Women's Health

A DIVISION OF THE CANADIAN PHYSIOTHERAPY ASSOCIATION

SPRING 2023 NEWSLETTER

WORD FROM THE CHAIR

Happy Spring WHD Members! Spring is always such a busy time of year, and your WHD Team is no exception. We have so many exciting projects on the go.

As you have seen in our e-blast, the WHD has hired Dr. A.J. Lowik as a consultant and guide for our renaming project. A.J. is currently a Postdoctoral Fellow and instructor at the University of British Columbia and is a renowned expert in trans-inclusion and has extensive experience working with researchers, health care and social service organizations, and lawyers and policymakers who are interested in trans-inclusive research and praxis, policy and practice, and legal reform. We have already begun our work with them, and now have a clear pathway on how to move this project forward — We are in the process of scheduling member activities for this project, so as always, keep an eye on your e-blasts. I'd like to extend a thank you to our Advocacy Lead, Catherine Rastin and our Secretary Linnea Thackar for their passion and extra work on this project. I know that this has been a topic at the top of many of our members minds for several years. I look forward to opening the discussion, working, and learning together.

Our 2023 Bursary campaign has just wrapped up and we had over 30 applicants for our 4 bursaries this year. Our team is working on determining our recipients, which will be announced via e-blast, social media, and on our website in late May. If you didn't apply this year, I'd highly recommend taking a look at our award descriptions so that you can apply for next year!

Lastly, we are working on planning our Congress 2023 activities - I am so excited to be able to meet in person again, and I hope to see many of our members in Quebec City. The WHD will be hosting our members meeting in person this July, and also plans to host a social event during our time in Quebec City. I will be there, along with many of our executive and operational subcommittee members - I hope to see you there.

Alison Gordon

Chair, Women's Health Division, Canadian Physiotherapy Association
Physiotherapist
(she/her)

IN THIS ISSUE

NOTE FROM THE EDITOR

Happy Spring, WHD Members!

This is always such an exciting time of the year, with the days getting longer, flowers starting to bloom and the anticipation for summer events!

A new season brings a new newsletter and a new opportunity to learn about a topic that you may not be familiar with. This edition is all about gynecological cancers and the role that physiotherapists can have throughout care, from screening to post-surgical care. You will find information on gynecological cancers, current screening recommendations, signs and symptoms and physiotherapy interventions!

Stephanie Boone, PT
WHD Newsletter Editor
(she/her)

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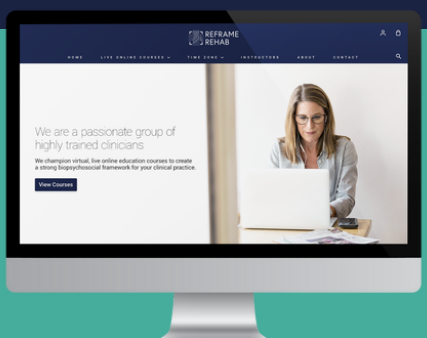

