Women's Health

A DIVISION OF THE CANADIAN PHYSIOTHERAPY ASSOCIATION

WINTER 2020 NEWSLETTER

WORD FROM THE CHAIR

We have reached the end of February - the days are getting longer (marginally) and we survived a severe cold snap (-30 and below) out on the Prairies. The cold cannot compare to the epic dump of snow that Newfoundland got blasted with, though! I am excited for the year ahead, as there is a lot going on with the Women's Health Division (WHD).

The Valentine's Day Challenge (VDC) is up and running. Students and clinics across the country are gathering menstrual cups, pads, tampons, hair and skin products, detergent, soaps, and dental hygiene products to donate to local women's centres. The WHD matches the largest student body donation (up to $500) to be shared with the centre of their choice.

Applications for the WHD awards opened on February 15th! We have six bursaries to choose from: assistance with sending a student to Congress in May in Ottawa to celebrate the 100th anniversary of the Canadian Physiotherapy Association (CPA); assistance to help those living in remote areas to get further education, assistance for new grads who are interested in learning more about women's/pelvic health; the Jodi Boucher leadership award and more. Take advantage of what the WHD can offer to support your professional development by visiting the Members section of our website **womenshealthcpa** for more information.

Our executive is eager to get started on our new strategic plan that will guide us for the next three to five years. If you have any thoughts or suggestions on where we should spend our time and energy, I would love to hear from you! Please feel free to email me any time, **whdchair@gmail.com.**

We are excited to celebrate the 100th anniversary of CPA this year at Congress from May 28-30th in Ottawa! Please join us on Friday, May 29th for our members meeting. Learn about our new strategic plan and share any ideas, comments, or concerns. Take advantage of the focused WHD-hosted stream of content on Saturday, May 30th between 10:30-3:00 to further your women's/pelvic health professional development. But that's not all! One of our executive members, Jessica Bergevin, will be teaching a post-Congress course: Clinical Pilates with Pelvic Health Perspective on Sunday, May 31st.

Finally, it is with great sadness that we share the news that Jodi Boucher, a wonderful former member of our executive; an amazing and driven physiotherapist, and a devoted mother, wife and friend, passed away on January 8th, 2020 after a hard battle with lung cancer. Jodi was a joy to work with - she had great ideas, a wonderful sense of humour and got jobs done! She will be sorely missed by the physiotherapy community in Calgary and across the country. The WHD executive passes on our sincere condolences to Jodi's family and friends.

Juliet Sarjeant
Chair, Women's Health Division of the Canadian
Physiotherapy Association Physiotherapist

IN THIS ISSUE

EDITOR'S NOTE

Hello dear readers, and welcome to the winter edition of the WHD Newsletter! We decided to start 2020 with a spotlight on men's health. Many of us treat men, so we thought – what could be better than giving some practical advice to help practitioners?

In this issue, you will find some excellent contributions from amazing practitioners, such as Jo Milios – a physiotherapist focused on men's health from Australia. Jo was also kind enough to share two of her published articles. You can find the abstracts here, and the full articles on our website. Another wonderful resource comes from Victoria Cullen – a specialist in sexual recovery after prostate cancer treatments.

On a more personal note, I would like to thank my amazing subcommittee. This, and all other newsletters, would not be full of such wonderful information without the wonderful Katie Kelly and Leslie Spohr. Their hard work is reflected on each page, as well as on our website, where you can find the handouts that they made (you can find them in our members section **at this link**).

If you would like to become part of the newsletter team, please let us know! Please contact Devonna Truong, at **whdsecretary@gmail.com.**

We hope you enjoy this newsletter, and please let us know if there are any specific questions you would like us to feature. Please let us know by writing an email to me, Katerina Miller, at **whdnewsletter@gmail.com**.

