$170 - \$190	\$115 - \$130
Common Physio Purchase Price (by companies giving registered physiotherapists a discount)*	\$165 - \$180	\$135 - \$150	\$80 - \$95

*Note: prices are approximate, as at June 2014, and vary from company to company. Prices indicated are simply given as an approximate price so that physiotherapists contacting stockists have a realistic idea of what to expect.

CHOOSING BETWEEN THE NEUROTAC PELVITONE, CONTINENCE & TENS

3. PRE-SET vs CUSTOMISABLE PROGRAMS

It is important to realise that each of the neurotrac e-stimulation units have two types of programmes programmed into the device:

PRE-SET PROGRAMS:

P01 to P11

Programs where the parameters are pre-set by the company.
Pre-Set Programs cannot be altered by the physiotherapist.
Each program already has its frequency, pulse duration etc set
Programs may be 'Continuous' or 'Intermittent', depending on the goal.
Pre-Set Intermittent programs have a pre-determined work:rest time, a pre-set ramp time, and a pre-set treatment time.

CUSTOMISABLE PROGRAMS:

PC1 to PC3

These programs are customisable so they can be set by the Physiotherapist
They vary in their capabilities between machines
Some only allow continuous programs to be set, some allow intermittent.
Customisable Intermittent programs allow the physio to set the work:rest times, the ramp times etc

Interestingly, most of the difference in price between the three units is due to the number of pre-set programs they each have, not the customisable programs.

Neurotrac Pelvitone	11 Pre-Set Programs, 3 customisable (continuous & intermittent)
Neurotrac Continence	9 Pre-Set Programs, 3 customisable (continuous & intermittent)
Neurotrac TENS	9 Pre-Set Programs, 3 customisable (continuous programs only)

It is important to realise that Pre-Set programmes are really designed for the general public. It enables a person to purchase an electrical stimulation unit themselves, follow the instructions to place the electrodes appropriately, and then select a Pre-Set Programme where the Frequency, Pulse duration, Mode (continuous, intermittent, burst), Ramp time and overall Program Time has been predetermined.

Pre-Set Programmes are never as ideal as customising a program individually for your patient (eg do you want the PF muscle contraction via stimulation to last for 3 seconds or 7 seconds? Do you want a 5 sec or a 10sec rest time? Do you want a slow ramp time because the patient is quite sensitive to the sensation or do you want a fast ramp time to facilitate a fast-twitch contraction?).

However, if you are only just returning to the use of e-stimulation in your clinical practice and feel uncertain which settings to choose, the Pre-Set programs are an easy and relatively safe way to start out.

NOTE

For those of you not wanting to customise the program for your patient, you should make your decision based on the pre-set programs available in each unit (I have included a summary of these at the end of this information)

Personally, I never use a pre-set programme for my patients. I always program the settings for each individual patient using one of the customisable program channels. Therefore, I am not particularly fussed about the number of pre-set built in programs a unit has. I will therefore buy the cheapest unit that has a customisable program capable of setting the parameters I need. Unfortunately, not all stimulation units have the same customisable options.

4. DECIDING ON THE UNIT BASED ON THE "CUSTOMISABLE PROGRAM CAPABILITIES"

The complex part is that different conditions require the unit to be able to perform different functions:

CONDITION	Type of Stimulation	Customisable Requirements Needed	UNITS THAT MEET THE CRITERIA		
			Pelvitone	Continence	TENS
Pelvic Floor Strength Lack of Contraction Poor Endurance	Vaginal Stimulation	Unit needs the ability to set <ul style="list-style-type: none"> - an <u>intermittent</u> program - set work : rest times - change ramp time 	Yes	Yes	<u>No</u>
Urinary Urgency / Urge Urinary Incontinence	Vaginal Stimulation or Tibial Nn Stim	Unit needs the ability to set <ul style="list-style-type: none"> - a <u>continuous</u> Program - 20-60min treatment time 	Yes	No (max is 99sec on: 2sec off)	Yes
Faecal Incontinence	Tibial Nerve Stim	Unit needs the ability to set <ul style="list-style-type: none"> - a <u>continuous</u> program - 20-60 min treatment time 	Yes	No (max is 99sec on: 2sec off)	Yes
	Sacral Stimulation	Unit needs the ability to set <ul style="list-style-type: none"> - a continuous program - 3-4 hour treatment time 	No (max 99min)	No (max 90min)	Yes
Chronic Pelvic Pain (eg dysmenorrhea)	Sacral / Low Back	Unit needs the ability to set <ul style="list-style-type: none"> - modulated / burst mode - >2 hour treatment time 	No	No	Yes

NOTES

'CONTINUOUS vs INTERMITTENT' CAPABILITIES

1. The Neurotrac **Pelvitone** can be customised to a Continuous Program or an Intermittent Program
2. The Neurotrac **Continence** cannot be programmed for continuous. Its customisable programs are primarily designed for contract/relax using intermittent. It can however be set as 99sec on: 2 sec off to get 'very close' to continuous if needed for pain or urgency treatments.
3. The Neurotrac **TENS** customisable programs can only be set for continuous, it can't be set for intermittent. It therefore **cannot** be used for muscle stimulation.

'DURATION OF TREATMENT' CAPABILITIES

Both the Pelvitone and Continence are limited to a total treatment time duration of ~1.5hours. The research on sacral stimulation for faecal incontinence is all long duration (3-4 hours or more). However, the customised program could simply be set for 90min, and the patient instructed to repeat the program 2-3 times each day.