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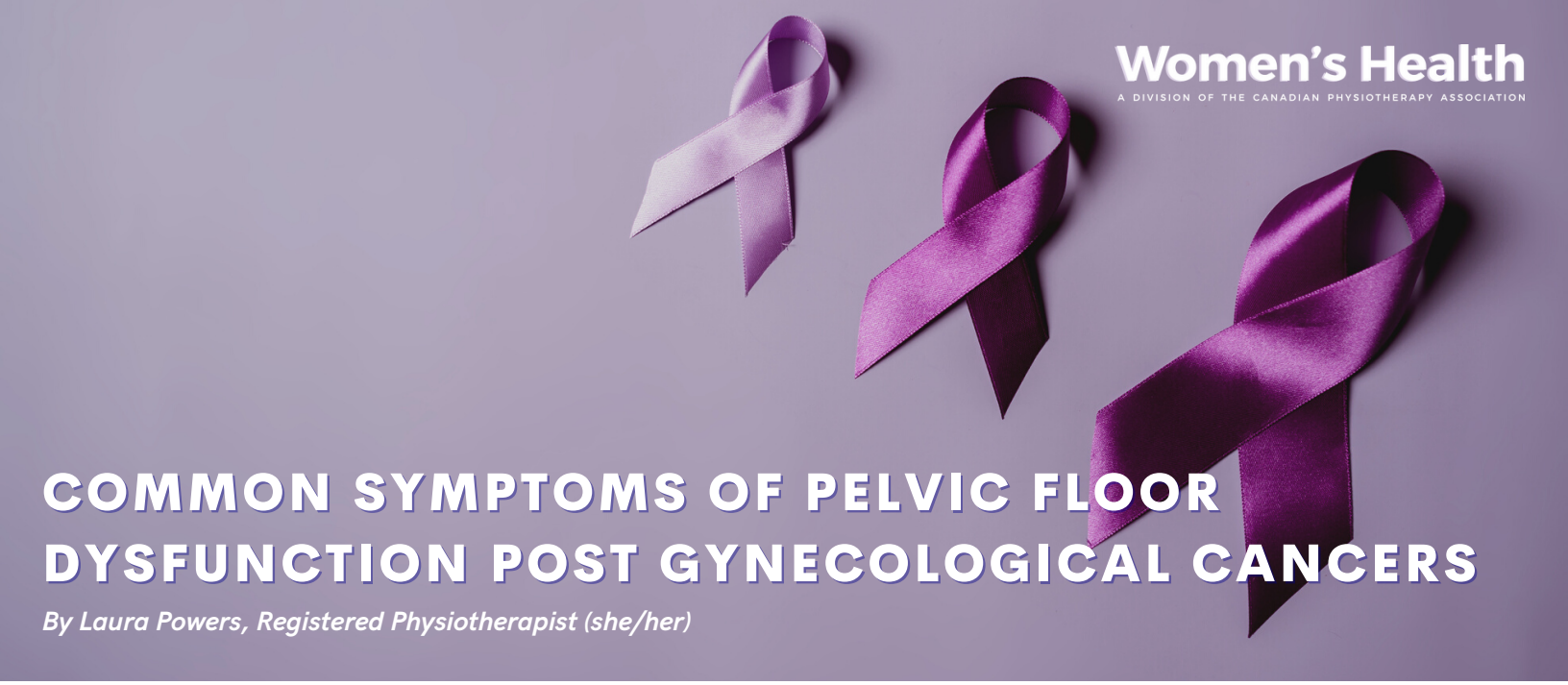

COMMON SYMPTOMS OF PELVIC FLOOR DYSFUNCTION POST GYNECOLOGICAL CANCERS

By Laura Powers, Registered Physiotherapist (she/her)

Gynecological cancers affect women across the ages and account for 17% of all cancers diagnosed in women (World Cancer Research Fund, 2020). The five main types of gynecological cancers include, cervical, uterine, ovarian, vulvar, and vaginal, but can also include fallopian tube and primary peritoneal. We know that in general pelvic floor dysfunction (PFD) is statistically prevalent among women. However, some gynecological malignancies can actually cause PFD and symptoms.

There is also substantiated research indicating that gynecological cancer treatments increase the risk of PFD. Some of the common symptoms associated with gynecological cancer treatments include, urinary/fecal incontinence, urinary/fecal urgency, urinary retention, and pain (vaginismus and vulvodynia).

Treatment options used for gynecological cancers include, surgery, radiotherapy, hormonal treatment, and chemotherapy, with a combination of modalities often administered. These treatments exert both direct and indirect effects resulting in functional anatomy, neurological, vascular, and myofascial alterations (Bodean et al., 2018).

SURGERY

Ceccaroni et al. (2012) suggest that the type of surgery affects the prevalence of PFDs. Nerve-sparing surgical techniques tend to be associated with lower rates of SUI, UUI, and urinary retention than the non-nerve-sparing approaches. It is common knowledge that every surgery comes with risk. In these cases the ureters can be injured during surgery, and there can be damage to pelvic nerves, blood vessels, and pelvic floor muscles, resulting in lower urinary tract dysfunction (Bodean et al., 2018). Manchana et al. (2010) reported that up to two-thirds of cervical cancer survivors after radical hysterectomy had urodynamic abnormalities. Half of them had voiding dysfunction and one-third had storage dysfunction. It has also been noted that symptoms may change over time given the type of intervention. Radical surgical interventions tend to result in immediate symptoms that can potentially improve over time. Whereas radiation tends to elicit late effects that can present over many months. In patients who undergo surgical management of cervical cancer, UI rates tend to be highest in the early post-operative period (Ramaseshan et al., 2018).

