W25: Collaboration of professionals: Physiotherapy and Nursing, networking to treat disorders related to the dysfunctional pelvic floor.

Workshop Chairs: Frankie Bates, Canada Marijke Slieker-ten Hove

13 September 2017 11:00 - 12:30

Start	End	Topic	Speakers
11:00	11:15	Nursing Assessment of the Dysfunctional Pelvic Floor and Key Factors for Determining Physio Referral	Sharon Eustice
11:15	11:30	Physio Assessment of Patient With Chronic Pelvic Pain and Key Determinates for Nursing Referral	Marijke Slieker-ten Hove
11:30	11:45	Overview of Treatment and Case Study: A Nursing Prospective	Frankie Bates
11:45	12:00	Overview of Treatment by Physiotherapist With Case Presentation	Claudia Brown
12:00	12:20	Helping the Pelvic Floor From a Musculoskeletal Prospective	Heather Moky
12:20	12:30	Questions	All

Speaker Powerpoint Slides

Please note that where authorised by the speaker all PowerPoint slides presented at the workshop will be made available after the meeting via the ICS website www.ics.org/2017/programme Please do not film or photograph the slides during the workshop as this is distracting for the speakers.

Aims of Workshop

Maintaining physical wellbeing and using holistic, conservative approaches to treat patients, is the primary concern for both physiotherapists and nurses. Aligning services of these important allied healthcare professionals is crucial in benefiting successful treatment outcomes. This workshop will focus on how a multidisciplinary healthcare team approach patient assessment and treatment of the dysfunctional pelvic floor. The presentations will include best care practice, the latest in research and demonstrate alignment of services. Case presentations will be presented.

Learning Objectives

- Understanding bladder, bowel and sexual function related to the dysfunctional pelvic floor.
- Focusing on collaboration of professionals and understanding specific and crossover roles.
- Determine a multifaceted approach, including assessment, education and therapeutic intervention.

Learning Outcomes

Following this workshop, the audience should have an understanding of how the nurse / physiotherapy relationship requires interdisciplinary communication and collaboration.

Target Audience

Physiotherapists, Nurses, Allied Healthcare Professionals, physicians.

Advanced/Basic

Basic

Conditions for Learning

A relaxed environment for health professionals to collaborate patient care by networking and aligning services.

Suggested Learning before Workshop Attendance

References listed below.

Suggested Reading

Hong Jun Li, De Ying Kang. Prevalence of sexual dysfunction in men with chronic prostatitis/chronic pelvic pain syndrome: a meta-analysis. World Journal of Urology July 2016, Volume 34, Issue 7,pp 1009–1017

Christopher P. Smith: Male chronic pelvic pain: An update. Indian J Urol. 2016 Jan-Mar; 32(1): 34–39.

Adil E. Bharucha MBBS, MD Tae Hee Lee MD, PhD: Anorectal and Pelvic Pain Mayo Clinic Proceedings, 2016-10-01, Volume 91, Issue 10, Pages 1471-1486.

Faubion SS, Shuster LT, Bharucha AE. (2012) Recognition and Management of Non relaxing Pelvic Floor Dysfunction. Mayo Clinic Proceedings. 87(2):187-193. doi:10.1016/j.mayocp.2011.09.004.

Kuo, Tricia L.C.a; Ng, L.G.a; Chapple, Christopher R (2015) Pelvic floor spasm as a cause of voiding dysfunction. Current Opinion in Urology: July 2015 - Volume 25 - Issue 4 - p 311–316; doi: 10.1097/MOU.0000000000000174

Sinha S. (2011) Dysfunctional Voiding: A review of the Terminology, Presentation, Evaluation and Management in Children and

Adults. Indian J Urol. (4) 437

Other Supporting Documents, Teaching Tools, Patient Education etc

Nursing Assessment; Sharon Eustice, RN (U.K)

Nursing Assessment of the Dysfunctional Pelvic Floor and Key Factors for Determining Physio Referral

Pelvic floor disorders include the non-relaxing (hypertonic) pelvic floor muscle, which is often not recognised in primary or secondary care (Faubion et al 2012). However, recent standardisation of terminology can facilitate with reducing variations of care and offer better understanding of the disorders experienced by many women (Bo et al 2017). Women can experience bladder, bowel and sexual problems leading to a significant impact on their quality of life (Tucker et al 2017; Davis and Kumar 2003). Improving their quality of life requires a multifaceted approach underpinned by robust assessment, education and therapeutic intervention with timely evaluation (Jundt et al 2015). Nurses play a crucial role in the multidisciplinary team by initiating clinical assessment and determining the need for onward referral (Davis 2010). Assessment should include collation of information about symptoms the woman experiences and checking for signs, which can elicited from simple investigations. Taking time to listen attentively to the woman's story, seeking information to guide their individual pathway of care, is a key requirement. The pathway of care should be directed by symptoms, the woman's preferences and her goals (Kuo et al 2015). This presentation will cover the essential elements pertaining to a quality assessment; and when to consider onward referral, with particular focus on the woman with hypertonic pelvic floor. Key factors for initiating referral to physiotherapy will be addressed; as well as wider multidisciplinary working to help women achieve symptom improvement.

Bo K, Frawley HC, Haylen, BT, Abramov Y, Almeida FG, Berghmans B, Bortolini M, Dumoulin C, Gomes M, McClurg D, Meijlink J, Shelly E, Trabuco E, Walker C, Wells A. (2017) An International Urogynecological Association (IUGA)/International Continence Society (ICS) joint report on the terminology for the conservative and nonpharmacological management of female pelvic floor dysfunction. Neurourol Urodynam 36:221–244.

Davis, K. (2010) Pelvic floor dysfunction: causes and assessment. Practice Nursing, 21(7), 340-346.

Davis, K., & Kumar, D. (2003) Pelvic floor dysfunction: a conceptual framework for collaborative patient-centred care. Journal of Advanced Nursing, 43(6), 555-568.

Faubion SS, Shuster LT, Bharucha AE. (2012) Recognition and Management of Nonrelaxing Pelvic Floor Dysfunction. Mayo Clinic Proceedings. 87(2):187-193. doi:10.1016/j.mayocp.2011.09.004.

Jundt K, Peschers U, Kentenich H (2015) The investigation and treatment of female pelvic floor dysfunction. Dtsch Arztebl Int; 112: 564–74 DOI: 10.3238/arztebl.2015.0564

Kuo, Tricia L.C.a; Ng, L.G.a; Chapple, Christopher R (2015) Pelvic floor spasm as a cause of voiding dysfunction. Current Opinion in Urology: July 2015 - Volume 25 - Issue 4 - p 311–316; doi: 10.1097/MOU.0000000000000174

Tucker, J., Grzeskowiak, L., Murphy, E. M. A., Wilson, A., & Clifton, V. L. (2017) Do women of reproductive age presenting with pelvic floor dysfunction have undisclosed anal incontinence: A retrospective cohort study. Women and Birth, 30(1), 18-22.

Nursing evaluation and treatment. Case presentation : Frankie Bates, R.N. Canada

Pelvic floor (PF) hypertonic disorders are a group of conditions that present with muscular hypertonia or spasticity, resulting in a diminished capacity to isolate, contract, and relax the PF. This hypertonia can interfere with daily basic functions, such as micturition and evacuation. Physical therapy plays an essential role in the management of these patients and can lead to significant improvement in quality of life.

Myofascial pelvic pain (MFPP) is a major component of chronic pelvic pain (CPP) and often is not properly identified by healthcare providers.

Maintaining physical well-being and using holistic, conservative approaches to treat patients, is the primary concern for both physiotherapists and nurses. Aligning services of these important allied healthcare professionals is crucial in benefiting successful treatment outcomes. This workshop will focus on an interdisciplinary healthcare team approach to patient assessment and treatment of the dysfunctional pelvic floor. The presentations will include best care practice, the latest in research and demonstrate alignment of services. Case presentations will be used to illustrate the concepts.

Nursing and Physiotherapy Case presentation:

41 year old male presents to nurse with history of dysfunctional voiding, frequent UTI's.