Katerina Miller, PT
WHD Newsletter Editor

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DR JO MILIOS : MEN'S HEALTH PHYSIOTHERAPIST (PHD) 2020

Dr. Jo Milios is an Australian Physiotherapist with a special interest in Men's Health, focusing on Prostate Cancer Rehabilitation, Pelvic Floor Muscle Dysfunction, Urinary Incontinence, Erectile Dysfunction, Chronic Pelvic Pain Syndrome, Peyronie's disease (PD), Exercise and Yoga. Graduating with a Bachelor of Science (Physiotherapy) in 1993, the big gap in Men's Health services proved pivotal in her decision to specialise in from 2005. Jo is has recently completed PhD studies at the University of Western Australia investigating quality of life outcomes following surgery for prostate cancer. In particular, non-invasive tests of pelvic floor muscle (PFM) function were developed and utilised in a large randomised control trial (RCT) aimed at improving continence and erectile function following radical prostatectomy. New 'high intensity' PFM training protocols for a faster return to recovery and quality of life were explored and compared to usual care. An unexpected case of Peyronie's disease (curvature of the penis) in one patient lead to a second RCT evolving, utilising therapeutic ultrasound to treat scar tissue in the 1 in 6 men who develop PD following treatment.

Complimenting this in recognition of the big gaps seen in Men's Health, Jo set up 'PROST! Exercise 4 Prostate Cancer Inc.', in 2012, a not-for-profit organisation, with the aim of providing an exercise and peer support program for ANY man with Prostate Cancer no matter his age, stage or prognosis. Jo has presented her research findings at several international conferences including WCPT 2015 (Singapore), 2017 (South Africa) & 2019 (Geneva), Asia Pacific Prostate Cancer Conferences 2014-18, Asia-Pacific Sexology Conference 2014-16, Men's Sheds Conference WA 2017-18, Prostate Cancer Foundation of Australia conferences, and ANZUS (Urology) WA State Meetings 2011-2018. Recent publications include write-ups in the Australian Physiotherapy 'In Motion' magazine, two paper publications in the Australian New Zealand Continence Journal and a recently published paper in BMC Urology outlining the new pelvic floor muscle training protocols for men undergoing radical prostatectomy. Jo also teaches Men's Health Physiotherapy workshops throughout Australia and internationally and is a casual academic at Charles Sturt University, Australia and casually lectures for Curtin University's Post-graduate Sexology Masters course in Western Australia. Jo's main passion, however, is to share her work within the community, to help educate others so that the everyday man on the street has better health outcomes and a much longer life versus the current situation, where globally, men's health is in crisis with a 5 year lifespan discrepancy vs women, a 30 year lag in health services and alarmingly, a world where 1 man/minutes commits suicide. There is work to be done. PROST!

INTERVIEW WITH JO MILIOS: POST-PROSTATECTOMY

Leslie Spohr PT, member of the Newsletter Subcommittee

WHAT ARE COMMON COMPLAINTS FOR MOST CLIENTS POST PROSTATECTOMY. IF POSSIBLE, CAN YOU BRIEFLY DESCRIBE WHY THESE SYMPTOMS OCCUR?

Following removal of the prostate by radical prostatectomy, it is expected that most men (up to 99%) will experience both urinary incontinence (UI) and erectile dysfunction (ED). This is due to the prostate providing support to the bladder and assisting in continence control via the autonomic nervous system, which when removed, is no longer possible. With sexual function, the cavernosal nerves responsible for erections, are wrapped around the prostate and these are damaged, removed or bruised intra-operatively. Each man will mostly likely have varying degrees of severity and duration of these physical side effects, which generally improve over time. Complete resolution of both is possible, however ,without physiotherapy intervention many symptoms remain ongoing, potentially leading to depression, anxiety and much reduced quality of life. In addition and less

commonly known, penile fibrosis due to reduced bloodflow to the penis may cause penile shrinkage, fibrosis and potentially Peyronie's disease(curvature or physical deformity of the penis). Physiotherapists have a huge role to play in the education, rehabilitation and support of these patients, as 1 in 6 men globally, will be diagnosed with prostate cancer and surgery is the gold standard treatment approach.

DO YOU FOLLOW A TREATMENT PROTOCOL POST-PROSTATECTOMY? IF SO, WOULD YOU BE WILLING TO SHARE THE PROTOCOL YOU USE?