RADIATION/RADIOTHERAPY

This type of treatment is typically administered by external beam therapy or brachytherapy and can have short-term and long-term side effects. Short term effects can be vulvovaginal skin irritation and discharge, radiation cystitis (bladder irritation), and radiation vaginitis (irritation of the vagina). Long-term side effects include vaginal dryness and vaginal stenosis due to scarring that develops post treatment (American Cancer Society, 2019). Ultimately, this may contribute to dyspareunia. Hazewinkel et al. (2010) reported stress incontinence after radical hysterectomy and lymph node dissection in 19- 81% of patients. But, a combination of surgery *with* radiotherapy had two times more severe urological complications and that primary radiotherapy was associated with increased urinary urgency and fecal incontinence in 8-67% of cases.

HORMONE THERAPY

This type of treatment may be used alone or in combination with other modalities and can have a spectrum of side-effects affecting each individual differently. Some of the common types of hormone therapy drugs include, Luteinizing-Hormone-Releasing-Hormone (LHRH), Anti-Estrogens, and Aromatase Inhibitors. Because these drugs create an effect on estrogen levels they can elicit treatment-induced menopause.

Many of the symptoms associated with the drugs are due to this change and patients may experience a new onset or worsening of peri/post-menopausal symptoms which include, vaginal itchiness or discharge, infections (bladder, vaginal, and/or urinary), dyspareunia, SUI, and UUI (Canadian Cancer Society, 2023).

CHEMOTHERAPY

This form of therapy is often used in conjunction with radiation or used after another treatment modality if the cancer has returned/spread. Therefore, it can be more challenging to say what symptoms of PFD are specifically associated to the chemotherapy. In a study looking at advanced endometrial cancer, De Boer et al. (2016) found no difference in UI rates between the use of chemo alone or in combination with radiotherapy, suggesting that the addition of chemotherapy contributes little to UI. Constipation and diarrhea are also known side effects, so the patient may ultimately experience a worsening of bowel issues secondary to underlying PFD.

Since the main goal of treatment is malignancy eradication, the concern of PFD may not be the primary focus for doctors or specialists. Unfortunately, due to this many of these changes may not be well discussed with the patient. If you have a patient who has upcoming treatment or has a history of gynecological cancer, you may want to have a discussion around the different treatments and risk factors, or encourage them to ask their doctor about potential side effects. Quality of life post treatment needs to be addressed and much of what Pelvic Health Physiotherapists do can help improve this.

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We invite Women's Health Division members to participate in the Storying Physiotherapy research study, led by University of Manitoba and Duke University researchers. We are studying physiotherapists' ideas and insights about best practices.