After a thorough history, the following findings were extrapolated:

Social background: Financial advisor, happily married for 10 years. Very active and cycles on a daily basis. Exercises at the gym daily. States his job is extremely stressful and he works long hours. Travels frequently with his job. He has three children all under the age of 8 years. His wife works part time.

Medical history:

Hypertension (controlled on meds)

Anxiety (since age 20 yrs)

Meds:

Atenolol 50 mgs UID

Ativan 2 mgs PRN

Surgical history

Appendectomy as a child
Current LUTS history:
Patient began experiencing pelvic pain 2 years ago, as well as staccato voiding pattern. He was initially referred with signs symptoms of prostatitis. He had difficulty initiating his void and often had to wait for up to 15 minutes. He also complained of urgency, frequency and nocturia. Often constipated. He had pain during intercourse, mostly with ejaculation. Sitting for long periods (when travelling for work particularly) increased the discomfort.
Nursing evaluation
Bladder diary, bowel chart, fluid intake and caffeine intake.
Pain scale and relation to activities. Post void residual measurements in clinic, uroflow, dipstick, C&S (as positive findings)
Treatment
Pelvic floor relaxation especially with voiding. Cessation of straining to void. Education regarding normal voiding pattern and flow of urine. Cold packs x10 mins to perineum, flowed by warm packs BID. Warm Sitz baths combined with relaxation techniques. Biofeedback x 8 treatment to improve proprioception of the pelvic floor to enhance pelvic floor relaxation. TENS x 8 treatments.
Dietary modifications including reduction in caffeine and other irritants. High fibre, flaxseed, increase in water for healthier bowel habits.
Referral to physiotherapist.
Referral to psychologist to help with relaxation techniques and stress relief.
Discussions and networking with nursing/ physio/ psychologist throughout the course of care.
See after physio evaluation and treatment completed. Working as a team, communication was required throughout the course of this patient's treatment plan to improve the results.

Physiotherapy evaluation and treatment. Case presentation: Claudia Brown, Pht. Canada
Global evaluation shows decreased flexibility in the lumbosacral region, shallow breathing pattern and retraction of the hamstrings and adductor muscles. Pelvic floor evaluation shows an overactive pelvic floor, with increased protective reactions and increased muscle tone. External palpation at the level of the central perineal tendon and at the two ischial tuberosities is painful. Patient is able to contract and relax the pelvic floor.
Physiotherapy treatment
Patient was seen in physiotherapy once per week for 6 weeks, and then once every two weeks for three more treatments. Education on the nature and control of chronic pain was given, with instruction on global and specific relaxation techniques and mindfulness. Advice was given on sitting positions at work and on defecation dynamiques (position and technique for the evacuation of stool).
Exercises were given for identification and relaxation of the pelvic floor musculature, for mobilisation of lumbo-sacral spine and for flexibility of the lower extremities. Internal and external manual techniques included massage, trigger point pressures and myofascial release.
Patient's urinary symptoms and constipation resolved completely. There was some residual pain, with much decreased frequency and intensity. Patient stated that when his pain presents itself, he is able to relax his muscles, perform some breathing techniques and prevent the pain from becoming more intense. Pain on ejaculation was no longer present, but patient sometimes had a certain degree of soreness after intercourse, which he was able to control with a hot bath or the application of warm compresses.

REFERENCES:

- Wise D, Anderson R: A Headache in the Pelvis A Headache in the Pelvis, a New Expanded 6th Edition: A New Understanding and Treatment for Chronic Pelvic Pain Syndromes, National Centre for Pelvic Pain Research, Occidental, CA, 2012

- Elizabeth Anne Pastore, Wendy B. Katzman J •Recognizing Myofascial Pelvic Pain in the Female Patient with Chronic Pelvic Pain Obstet Gynecol Neonatal Nurs. 2012 Sep; 41(5): 680–691

Physiotherapy assessment of a patient with chronic pelvic pain and key determinates for a nursing referral.
Dr. Marijke Slieker-ten Hove

Chronic pelvic pain patients most of the time suffer for a long time prior to arriving in a pelvic physiotherapy clinic or an academic pelvic floor centre.
Pain can have started with an event of prostatitis, psychological or sexual trauma, surgery or long term of stressful situations in work and private life or vice versa.
First options are always the medical part to exclude any illness, damage or nerve entrapment, but often the diagnosis are psychological diagnoses when nothing can be found. However, these types of diagnoses are often made to easy. Pudendal neuralgia for example is still a common overlooked condition in the diagnosis and treatment of chronic pelvic pain. Pudendal neuralgia can have the same symptoms as for example vulvar pain syndrome, prostate pain syndrome, scrotal pain syndrome, interstitial cystitis etc., or it can actually cause these conditions.

In the total assessment, a pelvic physiotherapist performs first an extended history with attention for urological, gynaecological/obstetrical, colorectal and sexual history, trauma history and musculoskeletal assessment. Furthermore, vaginal/anal assessment, myofeedback and ultra sound can be used to get more insight about the muscle function (sitting, standing and walking). Also the myofascial condition and referred pains need to be analysed. Special focus also will be given to the function of the obturator internal musculature that can be part of the status of coxarthrosis.
Interesting are also the measurements with the new Maple myofeedback that give us insight of the behaviour of the pelvic floor musculature and obturator internal muscle.

This presentation emphasizes on how a specialized physiotherapist can recognize the chronic pelvic pain patient, including the pudendal neuralgia, how to examine the patient and it will give an overview of the treatment options for the physiotherapist. Special attention will also be given to the multidisciplinary of treating these types of male and female patients and the pitfalls we all need to be aware of.

Learning objectives
Every participant of this workshop will

- Gain insight in the diagnose and treatment of the complex chronic pelvic pain patient
- Learn about the role of the different professions in the teams of pelvic floor centers.

References

Beco, J. Pudendal neuropathy. One of the main "defects" in perineology. in 31st Annual Meeting of the International Urogynecological Association. Athens.

Fitzgerald MP, Kotarinos R. Rehabilitation of the short pelvic floor 1 Int Urogynecol J (2003) 14:269-275
Labat JJ, Riant T, Robert R, et al. Diagnostic criteria for pudendal neuralgia by pudendal nerve entrapment (Nantes criteria). Neurourol Urodyn 2008;27:306–310.
Popeney C, Ansell V, Renney K. Pudendal entrapment as an etiology of chronic perineal pain: diagnosis and treatment. Neurourol Urodyn 2007;26:820–827.
Ramsden CE, McDaniel MC, Harmon RL, Renney KM, Faure A: Pu- dendal nerve entrapment
as source of intractable perineal pain. Am J Phys Med Rehabil 2003;82:479–484.
Tamaki T, Oinuma K, Shiratsuchi H, Akita K, Iida S.Hip dysfunction-related urinary incontinence: a prospective analysis of 189 female patients undergoing total hip arthroplasty. Int J Urol. 2014 Jul;21(7):729-31. doi: 10.1111/iju.12404. Epub 2014 Mar 4.

Pelvic Floor Muscles from a Musculoskeletal Prospective
Dr. Heather Moky Cordova

This presentation highlights the importance of understanding the role of the pelvic floor muscles and how it relates to postural, respiratory, and trunk stabilizer. It will also emphasize how essential it is to learn as well as be able to teach proper isolation of these muscles for men and women and the differences between the sexes. Inability to isolate muscles leads to dysfunction. Incontinence, tone issues and pain are the results of muscle dysfunction. Incorporating other muscles into your treatment and learning improved ways to isolate pelvic floor muscles decreases dysfunction for better patient outcomes and a swift return to function.

Learning objectives
Every participant of this workshop will

- Learn the roles of the pelvic floor muscles in relationship to other muscles in the body.
- Be able to identify the most accurate ways to activate the pelvic floor muscles and ensure proper isolation
- Understand the difference in isolation cues between male and female.