Up until my recently published treatment protocol for UI – also known as Post-Prostatectomy Incontinence (PPI)- recommendations have been lacking due to poor efficacy in research studies historically. This is mostly due to previous recommendations drawn from female pelvic floor muscle (PFM) training protocols , and a focus on contracting the external anal sphincter (EAS) , instead of the external urethral sphincter (EUS). However, based on my clinical experience with >3000 radical prostatectomy patients I devised a protocol that was relevant to the clinical presentations of most of my patients. Fortunately, my research was able to conclude that by performing PFM training in a functional position from the outset with a 4-6 week pre-operative training period, there was less leakage, much reduced duration of PPI and improved quality of life through all stages of recovery, with 1 in 6 never experiencing PPI from the outset.. The protocol we can now refer to is to perform a combination of 10 fast twitch 'rapid' PFM maximal contractions (and relaxations), followed by 10 slow twitch 'endurance' contractions, with up 10sec holding time and 10sec relaxation time. This needs to be performed in standing and repeated 6 times / day spaced over the day. To view the BMC Urology paper **visit our website**.

> "...there was no opportunity for education in Men's Health Physiotherapy as it was not a component in any under or post-graduate training programs. Instead, I learnt from the coal face by observing, listening and receiving mentorship from both local and international practitioners in the field."

DO YOU SEE MANY CLIENTS PRE-OPERATIVELY? IF SO, DO YOU FIND THIS BENEFICIAL?

Approximately 95% of patients are referred to me pre-operatively and this provides an opportunity for awareness, education, specific training, and a personalized PFM, bladder training and exercise program to be devised for each individual man. A 4-6 week lead in time is preferable and the time between biopsy and surgery is ideal to start implementing physiotherapy. From both clinical and now, research experience, I am personally quite distressed when I see men post-operatively who haven't had the opportunity to have a pre-operative work up. The difference in all facets of recovery – physical, emotional, psychological and social- is like day and night- and I feel this distress is completely avoidable with education from urologists and physiotherapists working together. This was the aim of my research because surviving is one thing, but a quality of life is equally, if not more important in my experience. You can find the abstract later on in the newsletter, in the research corner, and the entire article on our website: **www.womenshealthcpa.com.**

CAN YOU DESCRIBE HOW YOU PREFER TO ASSESS THE PELVIC FLOOR IN YOUR POST-PROSTATECTOMY CLIENTS (INCLUDING CLIENT POSITIONS, DRAPING, ETC.)?

Assessment- a mind field of its own in this population and a great question with a bit of a story to it!....When I first started working with men in 2005, there was no opportunity for education in Men's Health Physiotherapy as it was not a component in any under or post-graduate training programs. Instead, I learnt from the coal face by observing, listening and receiving mentorship from both local and international practitioners in the field. However, given the limited knowledge there were so many gaps with very few physiotherapists having broad clinical experience and only Prof Grace Dorey providing relatable research at the time. So I turned to my patients and learnt mostly from them! From the outset, I recognized that per rectal assessment was inappropriate for men who would endure a urinary issue and hence, I commenced training in Real Time Ultrasound (RTUS), a non-invasive option to assess PFM function. Initially this was only performed trans-abdominally (TrA) and I quickly shifted from assessing in supine to standing postures as I learnt that men will mostly leak in upright positions. As technology and research

has evolved, however, transperineal (TrP) RTUS approaches have been devised to better assess all three muscles of urinary control in men (the EUS, bulbocavernosus and puborectalis) and this adds another effective, but slightly more invasive option. TrP can also be performed in standing and is particularly useful for men with PFM overactivity or delayed continence recovery as EAS (anal) dominance is oftenthe problem and it is helpful to 'see' this with biofeedback. Draping needs to be provided for TrP approaches but removing the underwear is not absolutely necessary as most men will initially be wearing continence pads and simply shifting their underwear to one side is the task for my patient to control! In the real world, I initially scan most of my patients with TrA RTUS (standing) for developing awareness, trust, rapport and it's a quick, safe, easy and effective option, with TrP approaches introduced as appropriate.

ARE THERE ANY COMMON FINDINGS IN YOUR PELVIC FLOOR ASSESSMENT IN POST-PROSTATECTOMY CLIENTS?