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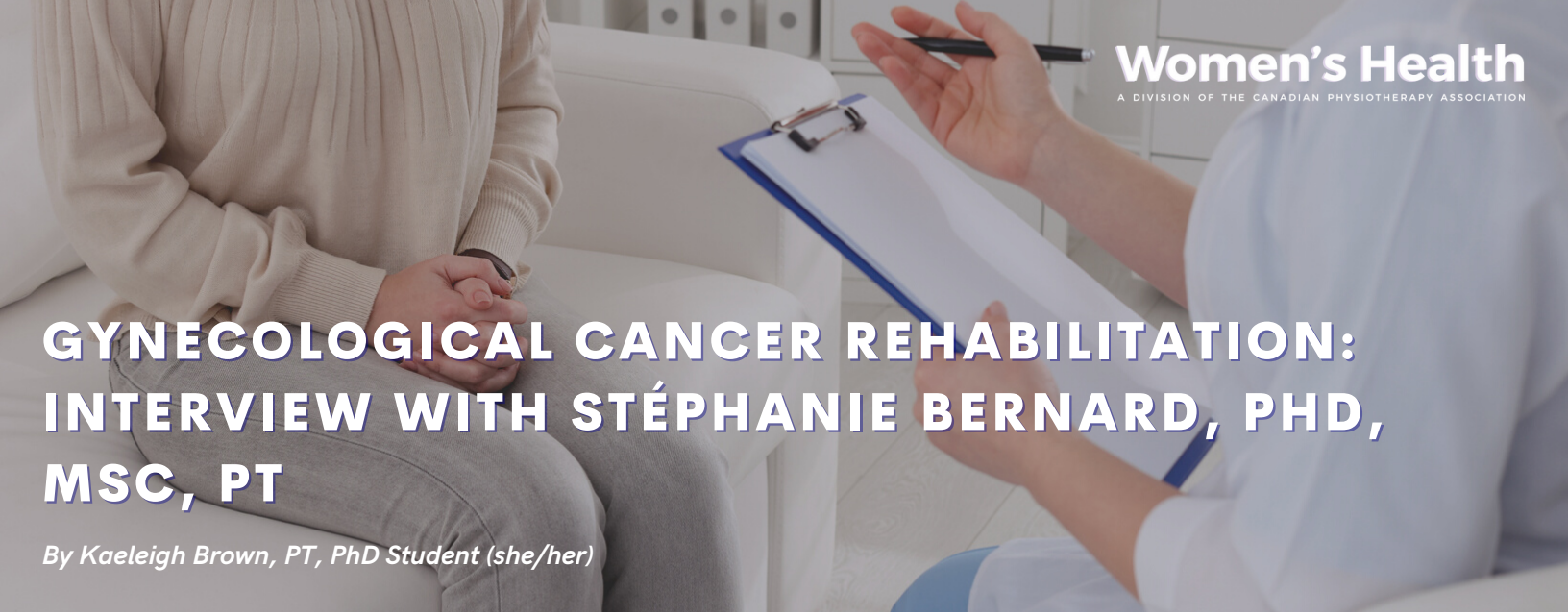


GYNECOLOGICAL CANCER REHABILITATION: INTERVIEW WITH STÉPHANIE BERNARD, PHD, MSC, PT

By Kaeleigh Brown, PT, PhD Student (she/her)

We are fortunate to have an oncological pelvic floor physiotherapist and researcher as a member of the Women's Health Division team. Stéphanie Bernard, Knowledge Translation Lead, and Postdoctoral Fellow at the University of Alberta, agreed to share her knowledge and experiences with us.

CAN YOU TELL READERS ABOUT YOURSELF, WHERE YOU WORK, YOUR AREA OF PRACTICE? HOW DID YOU BECOME INTERESTED IN PELVIC HEALTH AND ONCOLOGY?

I am a physiotherapist and have been practicing in the field of pelvic health rehabilitation in a private clinic for 17 years. I was trained at McGill University, where I was fortunate enough to receive theoretical training in pelvic rehabilitation from Ms. Claudia Brown. I literally fell in love with it and being exposed to this unique practice completely changed the career path I was about to follow. At the same time, and still at McGill University, I was fortunate enough to receive training in oncology rehabilitation from the very excellent Mary-Ann Delzell, which awakened a second passion in me. I will be eternally grateful for the opportunity to learn from these two exceptional physiotherapists and for their positive influence on my career as it led me to undertake graduate studies with gynecological cancer rehabilitation at the core of my work.

WHAT ROLE DO PHYSIOTHERAPISTS HAVE IN ONCOLOGICAL REHAB?

EDUCATE: If there is one thing that stands out in our current research, it is the fact that the majority of people diagnosed and treated for gynecologic cancer are not sufficiently aware of how cancer treatments can impact their pelvic health. When pelvic health dysfunction occurs, it can be not only surprising, but also frightening, as it can be mistaken for a sign of cancer recurrence.

EMPOWER: If knowledge is power, providing more information about pelvic health, pelvic health dysfunction, and pelvic health interventions can give patients affected by gynecologic cancer tools to recognize changes that may be occurring in their bodies, as well as to develop the self-efficacy to take action. We do not yet have evidence on the effectiveness of pelvic health interventions to prevent pelvic health dysfunction such as incontinence and dyspareunia, but most gynecologic cancer patients want to know more and want to do more.

REHAB: Adapt and use your pelvic health interventions to address any pelvic health dysfunction that may occur after cancer treatment. With urinary incontinence (stress and urge) affecting about 60% of survivors, fecal incontinence affecting just over 30% of survivors, and sexual dysfunction affecting between 60-100% of sexually active survivors, there is much to be done to improve the quality of life for this group of patients.