Women's Health Training Associates

SUMMARY OF THE PRE-SET PROGRAMS

NEUROTRAC PELVITONE & CONTINENCE	Program # on Neurotrac Pelvitone	Program # on Neurotrac Continence
Pelvic Floor Pain 3Hz Continuous 20min	P01	P01
Urge Incontinence 10Hz Intermittent (5on:5off) 20min	P02	P02
Stress I 40Hz Intermittent (6on:15off) 20min	P03	P03
Stress 2 30Hz Intermittent (5on:8off) 20min	P04	P04
Frequency/Urge-1 10Hz Intermittent (5on:5off) 20min	P05	P05
Frequency/Urge 2 10Hz Continuous 15min	P06	P06
Frequency/ Urge 3 10Hz, Continuous 20min	P07	-
Lack of Sensitivity 25min 5 Phase Program 1. 3Hz 4on:4off 3min 2. 10Hz 4on:4off 10min 3. 20Hz 4on:4off 5min 4. 30Hz 4on:6off 4min 5. 40Hz 4on:6 off 3	P08	P07
Pelvic Floor Workout 60min 5 Phase Program 1. 20Hz 4on:4off 4min 2. 10Hz 4on:4off 15min 3. 20Hz 4on:4off 8min 4. 30Hz 5on:6off 8min 5. 10Hz 5on:7off 10min	P09	P08
Building Up Endurance 20Hz Intermittent (5on:5off) 20min	P10	P09
Relaxing the Pelvic Floor 2Hz Intermittent (6on:10off) 20min	P11	-

NEUROTRAC TENS	Program #
4 Hours Continuous, 80Hz, 200us	P1
4 Hours Continuous, 80Hz, 175us	P2
4 Hours Burst, 2Hz, 200us	P3
4 Hours Modulated 100/65, 200/100	P4
4 Hours Continuous 10Hz, 175us	P5
4 Hours Continuous 100Hz, 175us	P6
4 Hours Continuous 50Hz, 100us	P7
4 Hours Continuous 60Hz, 75us	P8
4 Hours Continuous 2Hz, 175us	P9
1.5 Hours Continuous 80Hz, 175us	P10
45 min Modulated 65/100,200/100	P11
35min Burst 2Hz, 175us	P12

CLINICAL TIPS

Some easy to administer advice for the clinic....

Outlined below are some quick clinical tips that I use in my clinic, and hope that you all might find useful.....

TIP #1: Asking About "Coital Incontinence"

Over the last 8 months, many WHTA members have attended the Webinar "Sex, Lies and Suburethral Tape". The focus of this webinar is the issue of urinary incontinence during intercourse and the possible existence of female ejaculation.

During the webinar it is explained that research has now shown that ~30-50% of women with daytime stress or urge urinary incontinence are known to also suffer from incontinence during intercourse. When I first read this data I must admit that even I was surprised, as I knew that the frequency with which women were admitting to this symptom in my clinic was no-where near this number. This realisation led me to reflect on my questioning surrounding coital incontinence, and look for reasons as to why my questioning may be falling short of identifying this often distressing symptom for women.

What did I realise???

What I have now realised is that many of the women in my clinic seem to have sub-consciously taught themselves to always empty their bladder just prior to intercourse! This means that if I simply ask them whether they '*ever leak during intercourse?*' they simply answer '*no*'. They don't leak because their bladder is always empty!!!

What have I changed???

Basically... I have changed the series of questions I ask about bladder control during intercourse. My series of questions is now more commonly:

Q1: Do you mind if I ask if you are sexually active? (just a gentle way to start sexual questions)

Q2: Do you usually empty your bladder prior to having intercourse?

If YES:

Q2.1 "Is that just habit, or is there a specific reason why you prefer to empty your bladder prior to intercourse?"

Q2.2 "If you had intercourse with a full bladder, do you think you might leak during intercourse?"

Q2.3 "Has this ever happened during intercourse in the past?"

Since I have changed my questioning I have found a much greater number of women seem to be opening up their 'secret concern' that they may leak during intercourse, or an experience of leakage during intercourse in the past which has caused them to now always empty their bladder prior.

TIP #2: Assessing Genital Hiatus (GH) when the Urethral Meatus is hard to visualise

A little disclaimer..... the next tip I am about to suggest is a little daunting to formally admit to in a published piece of work that can be read by anyone who gets their hands on it.

Why would I be nervous?

Because I know that what I am about to suggest is something that would not pass an exam if I were being tested!!

So if it wouldn't pass an exam, why am I about to suggest this clinical tip?

Because I have always prided myself on the fact that any teaching I have done is not simply backed by significant research, but that it is also grounded in clinical reality (rather than a pretend, sterile version that I use to make it sound like I always do everything perfectly in my clinic).

So what is the tip??

The tip is in regards to measuring the Genital Hiatus (defined as the distance from the mid urethra to the posterior vaginal forchette) during a vaginal examination.

When I talk about the genital hiatus measurement in the Advanced Prolapse Course, Objective Testing Course or Exercise and Sport course, the most common question people ask is what I do if it is hard to visualise the urethra.

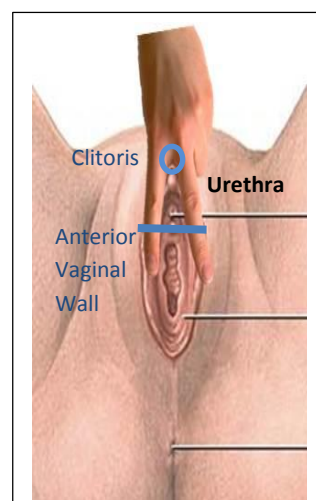
The reality is that whilst the external urethral meatus can be extremely easy to visualise in some women, in others it is almost impossible. Especially in nulliparous women, the tissue of the anterior vestibule is often still partially obstructing full visualisation of the external urethral meatus.

So what do I do if the external urethral meatus is almost impossible to visualise?

Well, I do the only option that there really is to do..... ***I estimate (ie guess) where it is!***

How Do I guess??

Basically.... I first locate the clitoris.... I then locate the anterior border of the vagina..... then I estimate that the middle of the urethral meatus is probably about half way between.



Is this accurate??

In truth.... Not exactly. The only exact way to get an accurate GH measure is to accurately visualise the urethral meatus. But if that is not an option (I am not exactly going to try to pull away any tissue that may be obstructing the view of the urethral meatus) I believe it is better than nothing. It may mean that a GH+PB that is actually 8.5cm gets assessed as 8cm or 9cm, but I am not going to be so far wrong that a 6.5cm GH+PB is measured as a 9cm GH +PB.