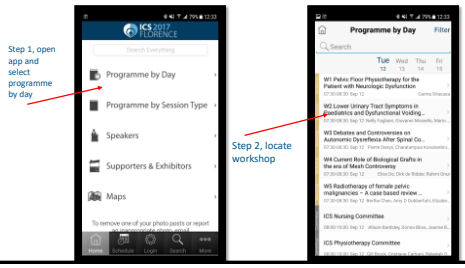
References:

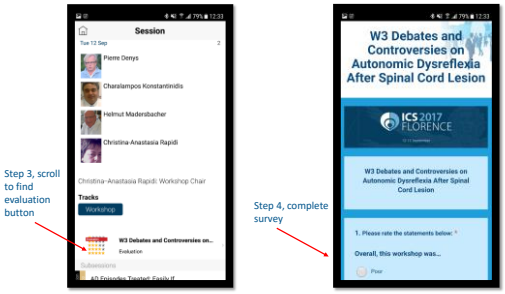
- Postural and respiratory functions of the pelvic floor muscles PW Hodges et al 2007 Neurourolgy and Urodynamics
- Rehabilitation of pelvic floor muscles utilizing trunk stabilization R Sapsford, manual therapy 2004
- Pattern of activation of pelvic floor muscles in men differs with verbal instructions. Stafford RE, Ashton-Miller JA, Constantinou C, Coughlin G, Lutton NJ, Hodges PW. Neurourol Urodyn. 2016 Apr;35(4):457-63.

- A shortened version of the handout has been provided on entrance to the hall
- A full handout for all workshops is available via the ICS website.
- Please silence all mobile phones
- Please refrain from taking video and pictures of the speakers and their slides. PDF versions of the slides (where approved) will be made available after the meeting via the ICS website.

NEW FOR 2017

Please complete the in-app evaluation in the workshop before leaving.





Sharon Eustice

Affiliations to disclose:

Medical Devices Technology and Innovation (MDTi)

Funding for speaker to attend:

Enter X in appropriate box

X	Self-Funded
	Institution (non-industry) funded
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ICS

NHS Cornwall Partnership NHS Foundation Trust

The lived experiences of women with rectal emptying difficulty: practice influencing theory

Il vissuto delle donne con difficoltà di svuotamento intestinale: la pratica influenza la teoria.

Sharon Eustice
Nurse Consultant
MSc, BPhil, DN, RN

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Image accessed on 27.01.17 from http://www.dailymail.co.uk/news/article-1325056/Taboo-menopause-leaves-women-suffering-silence.html

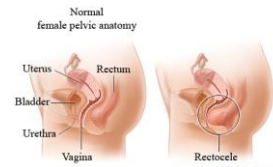
3

Background

40% for women over 50 years of age living with prolapse in the community, which equates to 4.6 million women across the UK.

Women may digitally position the anatomy to align the rectum for passing stool.

56% of women with rectocele, reported the need to use digitation to aid rectal emptying.



Accessed on 3 January 2017 from: http://www.webmd.com/women/rectal-prolapse-rectocele

Grimes & Lukacz, 2012; Hagen et al., 2014; Office for National Statistics, 2016; Sung, Rardin, Raker, LaSala, & Myers, 2012

40% delle donne over 50 ha un prolasso, 4.6 milioni in UK. Alcune correggono il prolasso con le dita per riuscire a scaricarsi. Il 56% delle donne con rettocele lo fa.

Why is this research important?

'I always need to know where a toilet is. Using my fingers has not been effective it feels like I am trying to give birth having to push so hard, it makes me dizzy'.

Accessed on 3 January 2017 from:

Ho sempre bisogno di sapere dove c'è un bagno. Usare le dita non serve, mi sento come se dovessi partorire quando devo spingere così forte, mi lascia stordita.

Research questions

Does a patient-centred device help women manage obstructive defaecation who have posterior compartment prolapse more effectively and satisfactorily than usual methods? *(Phase 1)*

What is the lived experience of women who experience obstructive defaecation? *(Phase 2)*

Quesiti di ricerca: un device personalizzato può aiutare le donne a gestire la defecazione ostruita in presenza di prolasso posteriore più efficacemente dei metodi tradizionali? Qual è il vissuto delle donne con sindrome da defecazione ostruita?

Objectives: Exploratory phase, Phase 1 and 2

Exploratory

Proof of concept: Preliminary insight into the lived experience of women using Femmeze®.

- **Objectives**
- Identify what interventions exist and improve the management of obstructive defaecation.
- Explore the views of women who have used Femmeze® for the management of obstructive defaecation.

Phase 1

1. Quantitative: Does Femmeze® device help women manage obstructive defaecation more effectively thank usual methods?

- **Objectives**
- Determine acceptability of Femmeze®.
- Demonstrate preliminary effectiveness of the device (comfort, ease of use, and quality of life).
- Identify any changes to the device or instructions for use (needs adjustment to its design in terms of length/width).

Phase 2

2: Qualitative: The lived experience.

- **Objectives**
- Seek to learn and understand the experience of women living with the problem.
- Determine the ease and willingness of participants to complete questionnaires; and ease of recruitment into a larger study.

Exploratory work

Age, duration of rectocele and current management

	Case 1	Case 2	Case 3	Case 4 (letter)	Case 5	Case 6	Case 7	Case 8	Case 9	Case 10
Age	49	37	62	73	69	54	70	54	38	50
How long had rectocele (months)	9	33	24	Unknown	24	130	540	30	72	56
Current management:										
• Do nothing	no	no	no	no	no	no	no	no	no	no
• Digitation	yes	yes	yes	no	no	yes	yes	yes	yes	yes
• Other				laxatives	vibrator	+ enema				

Effectiveness, preference and convenience of Femmeze ®

	Case 1	Case 2	Case 3	Case 4 (letter)	Case 5	Case 6	Case 7	Case 8	Case 9	Case 10
Effectiveness	yes	yes	yes	No information	yes	yes	no	yes	yes	yes
Preference	yes	no	yes	yes	yes	no	no	yes	No response	yes
Convenience	yes	yes	yes	No information	No response	yes	no	yes	no	yes

10 cases available for analysis
8 out of 10 found Femmeze very effective
6 out of 10 preferred using the device compared to usual care
Emerging themes about usual care

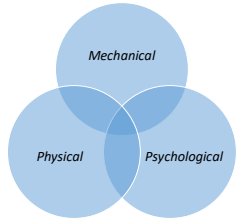
- mechanical problems
- physical effects
- psychological issues

Key concepts

Struggle to empty their rectum, leading to self-initiated use of digitation (or splinting).

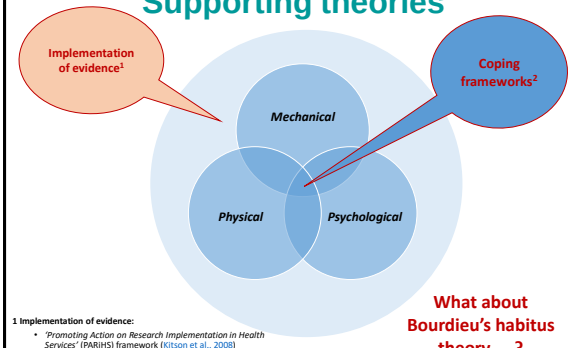
Experience mechanical problems, physical effects and psychological issues.

An alternative to digitation (Femmeze) may help offer a solution for the mechanical problems and ease physical and psychological issues.



Difficoltà a svuotare il retto, porta alla digitazione. Esperienza di problemi meccanici, problemi fisici e psicologici. Il FEMMEZE è un'alternativa alla digitazione.

Supporting theories



What about Bourdieu's habitus theory…..?