SCREEN: Keep lymphedema and sarcopenia on your radar; remain vigilant and be quick to identify these problems early and refer patients accordingly.

> "If there is one thing that stands out in our current research, it is the fact that the majority of people diagnosed and treated for gynecologic cancer are not sufficiently aware of how cancer treatments can impact their pelvic health."

WHAT TRAINING OPPORTUNITIES DID YOU SEEK OUT TO FOCUS ON ONCOLOGY? ARE THERE OTHER TRAINING OPTIONS AVAILABLE TO PRACTITIONERS WHO WANT TO EXPLORE THIS AREA OF PRACTICE?

There are a few options to get further training for the rehabilitation of gynecologic cancers; I attended a course in the US hosted by Herman and Wallace (Oncology and the Pelvic Floor) several years ago, and also more recently wanted to further my general training in Oncology by attending Mary-Ann Delzell's online course hosted by Bia Formations (Rehabilitation Strategies for Patients with Cancer). I know there are a few options with Pelvic Health Solutions as well as with Uro-Santé, with whom I participated in organizing and teaching the latest course on the topic.

YOU'RE ALSO A POST-DOCTORAL FELLOW AT THE UNIVERSITY OF ALBERTA. WHAT INFLUENCED YOUR DECISION TO ENTER ACADEMIA?

I decided to begin my academic journey after discovering that there were no scientific papers published on the effects of pelvic physical therapy on pelvic health dysfunction after gynecologic cancer treatments (at the time). I had several clinical questions due to the unique clinical presentation of these clients, and I already had a growing interest in research, but it was this realization that definitely pushed me to finally pursue graduate school.

> "...providing more information about pelvic health, pelvic health dysfunction, and pelvic health interventions can give patients affected by gynecologic cancer tools to recognize changes that may be occurring in their bodies..."

YOUR RESEARCH FOCUSES ON GYNECOLOGICAL CANCERS. CAN YOU SHARE WHAT YOU ARE WORKING ON RIGHT NOW?

We have just completed the data collection from our latest research project where we were investigating the knowledge that patients after gynecological cancers have on various pelvic health interventions, among several other topics (the protocol for this research has been published in Open Access: https://bmjopen.bmj.com/content/13/1/e067606.full). I will be presenting some of those results at the next CPA Congress this Summer, I hope to see you there!