TIP #3: Asking about "Stool Type" - make sure you also ask about frequency of 'urge to defecate'

(This is a tip I have included for more junior women's health physiotherapists)

Asking about "Stool Type" (usually via the Bristol Stool Chart) is a common question in any pelvic floor assessment. It is generally regarded as a quick and easy *first step* in attempting to differentiate constipation related to *Slow Colonic Transit* from constipation related to *Obstructed Defecation*.

In a simplified version of bowel dysfunction it is usually suggested that hard, pebbly, Type 1 or 2 Stool Types would be a significant clue that the constipation may be related to Slow Colonic Transit, whilst the symptom of high level straining followed by the passage of a normal Type 3 or 4 stool type would be more indicative of constipation due to Obstructed Defecation.

BE CAREFUL THOUGH..... THERE ARE A FEW TRICKS TO THIS!

1. SLOW TRANSIT CONSTIPATION

It is true that 'Slow Transit Constipation' most commonly results in Type 1 or 2 stool types at defecation and virtually never presents as Type 3 or 4 Stool type. The slow colonic transit time provides an excessive amount of time for water to be absorbed, making the stool hard and/or pebbly. It is therefore very unlikely that 'Slow Colonic Transit' would be the underlying pathophysiology if the person describes straining, or infrequent defecation resulting in Type 3 or 4 stool types.

However..... Slow Colonic Transit can also result in Type 7 Stool Type. If the slow colonic transit constipation is severe, people can become faecally impacted, resulting in the overflow of 'loose stools' around the impaction. This will result in the patient describing their stools as Type 7.








2. CONSTIPATION DUE TO OBSTRUCTED DEFECATION

Constipation related to an 'outlet obstruction' (eg paradoxical puborectalis) would most commonly present as high level straining followed by the passage of a normal Type 3 or 4 Stool type. This is due to the fact that there is not officially a 'slow transit time through the colon' and therefore the time for water to be absorbed out of the faecal matter is normal.

However..... There are two scenarios where Obstructed Defecation may result in Type 1 or 2 Stool Type

- 2.1 *The obstruction is severe, leading to a prolonged time the faecal matter remains in the rectum:*
If the faecal matter remains in the rectum for a prolonged period of time due to severe obstruction, water absorption and resultant hardening of stool will still occur.
- 2.2 *The incomplete emptying of the rectum (common in obstructed defecation) signals the colon to slow down.....*
Research has now shown that when Obstructed Defecation is severe, the colon begins slowing down its peristalsis. Therefore a slow colonic transit time develops (resulting in hard stool types), but this is only secondary to the obstructed defecation.

Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on the surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. Entirely Liquid

Question: So How do we get around these tricks???

Answer: Always also look at the frequency that the urge to defecate / sensation of a full rectum occurs!

If there is **obstructed defecation**, most people will experience ***a regular (every day or even multiple times a day) urge to defecate***. The rectum is regularly full giving an urge to open their bowels, they simply can't evacuate its contents.

In pure **slow colonic transit**, people may often experience ***days without an urge to defecate*** but gradually feel an increasing bloatedness and distension of their abdomen.

Therefore..... it is always safer to combine 'Frequency with which an urge to defecate occurs' and 'resultant Stool Type on defecation' to get a clearer idea of the underlying cause of someone's constipation.

PROFESSIONAL LINKS

SOCIAL MEDIA – FACEBOOK: **Continence and Women's Health Groups**

As most people are aware, I am not great with Facebook. I think I now have three different accounts and none of them I really know how to use. However, the last year has seen the creation of a "Continence and Women's Health Physiotherapy Facebook Group" in Australia, and an establishing page in New Zealand. I have therefore made it my goal to become more Facebook savvy by the end of the year.

The Australian group is already sharing knowledge, alerting each other to employment vacancies in the area of women's health, notifying each other of courses and conferences that are coming up, and generally just supporting the growth of this amazing field we work in. My understanding is that the NZ page is hoping to be very similar soon!

If you are already a "Facebook Person" (which I will try to be better at soon), I strongly encourage you to look up the following two groups:

1. **Australian Physiotherapy Continence and Women's Health Group** (up and running)
2. **NZ Women's Health Physios** (still in its early development phase)

CONFERENCES

Conferences can obviously be a great way to network with other professionals working within women's health, gain exposure to new products on the market and often hear ideas on assessment and treatment that may be new and up-coming. Two interesting conferences coming up are:

1. **September 10th -13th** **"National Conference on Incontinence"**
LOCATION: Cairn's Convention Centre

A joint conference between

- 1.1 Continence Foundation of Australia (CFA)
- 1.2 International Children's Continence Society (ICCS)
- 1.3 Urogynaecological Society of Australasia

PRICE*	Full Conference (excluding workshops)	Early Bird: \$580	Standard: \$745
	Single Full Day (either Thurs or Fri)	Early Bird: \$320	Standard: \$360
	Single Day Sat (half day)	Early Bird: \$190	Standard: \$210
	Workshops:	Vary from \$40 - \$140	

*Note: these are member prices. Non-member prices are \$100-\$200 higher. Membership can be bought for \$85.00 per financial year (July to June)

LINK www.continence.org.au

2. August 15th -16th 2014

AGES Pelvic Floor Symposium: "Pelvic Floor Surgery – Going Native"

LOCATION:

Hilton Hotel, Adelaide

A pelvic floor focused symposium of the Australasian Gynaecological Endoscopy and Surgery Society. Some of the Program Information from the Brochure

SESSION ONE Fundamentals of Pelvic Floor Surgery

SESSION TWO Live Surgery

SESSION THREE Issues with Continence Slings

SESSION SIX Mixed: Medicolegal Trends, Long-Term management of OAB, What PF Physios teach patients, Dyspareunia, What is the optimum support/continence pessary for your patient.