The post-op presentation of PFM function will directly correlate to how much pre-operative training we were able to achieve. Hence, this is highly variable and will be reflected in the assessment, which is a component of every consultation! For those with pre-op prep, observed from RTUS assessment- there will be enhanced specificity, awareness, more brisk 'fast twitch' reaction times to assist with reflex situations and EUS closure for cough/sneeze/ sit to stand mechanisms, and better PFM endurance, elevation and improved relaxation for 'holding' on tasks. Moreover, there will increased PFM hypertrophy and clinically, usually much less PPI vs a patient without pre-op training. I can also measure this function via the RRT (Rapid Response Tests) and SET (Sustained Endurance Test) tests I designed so I can also have an accurate baseline of PFM function, to objectively measure both fast and slow twitch fibre function, which strongly correlates to 24 hour pad leakage – the essence of my PhD Research.*

Aside from this, without doubt ,the NUMBER 1 issue in post-op PFM is fatigue! The longer a man is upright, the more PFM fatigue and simultaneous leakage he will likely experience.. This will usually worsen as the day progresses. This is where our physiotherapy expertise matters most! Some men will be naturally overactive in their PFM pre-op and they may need a down-training program , or a complete rest from PFM exercises for a few days...before we even consider PFM strengthening. Some men will experience perineal and scrotal pain due to this same issue post-operatively, and many men will dance between the two in the early post-op phase. All of this we can literally see on RTUS, however a per rectal assessment may be appropriate if symptoms persist. This is the challenge of research vs reality- something I am always striving to bridge.

WHAT ASPECTS OF TREATMENT DO YOU FEEL ARE OFTEN MISSED OR OVERLOOKED IN TREATING THIS POPULATION?

SEX! SEXUALITY! SELF-ESTEEM! Why? Every man undergoing radical prostatectomy is expected to be completely impotent immediately, with only 22% of men gaining their erectile function at 2 years post-operatively!!! Erectile Dysfunction (ED) = 'a man without his weapon' intact and for many, that can have the most devastating effect on their lives.

> "In the early days, some of my local colleagues were infuriated with me...Many years later penile rehabilitation is a standard and very necessary component of every physiotherapy consult I provide, with every Urologist I work with, now completely on board."

Early on I worked out that continence issues were relatively easy to fix, with an approximate 12 week intensive PFM training program in total, required for continence control. I also observed that the pre-op PFM training time could often be shed off this time post-operatively. (e.g. 6 weeks pre-op PFM training,= 6 weeks post-op PPI and pad wearing= a 3 month process in total). In my 'guestimation', this is how long it generally takes for the PFM to 'take over' the role of the prostate, which I always refer to as the 'plug' of the urinary system in men. Given most of my patients were getting dry quickly, they evolved to seeking guidance on their erectile function. My logical question to them was 'What is your Urologist providing you with for assistance/guidance on improving things?" Their blanket answer was always 'Nothing'. So, I started hunting and exploring and found a whole new world...called penile rehabilitation (PR)! This involved educating both Urologists and patients on the many physical applications we could utilize to assist erectile dysfunction- this included medication such as Viagra & Cialis,

vacuum compression pumps (VCDs), intra cavernosal injections (ICI's) and potentially penile implants. In the early days, some of my local colleagues were infuriated with me and I received three professional letters asking me to STOP discussing ED with patients as 'men weren't interested in their sexual function'. Many years later penile rehabilitation is a standard and very necessary component of every physiotherapy consult I provide, with every Urologist I work with, now completely on board. The long- term outcomes of erectile function are definitely on the improve – and I'm sure, just like early PFM training, that the introduction of PR from the outset – even if just in discussion- helps a man recovery physically, psychologically and socially from the outset. Manhood and masculinity- I have learnt over the years- is very linked to the state of a man's penis...and he's generally very keen to improve things ASAP!**

WHAT ASPECTS OF TREATING THE OPPOSITE GENDER DO YOU FIND DIFFICULT (IF ANY)? DO YOU HAVE ANY RECOMMENDATIONS FOR OTHER THERAPISTS WORKING IN THIS FIELD?