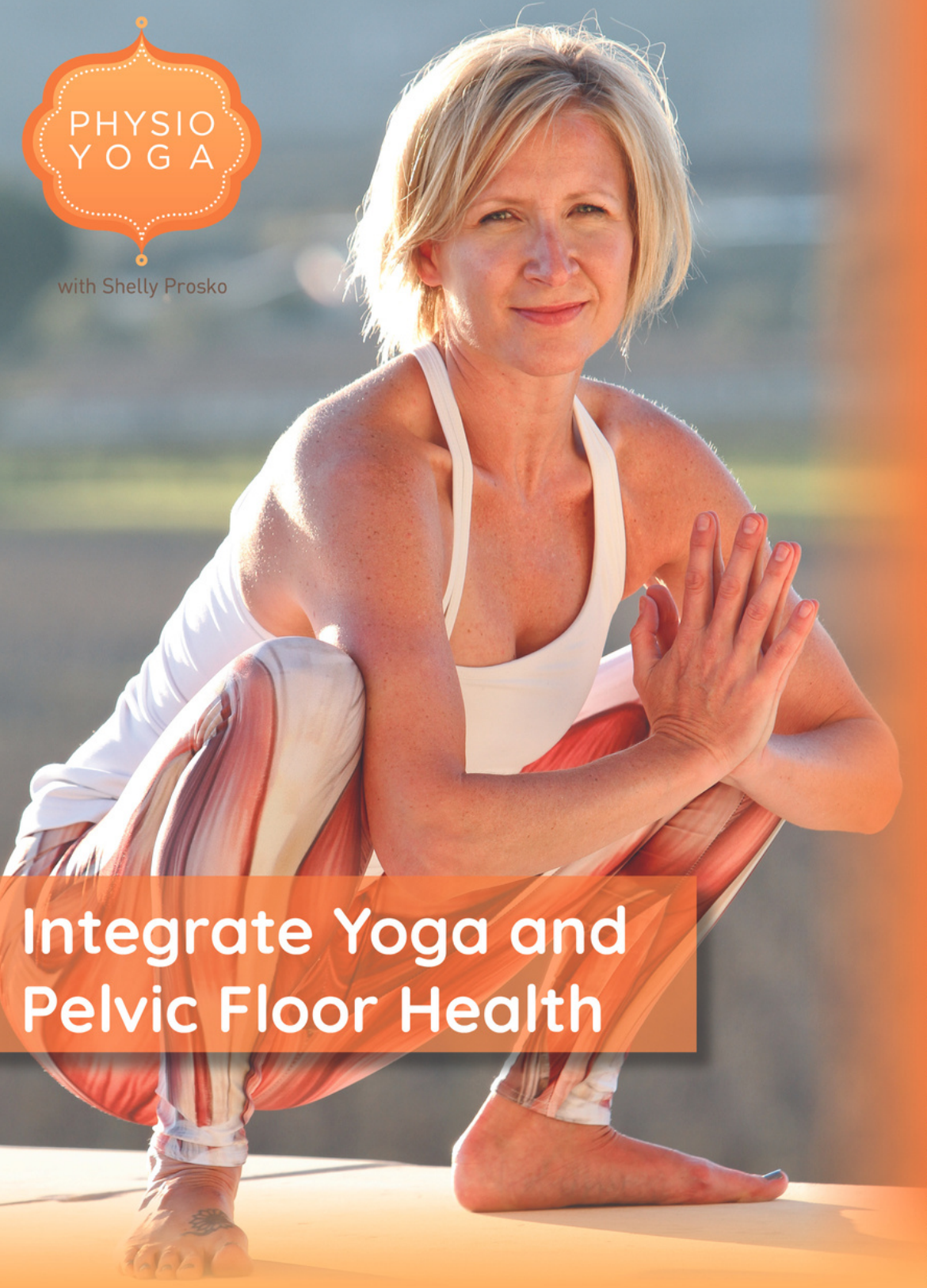
WHAT IS THE STATE OF RESEARCH AROUND PELVIC FLOOR REHABILITATION AND OTHER FORMS OF CANCER?

In terms of other cancers, such as breast cancer for instance, I would say the state of the research is more at the stage of understanding the prevalence of various pelvic health dysfunctions and their impact on the quality of survivorship, as well as to understand the relationship, the pathophysiology, between the cancer treatments and those dysfunctions. This evidence will help us understand how to best intervene, and maybe even prevent, those dysfunctions in the future.

Thank you for taking the time to answer our questions, Stéphanie!

PHYSIO YOGA

with Shelly Prosko



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THE EFFECT OF PHYSICAL THERAPY ON PELVIC FLOOR DYSFUNCTION AFTER GYNECOLOGICAL CANCER TREATMENT

By Alyssa Brunt (she/her)

Gynecological cancers (uterine/endometrial, cervical, vulvar or vaginal cancer) account for 7.7% of all new cancer cases,[1] with an estimated 1.39 million new cases reported in 2020.[1] Cancer and oncological treatment are physically and emotionally burdensome. Survivors are left with physical and psychological effects of treatment, reducing their overall quality of life.

It is increasingly understood that pelvic floor dysfunction (PFD) commonly occurs in gynecological cancer.[2] Medical and surgical treatment modalities have the potential to create vascular and neuromuscular damage to pelvic structures, affect the pelvic organs, and ultimately lead to PFD.[2] Urinary and bowel dysfunction, sexual dysfunction and pelvic pain are highly prevalent in gynecological cancer survivors and are thought to be a sequelae of treatment.[2,3,4]

Unfortunately, health care providers rarely screen for PFD following cancer treatment[4] and patients are often uneducated and unlikely to report any symptoms of PFD. In order to optimize recovery, it is integral that cancer survivors receive ongoing care within a multidisciplinary healthcare team that encompasses a biopsychosocial approach. Pelvic floor physical therapy (PFPT) has been shown to reduce symptoms of PFD following gynecological cancer treatment[2-6] and as such, should be considered when addressing the late and long-term effects of treatment.