SESSION NINE Colorectal Session: Gut motility and constipation, relevance to prolapse, faecal incontinence – what the gynaecologist should know

PRICE: There is no specific physiotherapist rate. The Nurse rate is **\$360.00**

NOTE: As written for session Two above, this symposium will include "LIVE PELVIC FLOOR" Surgery on the first day being transmitted to the audience from the operating room. You will see Doctors asking questions to the surgeon during the procedures via online audio whilst the audience watches the procedures in real time.

RESEARCH UPDATE

What research has recently been published?

The following pages are designed to provide members with a brief overview of recently published research within peer-reviewed scientific journals. For each of the articles a link is provided so that members can easily access the pubmed abstract (including full reference) of any topic that is of particular interest to their current clinical practice.

ANAL SPHINCTER INJURIES AND FAECAL INCONTINENCE RESEARCH

Maternal Body Mass Index and Obstetric Anal Sphincter Injury.

Blomberg 2014, have published data from 436,482 women with singleton term vaginal cephalic births as identified by the Swedish Medical Birth Registry. The Authors found that the **risk of obstetric anal sphincter injury decreases with increasing BMI**, with morbidly obese women having half the risk of sustaining a total anal sphincter injury when compared with normal weight women (OR 0.47).

PUBMED LINK ABSTRACT: <http://www.ncbi.nlm.nih.gov/pubmed/24839604>

FULL TEXT LINK: <http://www.hindawi.com/journals/bmri/2014/395803/>

Fecal Incontinence 20 years after one birth: a comparison between vaginal delivery and caesarean section.

Gyhagen et al 2014, Int Urogyn J have found that when comparing women who were 20 years post a single vaginal birth vs a single caesarean section, the prevalence of Faecal Incontinence was higher after vaginal delivery (14.5% vs 10.6%, OR 1.43). In addition:

- The prevalence of FI after vaginal delivery with episiotomy was similar to that after caesarean section (11.1% vs 10.6%).
- Sustaining a perineal tear of \geq Grade 2 during a vaginal birth increased the prevalence of FI compared with no tear (22.8% vs 13.9%, OR 1.95).
- Faecal incontinence rates were not significantly different between those who had an acute (in-labour) vs elective (prior to labour) caesarean section.

LINK TO PUBMED ABSTRACT: <http://www.ncbi.nlm.nih.gov/pubmed/24803215>

Vitamin D deficiency is associated with increased fecal incontinence symptoms

Parker-Autry et al 2014, Int Urogyn Journal have published data indicating that women with FI tend to have lower vitamin D levels, and that vitamin D deficiency may contribute to patient symptom burden in women with fecal incontinence.

LINK TO PUBMED ABSTRACT: <http://www.ncbi.nlm.nih.gov/pubmed/24807423>

Long-term function and morphology of the anal sphincters and the pelvic floor after primary repair of obstetric anal sphincter injury.

Sorensen et al 2014, Colorectal Disease

Background: More than 50% of women experience deteriorating continence over time following primary repair of obstetric anal sphincter injuries. The objective of this study was to therefore assess the function and morphology of the anal sphincters and pelvic floor in women with long-term faecal incontinence after sphincter repair and evaluate their correlation with severity of incontinence.

59 women were reviewed at a mean follow up of 24years post birth

- 'CASES': 29 women who had previously sustained a 3rd/4th degree perineal tear (OASIS)
- 'CONTROLS': 30 women who had not sustained anal sphincter injury at birth

Women were stratified into three categories: 1. Continent 2. Minor incontinence 3. Severe incontinence

Results

- Women who had previously sustained an OASIS (cases) had a significantly shorter anterior external anal sphincter length compared to controls when evaluated by 3D-EAUS (8.6 vs 10.2mm)
- Cases with severe incontinence had significantly shorter anterior sphincter length compared to cases with minor incontinence (7.7mm vs 10.4mm)
- No correlation could be found between anal pressures and severity of incontinence in the case group.

Conclusion

Anterior sphincter length correlated with increased severity of incontinence, whilst anal pressures did not.

LINK TO PUBMED ABSTRACT: <http://www.ncbi.nlm.nih.gov/pubmed/24502361>

LEVATOR ANI AVULSION / LEVATOR ANI DEFECTS

Levator Ani defect scores and pelvic organ prolapse: is there a threshold effect?

Berger et al 2014, Int Urogyn Journal performed a secondary analysis of two case-control studies comparing 284 women with prolapse to 219 controls. Levator Ani Defects (LAD) were assessed by MRI and graded from 0 (no defects) to 6 (Complete, bilateral defects).

The authors found a significant correlation between higher LAD scores and higher prolapse rates, with LAD alone being found to correctly discriminate between normal support and prolapse for nearly 70% of patients. Logistic regression found that higher parity and higher LAD scores are independent predictors of prolapse.

LINK TO PUBMED ABSTRACT: <http://www.ncbi.nlm.nih.gov/pubmed/24788366>

Effect of levator ani muscle injury on primiparous women during the first year after childbirth.

Chan et al 2014 have published the results of n = 328 primiparous women assessed at 8/52 and 12/12 post-delivery

At 8/52 post-delivery 48/328 women (19%) had evidence of LAM injury on translabial ultrasound, however only 79.2% of these persisted to have evidence of LAM injury at 12months (38/328). LAM injury was associated with prolapse symptoms, greater descent of POP-Q points Aa and Ba at 8/52 post-delivery as well as higher POPDI (Pelvic Organ Prolapse Distress Inventory) scores. There was no association between levator ani muscle injury and SUI, UI, MUI, or Faecal Incontinence at any time point.

LINK TO PUBMED ABSTRACT: <http://www.ncbi.nlm.nih.gov/pubmed/24556973>

Prevalence, Etiology and risk factors of pelvic organ prolapse in premenopausal primiparous women.

Durnea et al 2014, International Urogyn Journal conducted a prospective cohort study of 202 primiparous women 1 year postnatal. Analysis found that POP was significantly associated with:

- Joint Hypermobility
- Vertebral Hernia
- Varicose Veins
- Asthma
- High Collagen Type III levels

Caesarean section was found to be significantly protective against cystocele and rectocele but not for uterine prolapse.