Personally, I have always felt very comfortable working with males as I grew up with two brothers, was the only girl on the neighborhood street and have always enjoyed male conversation which is usually frank and often very funny! However, I know most men are absolutely mortified to be discussing their private parts in any capacity- let alone to an unknown female. My number one challenge, then is to develop trust and rapport immediately, by offering a strong handshake, direct eye contact and an invitation to bring a partner/companion into every consultation. Next, I sit down, side- by- side or across from the patient, without a desk as a barrier between us. I provide a lot of visual education initially- male anatomy models, worksheets (paper- this population tends to prefer to take something home in their hand) , pads to see (medium size Level 2 TENA, not'pull up pants' as this freaks most men out) Craig Allingham's 'Prostate Recovery Map' book and of course, PFM assessment via RTUS – with transabdominal approach on Day 1. My objective is to be open, educational, supportive, encouraging and respectful. I know most men don't even know they have a PFM, so even if I'm treating a Dr for e.g.,, I'll provide a basic anatomy lesson, just to familiarize and focus on all that they will need to understand to better equip themselves for a faster recovery. Surprisingly, talking about sex and erectile function, is not really a challenge for me or my patients, if they feel comfortable which all of the above, usually enables. We also have a highly motivated population as no man I've ever met is keen to be incontinent or impotent, so as a cohort of patients – you'll never work with easier, more obliging and more compliant ones! I've learnt so much from my patients too- including a whole new vocabulary with 'nuts; definitely the most internationally acceptable word to describe anything'down there'!! In light of this when teaching men PFM exercises, I'll use the correct terminology ' Squeeze the front passage to stop urine flow/ lift the testes and retract the penis' , but then 'humanize it – with a little bit of humour- by directing them to 'squeeze and lift nuts to guts '.....' 10 fast/ 10 slow'...etc.'

ARE THERE ANY ADJUNCT THERAPIES YOU FEEL GO ALONG WELL WITH PHYSIOTHERAPY WHEN TREATING THIS POPULATION?

EXERCISE! EXERCISE! EXERCISE! Every man I meet, from Day 1 is put on a walking program of up to 1 hour/day 5-7 days /week. In addition, he is invited to attend the 'PROST! Exercise 4 Prostate Cancer.inc' charity I established in 2012 for overall fitness and 'Nuts 2 Guts' training – a 1 hour, gym-based cardio & resistance program for any man diagnosed with prostate cancer. This helps to pre-operatively – lose weight, improve cardiovascular health, improve strength, balance and PFM function, but mostly to help him psychologically prepare as only men with a prostate cancer diagnosis are allowed to attend. This provides each man with a safe place to share his concerns and experiences in a masculine setting and many men (and their partners) tell me PROST! is the best thing they've ever done for themselves. Post-op many of my patients continue to attend - 8 years on- as some will need further treatment such as radiation, or hormone therapy, but most just get so much out of it on so many levels, that it brings them joy.

My conclusion is, if a man is working at things physically, I am simply providing him with the tools to fix himself – then he probably won't fall into a black hole; however, I certainly work with Psychologists and Sexual Medicine Physicians – who provide an integral service in a MDT that each man can access at any time. But exercise – including PFM training is definitely the best adjunctive therapy in my experience.
See **www.prost.com.au** for more information.

IS THERE ANY OTHER INSIGHT/INFORMATION YOU WOULD LIKE TO SHARE WITH OUR READERS?

Absolutely! My hunch is that every physiotherapist should have some level of men's health knowledge as men represent 50% of the global population. Sadly, men's health is 30 years behind women's health and 80% of all suicides are conducted

by men globally, with men living at least 5 years less than the average female in every country in the world!. There is also more prostate cancer (1 in 6 men) diagnosis vs breast cancer (1 in 8 men) globally and 9 out of the top 10 causes of death in males are preventable. There may be many physical causes relating to poor men's health generally, and as physiotherapists – we are the 'physical therapists' who can help change things at every consultation via the education process. It is an exciting time for our profession – we can do so much good- so upskill when you can and just consider 'men's health' as an opportunity to develop not only yourself, but the community around you. Also-look out for international men's health campaigns like 'Movember' and 'Prostate Cancer Awareness Month' in September every year. Grow a mo or get a man in your life to! Google your local prostate cancer support groups/ Men's Sheds… think 'blue', not always pink….seek information and ask your patients if they have any PFM concerns – bladder/bowel/ sexual health/ cardiovascular issues and refer on if they do- but mostly enjoy the educational process yourself. You will discover, just as I did, a whole new world – and a way to positively impact 50% of the global community. I promise you, it will be the most rewarding work you've ever done…and as Nelson Mandela always said, "Education is the powerful weapon which you can use to change the world"… PROST!!