1 Implementation of evidence:

- *'Promoting Action on Research Implementation in Health Services'* (PARiHS) framework (Kitson et al., 2008)

2 Coping frameworks:

- Avoid or approach (Roth & Cohen, 1986)
- Cognitive appraisal and coping (Lazarus & Folkman, 1987)

Project overview

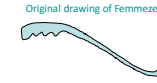
	Phases	Study Description	Patient and Public Involvement	Methodology	Theoretical Framework	Implementation of Evidence
Doctoral Study	**Exploratory Phase**	Proof of concept		Preliminary work with women-selected cases		
	Quantitative Phase 1	Implementing Femmeze (n=34)		Pre and post questionnaires Proctogram Biomedical data		
	Qualitative Phase 2	Interpretation of the lived experience		Phenomenological in-depth interviews		
Post-doctoral	**Formal testing of complex intervention**	Randomised Controlled Trial		Random allocation to intervention and control group across multiple sites		

Integrate by following a thread?

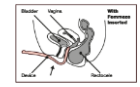
Phase 1: Quantitative

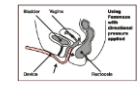
Does a patient-centred device device help women manage obstructive defaecation who have posterior compartment prolapse more effectively and satisfactorily than usual methods?

Original drawing of Femmeze



Femmeze following manufacture





Phase 2: Qualitative

What is the lived experience of women who experience obstructive defaecation?

Interview Schedule

An intervention to improve the management of posterior vaginal compartment prolapse using Femmeze®: a feasibility study

Pre-interview preparation	The participant will be reassured on the following: • Confidentiality • Interview is just between them and me • The location and time will be their choice
Introduction (5 minutes)	Thank you for agreeing to meet with me. I am Sharon Eustice, Nurse Consultant and Chief Investigator for the Femmeze Study. I will record our conversation using this recording machine (show machine and obtain consent). I would like to talk with you about your experience of living with the problem. Also, I will ask you about how acceptable and practical Femmeze has been for you; and what might make it easier for more women to take part in the study. What we learn from today's conversation will help us understand how women cope; and improve the study and the Femmeze device for other women. Today I am with you as a researcher, so you can be as honest as you wish, I won't be offended by anything you say. We will treat your answers as confidential. We will not include your names or any other information that could identify you in any reports we write. We will destroy the notes and audiotapes after we complete our study and publish the results. **Do you have any questions about the study or the interview today?**
Topic 1 (30 minutes) **Living with the problem**	**1.To begin, please tell me about your [illegible] with difficulty with emptying due to your rectocele.** a. PROBE: How has this made you feel? **2. Did anything prevent you from seeking help sooner?** a. PROBE: Why do you think you decided to seek help/ to wait for help?
	Check that the participant is still comfortable to continue with the interview (and revisit as and when appropriate)
Topic 2 (10 minutes) **Using Femmeze**	**I would like to discuss your impressions of Femmeze.** **3. What words would you use to describe when using Femmeze for the first time?** **4. What words would you use to describe when using it regularly?** a. PROBE: How accessible is information about your problem? b. PROBE: Is the Femmeze packaging user friendly? **5. If you could design the perfect device for your problem, what would it look like?** **6. What issues might concern you about using Femmeze for a long time?**
Topic 3 (10 minutes) **Being part of the study**	**I would like to seek your thoughts on being part of the study.** **7. Tell me about completing the questionnaires** a. PROBE: How can we make this easier for you? b. PROBE: Did you receive enough advice and information on completing them? **8. Do you have any thoughts on how we could we reach more women to recruit to the study?**
Final thoughts (5 minutes)	**Is there anything else you'd like to tell me?** Thank you for your time

Adapted from: Harrell, Margaret C. and Melissa A. Bradley. Data Collection Methods: Semi-Structured Interviews and Focus Groups. Santa Monica, CA: RAND Corporation, 2009.
http://www.rand.org/pubs/technical_reports/TR718.html

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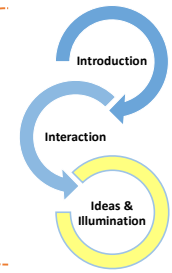
Public and Patient Involvement

- *Normalisation*
- *Access to help*
- *Emotions*
- *Hidden problem*
- *Increase awareness*



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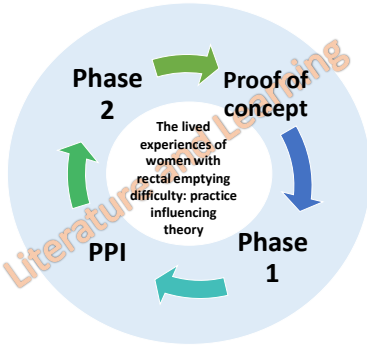
Summary



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My learning so far…..

What I thought I knew…..

Recruitment

Questionnaires

Using Femmeze

Challenges….can you help?

Defending theory choice

Identifying analysis and integration method

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Cornwall Partnership NHS Foundation Trust

Thank You

My contact details
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Sharon.eustice@plymouth.ac.uk
@sharoneustice

Find us online at cornwallft

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References

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Nursing assessment of the dysfunctional pelvic floor and key factors for determining physiotherapy referral

Sharon Eustice
Nurse Consultant
MSc, BPhil, DN, RN

ICS

Sharon Eustice

Affiliations to disclose:

None

Funding for speaker to attend:

Enter X in appropriate box

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Why is pelvic floor muscle dysfunction important?

Women can experience bladder, bowel and sexual problems leading to a significant impact on their quality of life (Tucker et al 2017; Davis and Kumar 2003).

'Pelvic floor dysfunction remains a neglected part of many health care professionals educational preparation' (Davis and Kumar 2003)

http://www.virametaal.nl/assemblage/ - accessed on 21.08.17

Pelvic floor disorders include the non-relaxing (hypertonic) pelvic floor muscle, which is often not recognised in primary or secondary care (Faubion et al 2012).

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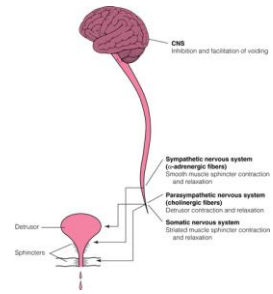
Normal micturition - when bladder contraction is coordinated with urethral sphincter relaxation



https://www.merckmanuals.com/professional/genitourinary-disorders/voiding-disorders/overview-of-voiding accessed on 05.09.17

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	Diagnosis	Treatment
Anatomic		
Pelvic organ prolapse (POP)	Physical exam	Pessary Surgical reduction Urethrolysis for iatrogenic urethral obstruction
Following anti-incontinence surgery • Bladder neck fascial sling or mid-urethral sling • Retropubic bladder neck suspension • Burch procedure or MMK	Surgical history and physical exam	Simple sling incision Urethrolysis (transvaginally or transabdominally) Suture release and scar dissection (transvaginally or transabdominally) Suprameatal urethra release
Strictures or Fibrosis	History plus **cystoscopy, MRI or** cystography	Dilation, transurethral incision, or urethral reconstruction
Functional		
Primary bladder neck obstruction	High-pressure, low-flow voiding with a closed bladder neck, no abnormal activity, at the level of the urinary sphincter	Observation Alpha-blockers Clean Intermittent Catheterization (CIC) Transurethral incision of the bladder neck
Dysfunctional voiding	Failure of pelvic floor (possible external sphincter) relaxation during void Increased EMG activity during a voluntary void	Observation Pelvic floor physical therapy Medical management Valium Anticholinergics Amitriptyline Alpha-blockers Baclofen
Fowler's syndrome	External sphincter EMG pattern during void: complex repetitive discharges with bursts of deceleration	**Sacral** neuromodulation (SNM)
Neurogenic	Known neurologic disease and abnormal UDS/EMG activity during voiding	Baclofen CIC SNM Botox injections

FIGURE 2. Diagnosis and management of bladder outlet obstruction in women by cause.

Meier & Padmanabhan (2016)

ICS

Possible causes

- Dysfunctional voiding or defecation
- Injury
- Pain syndromes
- Musculoskeletal abnormalities
- Sexual abuse
- Gender differences?

http://www.imgrum.org/media/1518421457415011132_20804891 - accessed on 21.08.17

Table 1 Demographics and clinical features

Clinical features	With OPFM	Without OPFM	P values
Median age (years)	51	59	0.001
Pelvic pain (%)	81.6	18.4	<0.001
Urge incontinence (%)	42.3	57.7	0.089
Recurrent UTI (%)	62.1	37.9	<0.001

OPFM, overactive pelvic floor muscle; UTI, urinary tract infection.