LINK TO PUBMED ABSTRACT: <http://www.ncbi.nlm.nih.gov/pubmed/24737300>

Comparison of forceps and vacuum-assisted vaginal deliveries in terms of levator ani muscle injury

Memon and Handa 2014 published the results of a retrospective cohort study of n = 89 women. Women who had undergone at least one forceps delivery were compared to women had undergone at least one vacuum birth. Participants were 5-10 years from first delivery.

Results:

- The odds of LA muscle avulsion were four times higher in the forceps group compared to the vacuum group.
- Women in the forceps group had wider levator-urethral gap, larger hiatal diameter, and widened hiatal area at valsalva and squeeze.
- Among women who had a forceps delivery, levator avulsion was associated with older age and lower parity.
- Anal sphincter injuries were also more common in the forceps delivery group.

LINK TO PUBMED ABSTRACT: <http://www.ncbi.nlm.nih.gov/pubmed/24770131>

The relationship between postpartum levator ani muscle avulsion and signs and symptoms of pelvic floor dysfunction.

Van Delft et al 2014, BJOG, epub ahead of print.

N = 269 primigravid women without LAM participated in the initial assessment with n = 191 (71%) returning for follow up postpartum

Results:

- LAM avulsion occurred in 21% of vaginal deliveries
- Women with minor and major avulsion had
 - o worse PF muscle strength ($p < 0.038$)
 - o more anterior compartment prolapse ($p < 0.024$)
- The antenatal antero-posterior levator hiatus diameter was significantly smaller in women who later sustained an avulsion ($p = 0.011$).
- Postnatal measurements were significantly increased following an avulsion.
- Women with avulsion were less sexually active at both antenatal and postnatal periods.
- Women with avulsion had more urinary incontinence, and symptoms such as reduced vaginal sensation and 'too loose vagina'.

LINK TO PUBMED ABSTRACT: <http://www.ncbi.nlm.nih.gov/pubmed/24548759>

SEXUAL FUNCTION

Women with greater pelvic floor muscle strength have better sexual function

Martinez et al 2014, Acta Obstet Gynecol Scand investigated the relationship between pelvic floor muscle strength and sexual function amongst women with higher and lower pelvic floor muscle strength. Female sexual function was assessed via the Female Sexual Function Index Questionnaire, whilst PF muscle strength was assessed by both transvaginal palpation and perineometry.

Results:

Women with stronger pelvic floor muscles scored higher in the domains of desire, excitement, orgasm and the general score of the questionnaire.

There was a moderate correlation between pelvic floor muscle pressure and both sexual satisfaction and lubrication.

Conclusion: The authors state that their findings suggest that women with stronger pelvic floor muscles have better sexual function.

LINK TO PUBMED ABSTRACT: <http://www.ncbi.nlm.nih.gov/pubmed/24628380>

Benefit of Pelvic Floor muscle therapy in improving sexual function in women with Stress Urinary Incontinence: A pretest-post test intervention study.

Martinez et al 2014, Acta Obstet Gynecol Scand

Authors found that a 3month pelvic floor muscle training program in women with stress urinary incontinence (without overactive bladder symptoms) resulted in improvements not only in incontinence but also sexual function.

LINK TO PUBMED ABSTRACT: <http://www.ncbi.nlm.nih.gov/pubmed/24512197>

INCONTINENCE & PROLAPSE SURGERY

Does prior vaginal prolapse surgery affect synthetic mesh erosion rates?

Kongoasa et al 2014 reviewed 810 cases of women undergoing mesh-augmented pelvic floor repair.

- n = 668 women underwent mesh augmented PF repair having had no prior vaginal prolapse surgery
- n = 142 women underwent mesh augmented PF repair having had prior vaginal prolapse surgery.

Results

Women who had never previously undergone vaginal prolapse surgery had a significantly higher chance of developing mesh erosion when compared with those who had previously undergone repair surgery (10.6% vs 2.8%, oR = 4.10).

Conclusion

Presence of scare tissue may be protective against mesh erosion. This further supports the American College of Obstetricians and Gynaecologists recommendations that vaginal mesh repair should be reserved for individuals with recurrent prolapse after previous surgery.

LINK TO PUBMED ABSTRACT: <http://www.ncbi.nlm.nih.gov/pubmed/24770140>

Long-Term Follow-up of Treatment for Synthetic Mesh Complications

Hansen et al 2014, vol 20 (3): 126-130, Female Pelvic Medicine Reconstr Surgery

LINK: <http://www.ncbi.nlm.nih.gov/pubmed/24763152>

Reviewed a total of 111 women who presented due to complications associated with synthetic vaginal mesh.

- The mean interval from index surgery was 2.4 years.
- Index surgeries included:
 - vaginal mesh kits/vaginally placed mesh (47%),
 - midurethral mesh slings (37%),
 - abdominally placed vaginal mesh (11%)
 - vaginal mesh kit with concomitantly placed mesh sling (5%).
- The most common complications were extrusion (65%), contraction (17%), and chronic pelvic pain (16%).

- A total of 98 women underwent some type of treatment (85 surgical) by urogynecologists, pelvic pain specialists, or physical therapists.

At follow-up of an average of 2.3 years later:

- 22% reported persistent vaginal discharge,
- 15% vaginal bleeding or spotting, and
- 45% sexual abstinence due to problems related to mesh.

A total of 71% reported being overall better, whereas 29% were the same or worse.

CONCLUSIONS

Two years after tertiary care level multidisciplinary treatment of vaginal mesh complications, many women still report symptoms that negatively impact their quality of life.

Changed women: the long-term impact of vaginal mesh complications

Dunn et al 2014, Female Pelvic Medicine Reconstr Surgery, vol 20(3): 131-6

Note: direct copy from Pubmed Abstract.