PELVIC FLOOR DYSFUNCTION AFTER GYNECOLOGICAL CANCER TREATMENT

The prevalence of PFD in gynecological cancer patients is affected by the timing and type of treatment received.[2] Surgeries (tumour debulking, hysterectomies, salpingo-oophorectomies), radiation, and chemotherapy are used alone or in combination as treatment options.[5] Although cancer eradication is the primary goal, these treatments can result in the development of scar tissue, lymphedema/swelling, stenosis of the vaginal canal, and hardening of the pelvic floor muscles (PFM) contributing to pelvic pain, urinary incontinence, and sexual dysfunction.[5] Treatments can also indirectly contribute to PFD by changing hormone function and inducing menopause, causing vulvar sensitivity, vaginal dryness, and low libido.[3-5]

Dyspareunia, urinary incontinence and fecal incontinence are most commonly reported after gynecological cancer treatment.[3,5,6] Incontinence is likely to occur from weak and/or uncoordinated PFM following treatment.[5] The prevalence of urinary incontinence was found to range from 4-76% in gynecological cancer survivors, while fecal incontinence was found to range from 2-37%.[2,3,6]

Dyspareunia has been shown to range from 12-58% after cervical cancer and 7-39% after endometrial cancer.[2,3] Vaginal stenosis, impaired tissue flexibility, increased PFM tone and vaginal dryness may contribute to dyspareunia.[7] However, survivors may also experience emotional challenges with sexual function.[2,3,6] In a cohort study, it was found that gynecological cancer survivors related their sexual dysfunction to low desire, less intense climax, deterioration in body image, and more negative emotional reactions to sexual activity.[6]

Discomfort and pelvic pain (abdominal, vaginal, vulvar and urethral) have also been reported in gynecological cancer survivors.[2,8] In sub-urban regions of India, 65% of gynecological cancer survivors reported moderate levels of pelvic pain, which was highest in endometrial and ovarian cancers.[8]

PELVIC FLOOR PHYSICAL THERAPY

Pelvic floor physical therapists are integral members of cancer care teams. Treatment techniques including manual therapy, biofeedback, pelvic floor muscle training (PFMT) and pelvic floor relaxation exercises can target the mobility and contractility of the PFMs and surrounding tissues to improve PFD.[2-8] Education, behaviour modification, helpful tools, and

guidance can further address the consequences of oncological treatments and improve the overall quality of life in gynecological cancer survivors.[2-8]

Pelvic floor muscle training has been shown to improve sexual dysfunction, urinary incontinence and fecal incontinence after gynecological cancer treatment.[2,3] Contraction and relaxation of the PFMs must be balanced and coordinated in order to support the pelvic organs, control bladder and bowel movements, and enable sexual intercourse. Cancer survivors who completed 4 weeks of PFMT after treatment demonstrated improvements in pelvic floor muscle strength, sexual function and health related quality of life (HRQoL) compared to controls.[9]

Additionally, gynecological cancer survivors who completed PFMT and behavioural therapy reported a significant reduction in urinary incontinence compared to control groups, 12 weeks after treatment.[6] Research also suggests that the effects of PFMT may be sustained over time. Women with gynecological cancers who completed a 12-week intervention comprising education, manual therapy and PFMT reported reductions in dyspareunia, improvements in sexual functioning and reductions in urinary symptoms after treatment, that were maintained at one year follow-up.[7]

Manual therapy, vaginal dilator therapy and behaviour modifications are also effective in treating PFD following gynecological cancer treatment. Manual therapy can directly target scar tissue, myofascial adhesions and mobility restrictions within the PFM to help restore normal pelvic floor function.[5] Vaginal dilator therapy has been shown to prevent/reduce severe scarring or stenosis after radiation therapy.[2,3,10] The combined intervention of PFMT and vaginal dilator therapy was shown to prevent stenosis in 90% of women with cervical cancer, 4 months post radiation therapy.[10] Behavioural changes including bladder and bowel training, fluid and constipation management, and bladder diary self-monitoring are also effective for improving PFD.[5]