Aw HC et al (2017)

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Key features of assessing

Listen to their story……..

Assessment features:
- Symptoms (bladder, bowel, sexual and pain)
- Investigations – bladder scan; bladder diary
- Physical examination
- Diagnostic testing

The pathway of care should be directed by symptoms, the woman's preferences and her goals (Kuo et al 2015).

'Hypertonicity: an increase in muscle tone related to the contractile or viscoelastic components that can be associated with either elevated contractile activity and/or passive stiffness in the muscle. The terms neurogenic hypertonicity and non-neurogenic hypertonicity are recommended to describe the diagnosis and inform management.' (Bo et al 2017)

http://persuasive.net/how-to-build-rapport/ accessed on 05.09.17

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Treatment opportunities

- Education
- Conservative measures – seek out the predominant symptom
  - ISC
  - Medications
  - Pelvic floor therapy
- Consider psychological support

http://watchfit.com/weight-loss/tips/lifestyle-changes-for-weight-loss/ - accessed on 21.08.17

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Working in collaboration

Referral onwards
- Sub-specialists
- Physiotherapy for pelvic floor rehabilitation

Key factors
- Refractory lower urinary or bowel symptoms

http://www.c3workplace.com/wp-content/uploads/2014/04/Working-together.jpg - accessed on 21.08.17

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"Coming together is a beginning, staying together is progress, and working together is success."

Henry Ford

ICS

NHS Cornwall Partnership NHS Foundation Trust

Thank You

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Find us online at cornwallft

References

NHS Cornwall Partnership NHS Foundation Trust

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f-act Pelvic Pain Clinic

Pro Fundum Instituut

Physio Assessment of Patient with Chronic Pelvic Pain and Key determinants for Nursing Referral

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Enkhuizen

Disclosure

- Consultant Novuqare

Content

- Introduction on Chronic Pelvic Pain
- Case
- Mis(sed) diagnoses
- Where are Dutch physios working together with our nurses
- Take home messages

Definition

'Chronic pelvic pain is chronic or persistent pain perceived in structures related to the pelvis experienced by men and women'

European Association of Urology,
Guidelines on Chronic Pelvic Pain, 2014

Prevalence

- 15-20 % women (18-50 yrs)
- Approximately 8% males in US

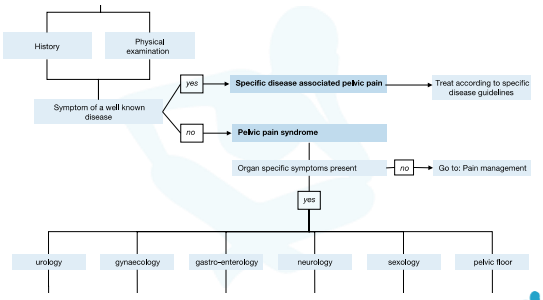
Howard 2000, Anderson 2008

Guidelines on Chronic Pelvic Pain

M. Fall (chair), A.P. Baranowski, S. Elneil, D. Engeler, J. Hughes, E.J. Messelink, F. Oberpenning, A.C. de C. Williams

European Association of Urology

Guidelines 2014



Concept CPPS

- Innervation and referred pain patterns of visceral and urogenital structures overlap musculoskeletal structures in the pelvic region. Syndromes overlap.
- Keep in mind that both systems influence each other

Travell and Simons

Case, Barbara 52 years

Barbara 52 years

G2P2, P1 squeezing period > 2 hr, G1 and G2 pelvic pain

- UTI sensation, burning pain meatus
- Urgency/Frequency DF>10, NF=2
- Mild Stress urinary Incontinence
- Abdominal pain left NPRS 6
- Vaginal bulging (POPQ stage 2 anterior wall asymmetric)
- Outlet obstructed defecation, daily, BSS 2, painful
- Dyspareunia left lateral in the vagina NPRS 9
- Groin pain right>left

Diagnostic: OAPF

- GP -> urine test -> negative urine culture
- Urologist -> urological tests -> no pathology > OAPF
- Gynaecologist -> gynaecological tests -> pain left lateral intra-vaginal, OAPF
- GE specialist -> colonoscopy -> no pathology, defecography-> dissynergy and IBS
- Surgeon -> proctoscopy -> fissura ani, OAPF

Therapy: Pelvic Pysiotherapy

- GP -> Antibiotics -> referral
- Urologist -> anticholinergic -> Pelvic physio
- Gynaecologist-> HRT-> Pelvic Physio
- GE-> fluid and food intake, metamucil-> Pelvic Physio
- Surgeon-> ISDN crème or fissurectomy-> Pelvic Physio
- Pelvic physio -> PF relaxation
- Nurse -> coordination of care

but then…

Did we miss something?

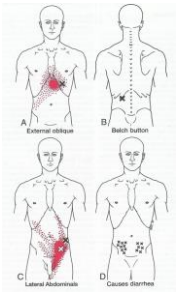
Or didn't we?

People are for 50% muscles, not only the pelvic floor complex

But beside that we have

- Ligaments
- Fascia
- Joints
- Nervous system

Abdominals!!!



- Abdominal TrPs can imitate visceral pain
- Often descibed as
  - Burning
  - Full
  - Blowing
  - Swelling

- These TrPs can cause increased irritation of the detrusor and urethral sphincter, urgency and frequency ver

Vaginal/anal palpation

Firm mild pressure
Normally no pain or recognizable pain?

Gyang et al 2013, FitzGerald 2003, Pastore 2012

the forgotten muscle…

Leonardo da Vinci

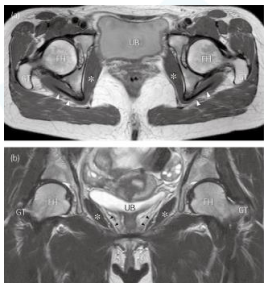
- *'You shall describe which are the muscles and which are the tendons that during the various movements of **each member become uncovered, or become hidden**, or that do neither the one nor the other; and remember that this action is **very important** and absolutely necessary for painters any sculptors who profession to be maestros, etc.'* (plus nurses, doctors and physios)

…the forgotten muscle….

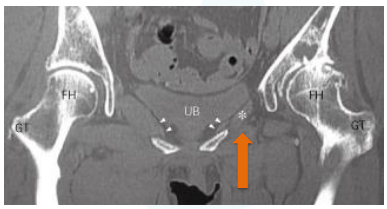

Obturator Internal muscle

- Can cause
  - Dull local sensation
  - Groin pain
  - Golfball sensation in rectum
  - Coccyx pain
  - Hamstrings pain
  - Urethral pain
  - Vaginal pain
  - Vulva (vulvodynia)

Tamaki 2014, female, no symptoms



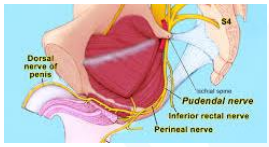
Tamaki 2014, female 66, symptoms coxarthrosis

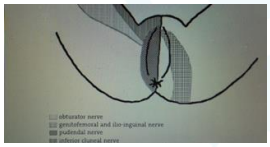
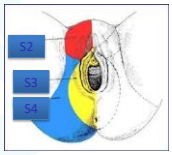


Function Pudendal nerve

Sensory innervation external genitals

Motory innervation perineal musculature and pelvic floor



Pudendal nerve entrapment

Deeper history taking with Barbara…….

- Pain when sitting, disappeared completely in standing and laying down, but when peeing……
- Sharp, shooting and burning pain
- Pain in genital area
- Defecation increased the pain
- Groin pain

Nantes Criteria, pudendal nerve entrapment

- Pain in the anatomical territory of the pudendal nerve
- Worsened by sitting
- The patient is not woken at night by the pain
- Pain with no objective sensory impairment
- Positive anesthetic pudendal nerve block

Labatt et al 2007

Pelvic Physiotherapy

Proper listening (f.e. trauma?)

Organs?