LINK: <http://www.ncbi.nlm.nih.gov/pubmed/24763153>

OBJECTIVES:

The aim of this study was to describe how women experience vaginal mesh complications after optimized tertiary care level treatment.

METHODS:

We conducted telephone interviews in 2012 with women at least 6 months after presentation to our tertiary care clinic between 2006 and 2011 for complications related to vaginal mesh and transcribed verbatim responses to 2 open-ended questions about their experiences surrounding vaginal mesh complications.

RESULTS:

Of 111 women, we successfully contacted 88, and 84 agreed to the interview. The mean duration from index mesh surgery to interview was 4.5 years, and the mean duration from presentation to our clinic for complications to the interview was 2.3 years. The effects of mesh complications caused both physical and emotional pain, in addition to the discomfort of the original pelvic floor dysfunction.

The women's experiences followed 1 of 3 recovery trajectories. In "cascading health problems," the women experienced a spiral of health problems, anxiety, and desperation. In "settling for a new normal," the women who once considered themselves healthy now believed that they are unhealthy and worked to adjust to their degraded health status. In "returning to health," the women described a return to health. The women still symptomatic discharged from tertiary care clinic expressed hopelessness and abandonment.

CONCLUSIONS:

Concomitant with ongoing research to improve the safety of vaginal mesh procedures, there must be dedicated efforts to develop and study a range of therapies for holistically treating women with mesh complications.

PELVIC FLOOR MUSCLE ANATOMY AND FUNCTION

Pelvic Floor muscle variables and levator hiatus dimensions: a 3/4D transperineal ultrasound cross-sectional study on 300 nulliparous pregnant women

Bo et al 2014, Int Urogynecol Journal found that PFM strength and endurance are strongly correlated. High vaginal resting pressure is moderately correlated with a small levator hiatus at rest, but there is no correlation between PFM strength and LH area at rest.

PUBMED LINK TO ABSTRACT: <http://www.ncbi.nlm.nih.gov/pubmed/24828605>

Pelvic Floor Muscles training versus no treatment, or inactive control treatments, for urinary incontinence in women. An update of the Cochrane Systematic Review

Dumoulin et al 2014 have provided an update on the Cochrane systematic review. The review now includes 21 trials with a total of 1281 women meeting the inclusion criteria, with 18 trials and a total of 1051 women's data being included for the forest plots.

The primary results are:

- Women with SUI in the PFMT groups were 8 times more likely than controls to report that they were cured (46/82, 56.1% vs 5/83, 6%. RR 8.38)
- Women with SUI in the PFMT groups were 17 times more likely to report cure or improvement
- In trials that included women with any type of urinary incontinence (not purely SUI) the PFMT were also more likely to report cure, although the effect size was reduced.
- Women in the PFMT groups were more likely to report satisfaction with treatment, whereas women in the control groups were more likely to seek further treatment.

The review provides support for the widespread recommendation that PFMT be included in first-line conservative management programmes for women with stress and any type of urinary incontinence.

LINK TO PUBMED ABSTRACT: <http://www.ncbi.nlm.nih.gov/pubmed/24823491>

Pelvic floor muscle dysfunctions are prevalent in female chronic pelvic pain: a cross-sectional population-based study

Loving et al 2014 in the European J Pain, reported findings from a set of standardised vaginal PFM examination manoeuvres in 50 female patients: 24 with CPP and 26 pain free.

The assessor was blinded to the participants CPP history.

Results: Women with CPP had higher PFM resting tone and decreased maximal PFM strength and relaxation capacity when compared with pain-free controls.

LINK TO PUBMED ABSTRACT: <http://www.ncbi.nlm.nih.gov/pubmed/24700500>

The improvement in pelvic floor symptoms with weight loss in obese women does not correlate with the changes in pelvic anatomy.

Gozukara et al 2014, Intern Urogyn Journal, published the results of a randomised controlled trial involving 378 overweight / obese women with urinary incontinence. The treatment group underwent a weight loss program whilst the control group underwent a structured education group.

Results

- No change in urinary incontinence episodes in the control group
- The intervention group had a mean weight loss of 9.4% which resulted in
 - o Reduction in number of SUI episodes on 3-day diary from 7.96 to 3.11
 - o Reduction in number of UUI episodes on 3-day diary from 2.85 to 1.08
 - o In terms of POP-Q assessment, only GH, PB and Ap measurements were significantly lower in the weight loss group after 6 months.

Conclusion

Weight loss reduction provides improvement in episodes of UI, decreases the incidence of drops of urine leakage, and increases quality of life related to pelvic floor symptoms. However, there is little to no change in parameters of the POP-Q system with weight reduction.

LINK TO PUBMED ABSTRACT: <http://www.ncbi.nlm.nih.gov/pubmed/24711149>

Ethnic differences in pelvic floor muscles strength and endurance in South African women.

Van der Walt et al 2014, Int Urogyn Journal

The aim of this study was to compare PFM strength and endurance in a group of black, white and mixed-race women in South Africa.

METHODS

A total of 122 nulliparous black (n = 44), white (n = 44) and mixed-race (n = 34) students participated. Maximum voluntary contraction (MVC) and endurance were measured with a perineometer and vaginal balloon sensor. Two sets of three MVC of the PFM were recorded; resting phase was 5 min. Demographic variables and factors associated with PFM strength were assessed.

RESULTS:

PFM of black women were stronger than that of white (p = 0.02) or mixed-race (p < 0.01) women. The MVC of PFM in black women decreased (p = 0.02) between the first and second set of contractions.

LINK TO PUBMED ABSTRACT: <http://www.ncbi.nlm.nih.gov/pubmed/24464469>

In patients with rectoceles and obstructed defecation syndrome, surgery should be the option of last resort.

Hicks et al 2014, Surgery, vol 155 (4): 659 -67.

Published the results of 90 female patients with obstructed defecation syndrome (ODS), treated with fiber supplements and biofeedback training.

