

Optimising uptake and implementation of pelvic floor muscle training exercise programs for people with urinary incontinence

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BACKGROUND

Level 1 evidence underpins the recommendation for pelvic floor muscle training (PFMT) as the first line intervention in the treatment of urinary incontinence (UI). Evidence from a meta-epidemiological study indicates that exercise programs are poorly reported for a range of health conditions.

PFMT systematic reviews indicate that intervention reporting is insufficient to: draw conclusions about exercise program elements that are important; make comparisons with other studies; and replicate and facilitate uptake in clinical practice.

We hypothesise that clinicians will be able to provide us with suggestions about the information they need in PFMT descriptions in order to implement this effective therapy.

AIMS

- to explore the beliefs and practices of clinicians who use PFMT for people with UI in order to understand what barriers, or enablers, may exist for clinicians to translate research evidence into practice.
- to summarise the elements of PFMT programs that clinicians believe require explicit description and make any modifications to the CERT checklist and Explanation and Elaboration Statement to customise it to PFMT

METHODS

Qualitative focus group and interview methods conducted by an experienced facilitator with a pre-determined set of questions. Participants were Continence Physiotherapists and Nurses from our publicly available membership registers. Interested participants were given an Explanatory Statement and provided a signed Consent Form prior to participation.

The sessions were audio-recorded and transcribed verbatim for independent analysis of emergent themes by at least two researchers. The data were analysed using thematic analysis within a Grounded Theory framework.

Study rigour was enhanced by a priori eligibility criteria, explicit data collection and analysis steps, participants giving opinions freely and results linked to the participant data.

RESULTS

There were 29 participants from the public & private sectors. Four key themes were identified: (abbreviated)

- 1) Need for detailed descriptions of PFMT content
- 2) Need for PFMT to be tailored to the individual
- 3) Essential PFMT-specific cues & language
- 4) Barriers to PFMT translation into practice

Theme 1: Detailed descriptions of content are required

- **Specific details such as dosage are not described**
PFMT programs are not comprehensively described in research reports.

“research articles frequently refer to a particular type of exercise...then give very little specifics “
“needs to be exactly spelled out, what exercises, instructions they gave, position the person was in “

- **Peer practice & post-graduate course content**

Clinicians seek advice from experts when they are unable to access or interpret the literature.
“our employers are specialists in the field, so learning a lot from them and picking their brains”

- **Default to principles of exercise physiology**

Clinicians default to clinical reasoning and exercise physiology principles derived from sports medicine literature.

“often find ourselves going back to is the physiology, exercise physiology, and trying to extrapolate “

Theme 2: PFMT needs to be tailored to the individual

- **Need to tailor PFMT programs to the individual**

“it has to be individualised...it has to be what the patient can do

“incorporate into functional training for what the patient needs in their life..what their goals are”

“you’re personalizing it to different people and looking at their goals”

Theme 3: Specific cues & language assist exercise engagement

Language used to assist PFMT performance is unique. Clinicians would benefit from an “information bank” of terms to facilitate pelvic floor muscle contractile response. This is not currently provided in the literature.

- **Cues used to facilitate engagement are specific to PFMT**

“pulling up through a straw”, “or “pulling saddle area up away from underwear, “reverse drop of water”, “lifting the testicles”, “walking into water”

- **Benefits of a “bank” of cues**

“we totally need a bank, because everyone uses it (owrds for exercise instruction) differently, and it depends if they're visual learners “

Theme 4: Perceived barriers for translation into practice

- **Limited access to published research**

“we don't have access (to journals)”

“we rely on colleagues to share information”

- **clinical guidelines are not user-friendly**

“ICS recommendations...they will list research in that but it's very big”

“a lot of discrepancy and a lot of unanswered questions ... it's (guidelines) definitely confusing”

1. Detailed descriptions of PFMT content

- PFMT exercise details not described
- Peer practice & course content
- Default - exercise physiology principles

2. Individual tailoring

- PFMT programs need to be tailored to the individual

3. Cues & language for engagement

- Facilitation cues are PFMT specific
- Benefits of a “bank” of cues

4. Barriers for translation into practice

- Limited access to published research
- Clinical guidelines are not user-friendly

DISCUSSION

- The 16 items contained in the CERT appear to be applicable to descriptions required of PFMT programs that have been reported as effective
- PFMT-specific amendments to the CERT checklist and Explanation & Elaboration Statement include:
 - ❖ guidance on exercise equipment (e.g. weighted cones, real-time ultrasound)
 - ❖ decision rules for program commencement level (e.g. maximum voluntary contraction)
 - ❖ progression (number of MVC until fatigue; change in urine leakage, continence pads used)
 - ❖ progression - functional activities
 - ❖ motivation & engagement strategies
 - ❖ explicit descriptions of functional or applied exercises - not jargon
 - ❖ explicit descriptions of dosage & exercises

CONCLUSIONS

Clinicians who use Pelvic Floor Muscle Training for Urinary Incontinence have indicated that they need explicit details of the interventions that have been tested in the research and reported as effective. Currently explicit descriptions are lacking in the published research and clinicians must defer to their experience, clinical reasoning and mentors.

We encourage journal editors & authors to provide explicit details of exercise programs and implement the Consensus on Exercise Reporting Template.