Muscles, ligaments, fascia, joints, nerve system

environmental influences

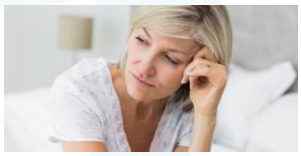
context

Adding more diagnostics

- Posture
- Movement
- Breathing pattern
- Musculature – measurement with biofeedback
- Nervous system
- Joints of back, pelvis and hips
- Obturator internal muscle

Case, Barbara 52 years

Treatment



Treatment (tailor made program) depending on availability of different professions

- Normalizing fiber intake, toilet behavior etc.
- Mobilization right hip
- Release obturator internal muscle
- Correction of posture
- Advices for exercise programs
- Trigger point treatment
- Mobilizing the pudendal area in Alcock's canal
- Biofeedback and Electrical stimulation
- Relaxation
- Coaching and advice

In general CPPS pts in NL depend on

Nurses

- To recognize the symptoms
- Assist with referrals
- To support in the extensive therapy
- To motivate
- Support in practical issues

Pelvic Physiotherapists

- To recognize CPPS in time
- To deal with the complexity of the issues
- To call in help of a colleague
- To discuss with the nurse during the process

Working together with our nurses in NL

- Working in multidisciplinary settings in hospitals with pelvic floor centres
- Only accessible with referral from specialists in hospitals
- Nurses mostly focus on continence/wound care and/or stoma care
- And work together in these hospital settings
- Settings may dictate availability

Take home messages

- Working multidisciplinary is essential
- Ask for musculoskeletal issues is relevant
- Stress urinary incontinence is not always based on weak pelvic floor and there we rely on the multidisciplinary approach
- OAPF had not always only a psychological cause
- Refer to a pelvic physiotherapist specialized in pelvic pain/CPPS

Frankie Bates

Affiliations to disclose:

None

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Case Presentation
Aligning Nursing and Physiotherapy

Social background:

- 41 year old male "Al" presents with history of dysfunctional voiding, frequent UTI's.
  Happily married for 10 years, His wife works part time.
  Very active and cycles on a daily basis.
  Exercises at the gym daily.
  Financial advisor, states his job is extremely stressful and he works long hours.
  Travels frequently with his job.
  He has 3 children all under the age of 8 years.
  Non Smoker, occasional alcohol.

Medical history:

Hypertension (controlled on meds)
Appendectomy as a child
Anxiety
Insomnia
Meds: Atenolol 50 mgs UID, Ativan 2 mgs PRN
Height 185 cm
Weight 86 kgs

LUTS History

Began experiencing pelvic pain 2 years ago as well as a "staccato" voiding pattern.

Initially treated with antibiotics for prostatitis and referred to Urology. Some symptoms resolved but pain persisted.

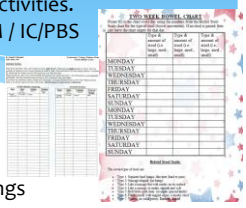
Difficulty initiating his void.
C/O urgency, frequency and nocturia.
Constipation Issues.
Pain during intercourse, mainly with ejaculation.
Increased pelvic discomfort when sitting.

Nursing Evaluation:

Extrapolate thorough Hx

Bladder Diary, 3 to 5 days (? Fluid / Caffeine Intake?)

Pain scale and relationship to activities.
Validated questionnaires ICIQM / IC/PBS



Uroflow, PVR.

Bowel chart (2 week)

Dipstick, C & S as positive findings

Discussion Of Patient's "Bucket List":

What are the patients needs ? (not provider's needs!)

Is patient willing to make adjustments to his lifestyle? (i.e. change in pace, in diet, decrease stress in work and home environment?)

What did he see as attainable goals?

What was the most bothersome symptom for him?

Did he want his family involved?

Patient and spousal support

Spouses may respond to patient pain behavior in the following manner:

(1) Solicitous (i.e. helps out with chores or encourages patient rest.) (increases the negative impact of pain)

(2) Distracting (i.e. gets patient involved in activities). (decreases the negative impact of pain)

(3) Negative or punishing (i.e. gets angry with the patient). (No effect on outcome)

Ginting JV, Tripp DA et al Urology. 2011;78:1136–41.

Treatment Plan :

Pelvic floor relaxation especially with voiding.
Cessation of straining to void.
Education regarding normal voiding pattern and flow of urine.
Warm packs x10 mins to perineum BID and warm baths combined with relaxation techniques.
Biofeedback x 8 tx to improve proprioception of location of PFM and enhance pelvic floor relaxation.
TENS x 8 treatments. (Discuss with Physio)
Dietary modifications including reduction in caffeine and other irritants. avoiding spicy foods and alcohol.

Food sensitivities

A validated questionnaire to detect the effect of foods, beverages, and/or supplements on pelvic pain symptoms and urinary frequency/urgency.

47 % reported that the consumption of certain comestibles aggravated their symptoms.

The most aggravating items were spicy foods, tea,coffee, hot peppers, alcoholic beverages and chili. Higher symptom severity was associated with increased consumption of alcohol and coffee.

Herati AS, Shorter B et al . Urology. 2013;82:1376–80.

Treatment Plan continued:

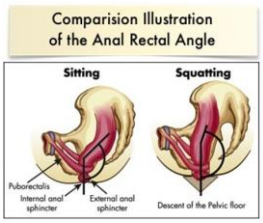
High fibre, flaxseed, increase in water for healthier bowel habits. Correct sitting position on toilet.

Counselled to participate in as many activities of daily living as possible, with inclusion of spouse.

Referral to psychologist to help with relaxation techniques and stress relief.

Discussions and networking with nursing/ physio/ psychologist throughout the course of care.

Correct Positioning on toilet



Treatment Plan continued:

Counselled to participate in as many activities of daily living as possible, with inclusion of spouse.

Discussions and networking with nursing/ physio/ psychologist throughout the course of care.

Referral to psychologist to help with relaxation techniques and stress relief.

Treatment Plan continued:

Professional psychotherapy can improve the psychosocial component of CP/CPPS, in particular, by reducing catastrophizing and improving coping mechanisms.
Techniques include guided imagery, progressive relaxation training, self-hypnosis, biofeedback, and cognitive behavioral therapy. Parker J, Buga S.Curr Urol Rep. 2010:286–91.

Referral to physiotherapist.

Over to Physio:

Follow Up:

See after physio evaluation and treatment completed. Discuss changes; i.e. D/C cold packs. Progress report.

Re- evaluate bladder diary, pain scale, ICIQM.

How is the PATIENT feeling? Is he coping better?

Working as a team, communication was required throughout the course of this patient's treatment plan to improve the results.

References

Herati AS, Shorter B et al. (2013) Effects of Foods and Beverages on the Symptoms of Chronic Prostatitis/Chronic Pelvic Pain Syndrome Urology 82(6): 1376-80

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Collaboration of professionals: physiotherapy treatment

ICS, Florence 2017

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ICS 2017 FLORENCE

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Owner, Physiothérapie Polyclinique Cabrini, a private physiotherapy clinic
Owner, La Clinique de Physiothérapie Concorde, a private physiotherapy clinic

† All financial ties (over the last year) that you may have with any business organization with respect to the subjects mentioned during your presentation

Funding for speaker to attend:

- [X] Self-funded
- [ ] Institution (non-industry) funded
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Physiotherapy referral

41 year old male presents to physiotherapist, referred by nurse who had seen him for history of dysfunctional voiding, frequent UTI's

Physio to address related issues of pain and muscle dysfunction

Evaluation findings (from interview)

Voiding and pain patterns as described above

Often constipated, feels stool in rectum, but has difficulty evacuating

Avoiding sex altogether to prevent increase in pain

Has decreased cycling to twice weekly, 20k per ride, down from three times weekly, 40k per ride

Dislikes ice application, but feels rewarded when heat is applied

Evaluation findings (interview)

Gradual onset of symptoms during wife's pregnancy of third child

Increase in symptoms during periods of increased stress

Questionaires

McGill Pain Questionnaire Score : 45 (max 78)