Pelvic floor physical therapy may be beneficial for improving PFD following gynecological cancer treatment, however there is insufficient evidence from high-quality studies to draw any conclusion of a possible effect.[3] In a recent systematic review, it was highlighted that further high-quality studies are needed as there was only moderate-level evidence that PFMT with counselling and yoga or core exercises were beneficial for sexual function and HRQoL in survivors of cervical cancer.[3] There was insufficient data for analysis of bladder and bowel dysfunction and very low-level evidence for dilator therapy in reducing vaginal complications in survivors of cervical and uterine cancer.[2,3]

Although more evidence on PFPT in treating PFD after cancer treatment is needed, it is important to remind ourselves that education is one of the most effective tools physical therapists can integrate into cancer care.[2-10] Well-informed patients are more likely to discuss problems with their health care providers and seek out treatment options.[6,11] It is paramount that patients are educated on the possible long-term effects following cancer treatment as well as treatment options available to them.[11] Pelvic floor physical therapy provides a low cost, low risk treatment option that can reduce symptoms, improve QoL and effectively treat PFD following gynecological cancer treatment.[2-11]

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CERVICAL AND VULVAR CANCER SCREENING

By Katie Kelly, PT (she/her)

When it comes to gynecological cancers, screening is of utmost importance. In pelvic physiotherapy, it is always useful to be familiar with current screening recommendations. Each provincial healthcare system develops their own screening protocols, though they are generally similar. Please check with your local health authority if you would like more details.

CERVICAL CANCER SCREENING

Cervical cancer screening via Papanicolaou test (pap test/smear) is encouraged in anyone sexually active, with a cervix, beginning between ages 21-25, depending on provincial protocol, and continuing until 70 years of age. Tests are performed regularly, 1 to 3 years apart, depending on risk factors, including previous pap test findings. Positive test findings result in more sensitive testing, more frequent follow-up, or treatment aimed at reducing risk of dysplasia progression towards cancerous cells.

Pap testing is done via two different methods; conventional cervical smear where the sample is placed on a slide, or liquid-based cytology where the sample is placed in a liquid-filled specimen jar. Though debated in the literature, it is still generally accepted that relative sensitivity is similar between both methods, when proper collection technique is used and sufficient sample is collected.[1] However, conventional pap tests have a higher prevalence of insufficient cervical cells collected within the sample, and blood being detected in the sample, resulting in more samples being rejected from the lab.[2-5] Liquid-based testing is an easier collection process resulting in fewer false-negatives due to collection error, and therefore greater detection rates.[2-5] In fact, collection is so easy, that patients can collect the sample themselves. Self-collection might remove the barrier of a physician-patient exam, and increased compliance in regular cervical cancer screening. However, further testing is required before this becomes common practice.[6]

Additionally, liquid-based pap test samples can also be analyzed for HPV, a well-known virus, and a prerequisite to almost all known cervical cancers.[7] Most Canadian provinces do not routinely test for HPV infection, and testing might come with additional cost, creating a barrier for some. Current discussion centres around using HPV screening in combination with pap testing, or as a stand-alone test for cervical cancer. Ontario Health and Cancer Care Ontario are currently working with their provincial government to implement HPV testing with cervical screening.[8] We will likely see this discussion in other provinces in the future.

For a scoping review of cervical cancer screening recommendations in Canada – please see this open access article "Screening for the prevention and early detection of cervical cancer: protocol for systematic reviews to inform Canadian recommendations" by Gates et al.[9]

VULVAR CANCER SCREENING

Vulvar cancer screening is largely dependent on symptom reporting and physical exam. Symptoms of vulvar cancer include itching (pruritis), bleeding or discharge in the area unrelated to menstruation, and pain or burning in the vulva. While there seems to be no supporting research, according to Canavan and Cohen, experts opinion supports annual visual inspection of vulva by a physician.[10] Monthly self vulvar examination is also recommended, in an effort to detect any visible changes related to cancer.[11] Using a mirror and proper lighting, women are encouraged to examine their vulvar tissues, including the intra-labial folds, and clitoral hood, for signs of skin color changes, irregularities in skin color, changes in skin texture, ulcerations or sores, wart-like growths, lumps, bumps and thickening of tissues. These changes should be immediately reported to a physician and can be sent on for biopsy if warranted.

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