Results:

- 71.1% of patients responded to medical management and biofeedback
- The presence of internal intussusception was associated with a lower chance of needing to undergo surgery
- Inability to expel balloon, contrast retention on defecography and splinting were not associated with risk of needing surgery.

Conclusion:

Rectoceles with concomitant intussusception in patients with ODS appear to portend a favourable response to biofeedback and medical management. All patients considered for surgery for rectocles because of ODS should first undergo appropriate bowel retraining.

LINK TO PUBMED ABSTRACT: <http://www.ncbi.nlm.nih.gov/pubmed/24508117>

The effect of a precise contraction of the pelvic floor muscle using visual feedback on the stabilization of the lumbar region

Kim, Cho and Jang 2014, Journal of Physical Therapy Science, analysed the impact of performing a pelvic floor muscle contraction on the thickness of each of the abdominal muscles as assessed by ultrasound. The authors found that a correct pelvic floor muscle contraction resulted in a significant increase in thickness of Transversus Abdominus, but no difference in thickness of external or internal oblique.

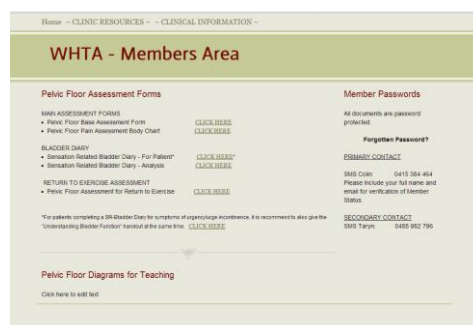
LINK TO PUBMED ABSTRACT: <http://www.ncbi.nlm.nih.gov/pubmed/24764643>

LINK TO FREE FULL TEXT: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3996431/>

WHTA Update

Members Website Replacing Dropbox

As many of you are probably aware, a couple of months ago we launched the new WHTA-Member website. It gives members access to all the WHTA Member Benefits including Clinical Resources (assessment forms, handouts, diagrams) as well as past newsletters, links to past mini-tutes etc.



If you haven't accessed the main member website I encourage you to do so!! 😊😊😊

Web Address: www.whta-members.com

To enter the Website you will need the following:

USERNAME: **Member** (everyone's username is the same).
 PASSWORD: **WHTA2014** (everyone's password is the same but will change periodically)

To open each document you will also need to type the password. Please also be aware that it is case sensitive.



PLEASE NOTE!

Whilst drop-box served its purpose for a while, obviously there were some difficulties in ensuring that information remained active on the site. Dropbox is therefore being phased out and all new information will be listed on the Member Website.

NEW COURSES FOR WHTA! – Advanced Pelvic Floor Courses

Being conscious that many members have completed all the courses that WHTA was previously offering (btw, thank you for your wonderful support), I am pleased to announce that there are three additional courses being added to the WHTA Educational Program this year.

COURSE #1:	Advance Pelvic Floor – ‘Predictive Pelvic Floor’
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This course is designed to provide physiotherapists with the knowledge and skills required to answer those tricky questions where patients want us to ‘predict the future’. The course will be split into three sections

Section One: First Time Mothers – Am I at risk of postpartum PF/Urinary/Bowel Dysfunction?

In this section we will review the research on predictive factors for urinary incontinence, faecal incontinence, anal sphincter injury and pelvic organ prolapse in a first time mother. Physiotherapists will learn how to utilise pre-birth symptoms, family history, and assessments of current pelvic floor structure and function to assist women in determining their relative risk of pelvic floor dysfunction if they undergo a vaginal birth.

Section Two: Second Time Mothers – another vaginal birth?

Similar to the first section, the goal of this component is to assist women in deciding whether a vaginal birth is likely to result in worsening of pelvic floor dysfunction – however the focus in this section is women who have already undergone significant trauma in a first birth. The two main groups that will be the focus of discussion are:

- A) Women who sustained an anal sphincter injury during their first birth*
- B) Women who developed pelvic organ prolapse or urinary incontinence after their first birth*

Section Three: Conservative or Surgical – which patients are they likely to fail?

As any experienced pelvic floor physiotherapist would know, conservative treatments for pelvic floor disorders don't work in everyone, and surgery doesn't work in everyone. Being able to accurately advise patients on the chance of success of each option based on their individual scenario is extremely useful information for the patient (especially when cost of treatment is taken into account!). The focus of this section is to review research on factors that may indicate conservative treatment is unlikely to be successful (and therefore surgery should be considered), as well as factors that may indicate that surgery is unlikely to be successful (and therefore conservative treatment should be the focus).

COURSE #2: Advanced Pelvic Floor – ‘Pelvic Floor Related to Co-Morbidities’
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Whilst many urinary, bowel and pelvic organ support disorders are simply related to pelvic floor muscular dysfunction, birth related trauma and lifestyle factors, in some instance these symptoms are influenced by a larger underlying diagnosis. It is therefore vital that physiotherapists have an understanding of these conditions and the implications for the assessment and treatment any associated pelvic floor disorder.

This second course will therefore cover the impact of the following conditions on pelvic floor, urinary, bowel and sexual symptoms:

- Diabetes Mellitus
- Multiple Sclerosis
- Stroke
- Parkinson's Disease
- Cystic Fibrosis
- Spinal Cord Injury

Note: *The Co-Morbidities course is the only course run by WHTA that will have a formal pre-requisite. Participants need to have completed either the Advanced Pelvic Floor – Overactive Bladder Course, or the webinar “Advanced Urinary System Anatomy”.*

COURSE #3: Advanced Pelvic Floor – ANORECTAL DYSFUNCTION	Friday 10th – Sunday 12th October
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In October this year WHTA will run (in combination with Sydney Pelvic Floor Centre) its first ever “Advanced Pelvic Floor – Anorectal Dysfunction course”. This course will be taught jointly by myself and Professor Marc Gladman, Head of Colorectal Surgery at Concord Hospital, Sydney.

COURSE OVERVIEW

The course will run over three days with the first two days open to Physiotherapists, Colorectal Surgeons, GPs and possibly nurses. The final day will be a workshop exclusive to physiotherapists, teaching specific physiotherapy skills required for the assessment and management of patients with anorectal pelvic floor disorders.