NIH-Chronic Prostatitis Symptom Index (NIH-CPSI) : 23 (max 43)

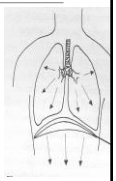
Evaluation findings (physical examination)

GLOBAL

Decreased mobility in lumbosacral region

Decreased flexibility of hamstrings and adductors bilaterally

Shallow breathing pattern



Evaluation findings (physical examination)

PELVIC FLOOR

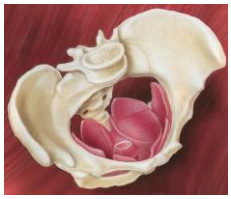
Pelvic floor muscle overactivity , presence of protective reactions on palpation
Pain upon palpation of ischial tuberosities, central perineal tendon
Decreased ano-rectal angle, with increased tension on puborectalis muscle
Increased tension on iliilcoccygeus portion of levator ani, especially on left
Ability to contract and relax pelvic floor on command, yet with incomplete relaxation

Goals of treatment

To decrease pain
To decrease urinary symptoms and constipation
To increase lumbosacral mobility
To increase flexibility of lower extremities
To improve breathing pattern and educate on use of breathing in pain management
To decrease muscle overactivity and protective reactions
To improve post-contractile relaxation of pelvic floor musculature
To facilitate return to normal activity

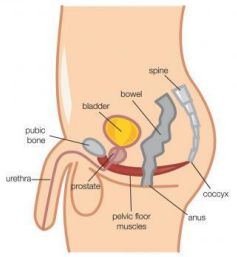
Treatment modalities

Education
Exercises
Manual techniques
Biofeedback
Electrotherapy
Functional applications



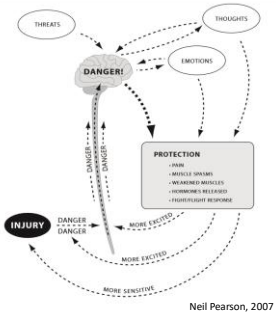
Education

Role of musculature in micturition cycle
Reason for pain during orgasm
Defecation dynamics
- timing
- positioning
- push



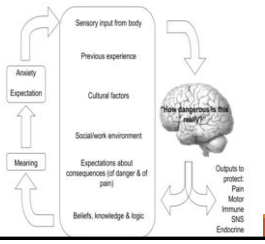
Education

Origin of pain
Pain science
Strategies for pain management



Neil Pearson, 2007

Education



Lorimer Moseley, 2007

http://www.bodyinmind.org

Education

"Are you worried
about what might be causing your pain?"

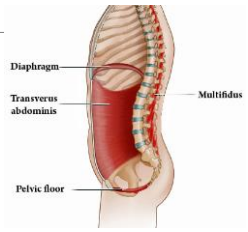
"How has the
pain affected your life?"

"How does the pain make you feel emotionally?"

EAU Guidelines on Chronic Pelvic Pain, 2010

Exercises

Lumbosacral mobility and stability
Lower extremity flexibility
Diaphragmatic (piston) breathing
Pelvic floor relaxation



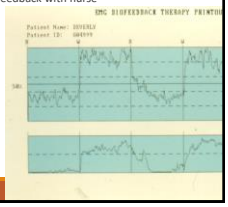
Manual techniques

Global mobilisations, sacral tractions
Trigger point pressures
Myofascial release, massage
Skin rolling techniques
Muscle elongation
Muscle energy
External massage and transverse friction near tuberosities

Weiss (2010), Wehbe et al (2010), FitzGerald et al (2009)

Biofeedback

Patient has already worked on pelvic floor relaxation with biofeedback with nurse
Dynamic training: return to baseline after contraction
return to baseline after abdominal activity
relax pelvic floor with deep breathing



Electrotherapy

Patient has already had PTNS with nurse for OAB symptoms. TNS may also help to relieve pain

Pulsed ultrasound therapy applied at levator ani muscle near ischial tuberosities, to decrease pain and muscle tension

Gam (1995), Armijo-Olivo (2013)

Functional applications

New response to pain
Breathing techniques
Positioning: change of position in sitting, standing work station
Pelvic floor relaxation after cycling

Treatment progression : 11 visits

6 treatments, once weekly

3 treatments, once every two weeks

I treatment after one month

Follow-up after three months

Treatment outcome

Significant decrease in pain frequency and pain intensity (McGill 15, NIH-CPSI 10)

Decrease in anxiety in relation to pain

Urinary symptoms and constipation problems resolved

Ability to use pain-management strategies to prevent increase in pain episodes

- Breathing
- Pelvic floor relaxation
- Positioning
- De-catatastrophizing thought processes

Professional collaboration

Suggest topics to discuss with psychologist, sex therapist

Sharing of results of UDI, McGill pain questionnaire.

Discussion with nurse re ice application

Ask nurse to cover stool softening diet

De-catastrophization

Common language, re: pain science

Mehik et al, 2001

GRAZIE!

Follow Up:

See after physio evaluation and treatment completed. Discuss changes; i.e. D/C cold packs. Progress report.

Re- evaluate bladder diary, pain scale, ICIQM.

How is the PATIENT feeling? Is he coping better?

Working as a team, communication was required throughout the course of this patient's treatment plan to improve the results.

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COLLABORATION OF PROFESSIONALS

HELPING THE PELVIC FLOOR FROM A MS PROSPECTIVE

HEATHER MOKY CORDOVA PT, DPT
UNIVERSITY OF ILLINOIS HOSPITAL AND HEALTH SCIENCE SYSTEMS
&
ICS 2017 FLORENCE

DISCLOSURE

- NOTHING TO DISCLOSE

TEAMWORK

COMING TOGETHER IS A BEGINNING
KEEPING TOGETHER IS PROGRESS
WORKING TOGETHER IS A SUCCESS

HENRY FORD

HOW EFFECTIVE ARE YOU ?

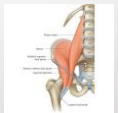
WHAT MAKES YOU EFFECTIVE ?

- EDUCATION
- EXPERIENCE
- PASSION
- DESIRE TO HELP OTHERS

- MY COLLEAGUES

KEY PLAYERS

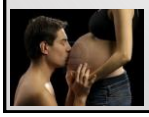
- YOUR PATIENTS
- YOUR EDUCATION AND ANATOMY
- YOUR RESOURCES



KNOW YOUR PATIENTS

- WHAT ARE THE BARRIERS FOR YOUR PATIENT ?
  - LANGUAGE, EDUCATION, STRESS, DEPRESSION, OTHER
- WHAT ARE THE BARRIERS FOR YOU?

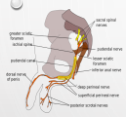
- HOW CAN WE BE MORE EFFECTIVE FOR THEM ?
  - LISTEN !! LISTEN !! AND LISTEN SOME MORE
  - THEY WILL TELL YOU WHAT THEY NEED

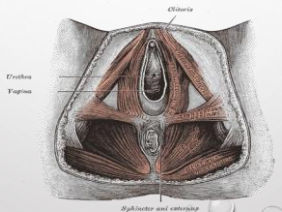


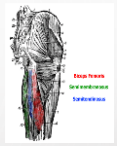
- HOW DO YOU MOTIVATE THEM ?

- HOW DO YOU HOLD THEM ACCOUNTABLE ?

KNOW YOUR ANATOMY







PELVIC FLOOR MUSCLE TRAINING

- ABLE TO CONTRACT ?
- ABLE TO RELAX?
- BEARING DOWN TO COMPENSATE ?
- QUALITY OF CONTRACTION
  - STRENGTH AND ENDURANCE
  - TIMING OF CONTRACTION
- BREATHING - ARE THEY HOLDING THEIR BREATH ?
- EFFORT ?
  - USE 50 % EFFORT
  - USE 25 % EFFORT
- OVERACTIVE AND UNDERACTIVE MUSCLES
- POSTURE
- CO-ACTIVATION OF OTHER MUSCLES AND MUSCLE COMPENSATIONS – MAYBE YOU NEED TO NOT FOCUS ON THE PELVIC FLOOR AT FIRST.