The first day will begin by providing detailed lectures on the anatomy and physiology of colon and anorectal system. This will be followed by detailed description of the pathophysiology underpinning obstructed defecation disorders, faecal continence disorders as well as anorectal pain disorders. Detailed explanation of the colorectal assessment options (including endo-anal ultrasound, anal Manometry, PNTML, defecating proctograms etc) will be given. Discussion surrounding the implication of multi-compartment disorders will be discussed.

The second day will continue with a brief overview of gastrointestinal / colorectal disorders that may influence rectal compliance and sensation, as well as digestion and formation of stools (eg ulcerative colitis, inflammatory bowel disease etc). Day 2 will also cover the medical and surgical management options for obstructed defecation disorders, anorectal pain disorders, and faecal continence disorders.

The third day will be exclusive to physiotherapists and will provide education and teaching on physiotherapy assessment (subjective history taking for bowel disorders, rectal examination, anal Manometry, anal EMG) as well as physiotherapy treatment options. Detailed instruction will be given on lifestyle management, defecation retraining, balloon retraining and electrical stimulation options (rectal, sacral, TTNS, interferential.)

PLEASE NOTE This Anorectal course is guaranteed to run in Sydney this year. Whilst it is hoped that we will travel this course interstate and across to New Zealand in the future, we cannot currently guarantee that this will occur.

WHTA CONFERENCE - 'Sharing Knowledge'

If someone were to ask me *"What has been the most significant personal benefit of setting up WHTA?"*, I would have to say the privilege I have had in getting to regularly interact with so many amazing physiotherapists working in the women's health field. Not a course goes by where I haven't personally learnt something from participants attending. There is a wealth of knowledge out there, and an enormous opportunity for us all to grow our skills simply through the sharing of knowledge.

This is the basis for attempting to run the first "WHTA Conference" next year. This will not be a conference in the traditional sense. If you believe you have an ability to teach, have a topic that you are passionate about, and would like to share your knowledge then we want to hear from you!!

Answers to some questions about the conference.....

Will there only be physiotherapists presenting?

No, we are hoping to have about an 80:20 split..... 80% of presentations will be physiotherapists and the other 20% will be made up of other professionals. We are considering Doctors (gynaes, urogynaes, obstetricians, colorectal), Sexual Health Nurses, Sexual Counsellors, Domestic Violence Workers etc.

Will the conference only be in Sydney?

It is envisaged that if this does become a regular event, that the conference will only be held in one location each year (or every 2 years). The 2014 conference will therefore only be in Sydney. However, if all goes well and the conference is a success, we plan to choose a different location for each conference. I haven't yet decided whether they will be annually or biannually, and so the possible conference schedule will be either:

SYDNEY	2014		
BRISBANE	2015	or	2016
AUCKLAND	2016	or	2018

If I apply to present, how long will my presentation need to be?

Presentation lengths will vary, ranging from 5minutes to 30minutes depending on the topic and type of presentation.

Do I need to present my own personal research?

No..... Any physiotherapists is welcome to present. You do not need to be involved with research. The purpose of the conference is simply to facilitate the sharing of knowledge between practitioners. You could choose to present (just some examples):

- A Clinical Focus Topic Presentation
 - 10-20min duration
 - Review anatomy and pathophysiology
 - Summary of recent research on assessment and treatment
- Clinical Case Study Presentation
 - 5-10minutes and must be a patient that you personally treated

- Must include summary of Subjective Hx, Objective Ax Results, Rx, and Outcome
- Preferably something a little different – maybe a unique comorbidity that made the patient interesting, or something 'new' you tried for treatment when everything else had failed, or a technique you have found works for a lot of patients that has not been currently research (a great way to stimulate ideas amongst the profession for future research ideas).

What are the benefits of presenting at the Conference?

The first benefit is that any physiotherapist presenting at the conference will be given a discount on attendance at the whole conference (we are currently thinking free attendance on the day you are presenting....so that you only pay for additional days you choose to attend). In addition though, presenting at the conference is also designed to give presenters the opportunity to gain exposure amongst their peers.

JUST A LITTLE NOTE FOR THOSE OF YOU HOPING TO PRESENT FOR WHTA IN THE FUTURE.....

Many physiotherapists have spoken to me about their interest in becoming a presenter/trainer for WHTA. There is the possibility that in the future I will consider other physiotherapists presenting WHTA courses, however I am obviously going to be quite particular about choosing people for this role. This is usually less about knowledge (virtually every women's health physio I meet has an amazing knowledge base), it is more about being able to convey that knowledge to others in an engaging, logical way that can make PD enjoyable!

If you are one of the many physiotherapists who have asked about becoming a presenter for WHTA in the future, this is the ideal platform to show us your skills!!! (Positive feedback on a presentation you gave at a WHTA Conference will hold a lot of weight when I am trying to find people to present WHTA courses in the future ☺ ☺ ☺).

I am really hoping that the Conference will provide a wonderful opportunity to share the amazing knowledge I know is out there. I will send more information on how to apply to present soon!

FINALLY.....PROFESSIONAL PROMOTION – options for the future....

There is no doubt that there is power in numbers!! It is much easier to promote our profession to GPs, Midwives, Sexual Counsellors etc when there is a central location for them to access to find a physiotherapist working in women's health.

That was the primary motivation behind why we ultimately set up the physio locator aspect of WHTA.... So that as WHTA moves into education and promotional activities with other professional groups, we will have an easy way to facilitate referrals to each of you and your clinical practices.

There are a range of promotional strategies that we have been working on recently that we hope to start implementing over the next 6months..... Watch this space!! But please make sure that you have your practice listed on our physioloicator.... So as we start to promote, you can receive referrals!

Anyway.... That is about it for the WHTA update and therefore the end of the newsletter!! ☺

If you have reached this far you have done really well. I hope you found it useful and look forward to interacting with you all soon.

Taryn