IS THERE A DIFFERENCE BETWEEN MALE AND FEMALE ?

- THE MUSCLES ARE THE SIMILAR…….BUT DIFFERENT.
- BIAS IN THE LITERATURE AND PRACTICE
- EXPERIENCES ON THE PELVIC FLOOR MUSCLES ARE DIFFERENT
  - WOMEN – CHILDBIRTH, MENOPAUSE AND HYSTERECTOMIES
  - MEN : BPH, PROSTATECTOMY

DIFFERENT CUES FOR ACTIVATING PELVIC FLOOR

- TIGHTEN THE AROUND THE ANUS – COMMONLY USED IN RESEARCH- NOT EFFECTIVE
- **USE DIFFERENT CUES- STAFFORD** ET AL., 2016
- TRY TO PRETEND TO STOP THE FLOW OF URINE
- PRETEND YOU ARE A TURTLE, AND PULL YOUR HEAD INTO THE SHELL OR SHORTEN THE PENIS
- OTHERS

DEVELOP DIFFERENT STRATEGIES FOR DIFFERENT MUSCLE ACTIVATION PATTERNS

- STAFFORD ET AL, 2013 FOUND
- 2 DIFFERENT DOMINANT MUSCLE ACTIVATION PATTERNS FOUND IN MEN WITH PELVIC FLOOR MUSCLE ACTIVATION
- STRIATED URETHRAL SPHINCTER DOMINANT -COMPRESSES
- PUBORECTALIS DOMINANT –PULL UP TOWARDS THE PUBIC BONE

QUESTIONS TO ASK OURSELVES

- ARE THE CORRECT MUSCLE BEING ACTIVATED?
- HOW DO WE KNOW?
- IS THE PT. OVERCOMPENSATING?
- ARE THEY BREATHING CORRECTLY

SHOULD WE TRAIN OR TREAT OTHER MUSCLE BESIDES THE PELVIC FLOOR MUSCLES ?

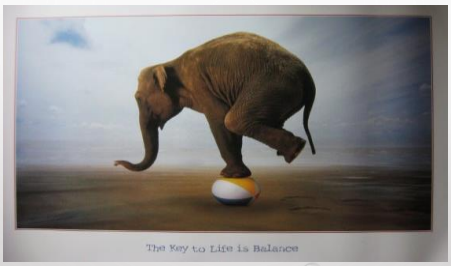
THERE ARE OVER 45 DIFFERENT MUSCLES THAT ATTACHED IN AND AROUND THE PELVIS.

MUSCLES WORKING TOGETHER FOR STABILITY

- **PFM AND ABDOMINAL MUSCLES :** SAPSFORD AND HODGES, 2001; SAPSFORD ET AL., 2001; NEUMANN AND GILL, 2002; THOMPSON ET AL., 2005 B
- **PELVIC FLOOR MUSCLES WORK IN CONJUNCTION WITH THE DIAPHRAGM.** HEMBORG ETAL, 1985
- **PFM CONTRIBUTE TO BOTH POSTURAL AND RESPIRATORY FUNCTIONS.** THOMPSON ET AL, 2006
- **PFM CO-CONTRACTIONS WITH TRA AND MULTIFIDUS**

THE MUSCULOSKELETAL LINK TO PELVIC FLOOR DYSFUNCTION (PFD)

- INCREASED INCIDENCE OF LOW BACK PAIN (LBP) IN PEOPLE WITH PFD
- PFD HAS STRONGER ASSOCIATION WITH LBP THAN OBESITY AND LEVEL OF PHYSICAL ACTIVITY
  - SMITH ET AL 2006
- ↑ SEVERITY OF LBP ASSOCIATED WITH ↑SEVERITY OF UI
  - KIM ET AL 2010
- ↑ LBP IN PATIENTS WITH RESPIRATORY PROBLEMS, UI, GI ISSUES
  - SMITH ET AL 2010



OTHER ANATOMY
TO BE NOTED

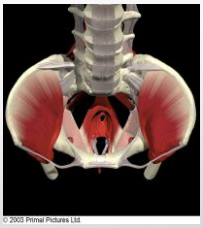
- VISCERA
- LIGAMENTS HOLDING VISCERA IN PLACE
- FASCIA
- TENDON INSERTIONS IN AND AROUND THE PELVIS
- LYMPH AND BLOOD SUPPLY

TRIGGER POINT REFERRAL PATTERNS

- GLUTE MINIMUS
  - BUTTOCK, AND MIMICS THE PATH OF SCIATIC PAIN OR SCIATICA
- GLUTE MEDIUS
  - BUTTOCK, SACRUM, AND POSTERIOR MEDIAL ILIAC CREST
- ILIOPSOAS
  - MEDIAL BACK AND/OR ANTERIOR THIGH
- OBTURATOR INTERNUS AND EXTERNUS
  - PELVIC FLOOR, BUTTOCK, ANTERIOR THIGH

HOW DOES CERTAIN DIAGNOSIS, HISTORY AND COMORBIDITIES AFFECT OUR BODIES ??

- CHRONIC BRONCHITIS / ASTHMA
- ABDOMINAL SURGERY
- DIABETES
- SCARS – PHYSICAL AND EMOTINAL
- PSYCHOLOGY



MULTIDISCIPLINARY APPROACH

- MANY DISORDERS CONTRIBUTE TO CCP; AN INTEGRATED MULTIDISCIPLINARY APPROACH TO DX AND TX IS ESSENTIAL TO ACHIEVE THE GREATEST SUCCESS.
- OBSTETRICAL & GYNECOLOGICAL SURVEY: SEPTEMBER 2003 VOLUME 58- ISSUE 9 PP 615-623

RESOURCES

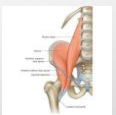
- WHAT DOES YOUR FACILITY OFFER?
- WHAT DOES YOUR COMMUNITY OFFER?
- OTHER REFERRALS- PSYCHOLOGY, PAIN CONTROL, NUTRITION, FOOD BANKS
- FIND GOOD RESOURCES EVEN IF ITS OUTSIDE OF WHERE YOU WORK
- START A RESOURCE BINDER THAT PATIENTS HAVE ACCESS TO.

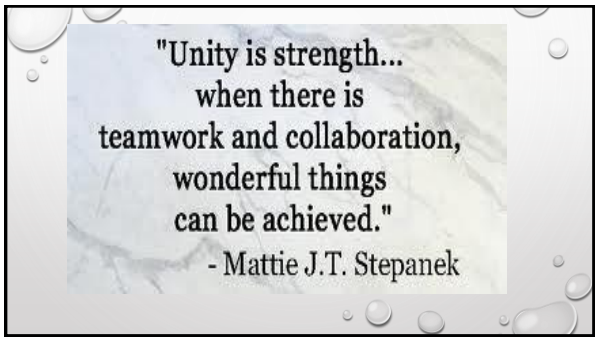
JOURNAL OF SEXUAL MEDICINE- MARCH 2008

- METHODS: REVIEW LITERATURE AND DETERMINE EFFICACY OF PT INTERVENTIONS
- RESULTS: PT TREATMENT OF CPP IS AN INTEGRAL COMPONENT OF TREATMENT THAT INCLUDES A MULTI-DISCIPLINARY APPROACH

KNOW THE KEY PLAYERS

- KNOW YOUR PATIENTS
- KNOW YOUR ANATOMY
- KNOW YOUR RESOURCES





TAKE HOME MESSAGES

1. PELVIC FLOOR MUSCLE TRAINING IS RECOMMENDED AS A FIRST LINE TREATMENT, BUT MAKE SURE THE PT. IS DOING IT CORRECTLY.
2. YOU NEED TO INDIVIDUALIZE A PROGRAM FOR YOUR PATIENT TREATING THE WHOLE PERSON AND USE DIFFERENT CUES TO GET BETTER PELVIC FLOOR MUSCLE ACTIVATION.
3. KNOW YOUR RESOURCES AND WHAT THEY CAN OFFER YOUR PATIENTS.