*The results of the RRT and SET test, then provide a baseline for training. We want the RRT time to be less than 8sec (0.8 sec/ contraction) and up to 60sec for SET.
2018 & 2019 ANZCJ papers are available **on our website: womenshealthcpa.com**

**In addition, 1 in 6 men will experience Peyronie's disease (penile deformity) and without PR and PFM training to enhance penile blood flow- the biopsychosocial implications can be much worse! (Another chapter in my PhD- an unexpected one- with a paper currently in review!)

PELVIC HEALTH SOLUTIONS

www.pelvichealthsolutions.ca

Visit www.pelvichealthsolutions.ca for our regularly scheduled courses, including urinary incontinence and female & male pelvic pain (levels 1, 2 & 3)

The Male Pelvic Health Masterclass - April 24

The Evil Triplets of Pelvic Pain (and their friends…) - April 25-26

7th Pelvic Health Symposium - May 1

Body Image, Motor Skill Learning Midline For Pelvic Health - May 2-3

Pelvic Floor Support Systems in Postpartum Recovery, Pelvic Pain and Prolapse - May 24

CBT Skills For Distressing Physical Symptoms (Live Online Course) - May 27 start date

Mobilization of the Myofascial Layer: Pelvis & Lower Extremity - May 29-31

Bowel & Bladder Treatment of the Client with Neurologic Dysfunction - June 6-7

Pediatric Incontinence & Pelvic Floor Dysfunction - June 27-28

Treating & Training the Female Runner - July 11-12

Treating Male Pelvic Pain - July 18-19

The Female Athlete - July 25-26

Labour & Delivery: Maternal Support through Comfort Measures and Pelvic Biomechanics - Sept 18-19

Menopause: An Integrative Approach For Physiotherapists - September 26-27

Motivational Interviewing & Coaching Tools for Physiotherapists/Allied Health Professionals - October 2

Pediatric Incontinence & Pelvic Floor Dysfunction - October 3-4

The Assessment and Treatment of Breastfeeding Conditions - Oct 30- Nov 2

Nutrition & Physical Therapy for Pelvic Pain & Endometriosis - November 7-8

Gastrointestinal Disorders & The Pelvic Floor - November 13-14

Improving Pelvic Floor Function Through Spinal Manual Therapy - November 15

CBT Skills For Distressing Physical Symptoms - November 28-29

The Use Of Pessaries For Pelvic Organ Prolapse (POP) In Pelvic Floor Rehabilitation - Dec 5-6

Out Of Provinces Courses

The Use Of Pessaries For POP In Pelvic Floor Rehabilitation - April 4-5 / Calgary, AB

Oncology & The Pelvic Floor - April 17 / Calgary, AB

Level 1: Female & Male Urinary Incontinence - April 24-26 / Abbotsford, BC

Gastrointestinal Disorders & The Pelvic Floor - May 1-2 / Calgary, AB

Pregnancy, Pelvic Girdle Pain & The Pelvic Floor - May 1-3 / Beausejour, MB

Improving Pelvic Floor Function Through Spinal Manual Therapy - May 3 / Calgary, AB

Level 1: Female & Male Urinary Incontinence - May 22-24 / Calgary, AB

Pediatric Incontinence & Pelvic Floor Dysfunction - May 23-24 / Abbotsford, BC

The Assessment and Treatment of Breastfeeding Conditions - Oct 1-4 / Calgary, AB

Mobilization of Visceral Fascia: GI System - October 23-25 / Calgary, AB

The Use Of Pessaries For POP In Pelvic Floor Rehabilitation - November 7-8 / Abbotsford, BC

Labour & Delivery: Maternal Support through Comfort Measures and Pelvic Biomechanics - November 7-8 / Beausejour, MB

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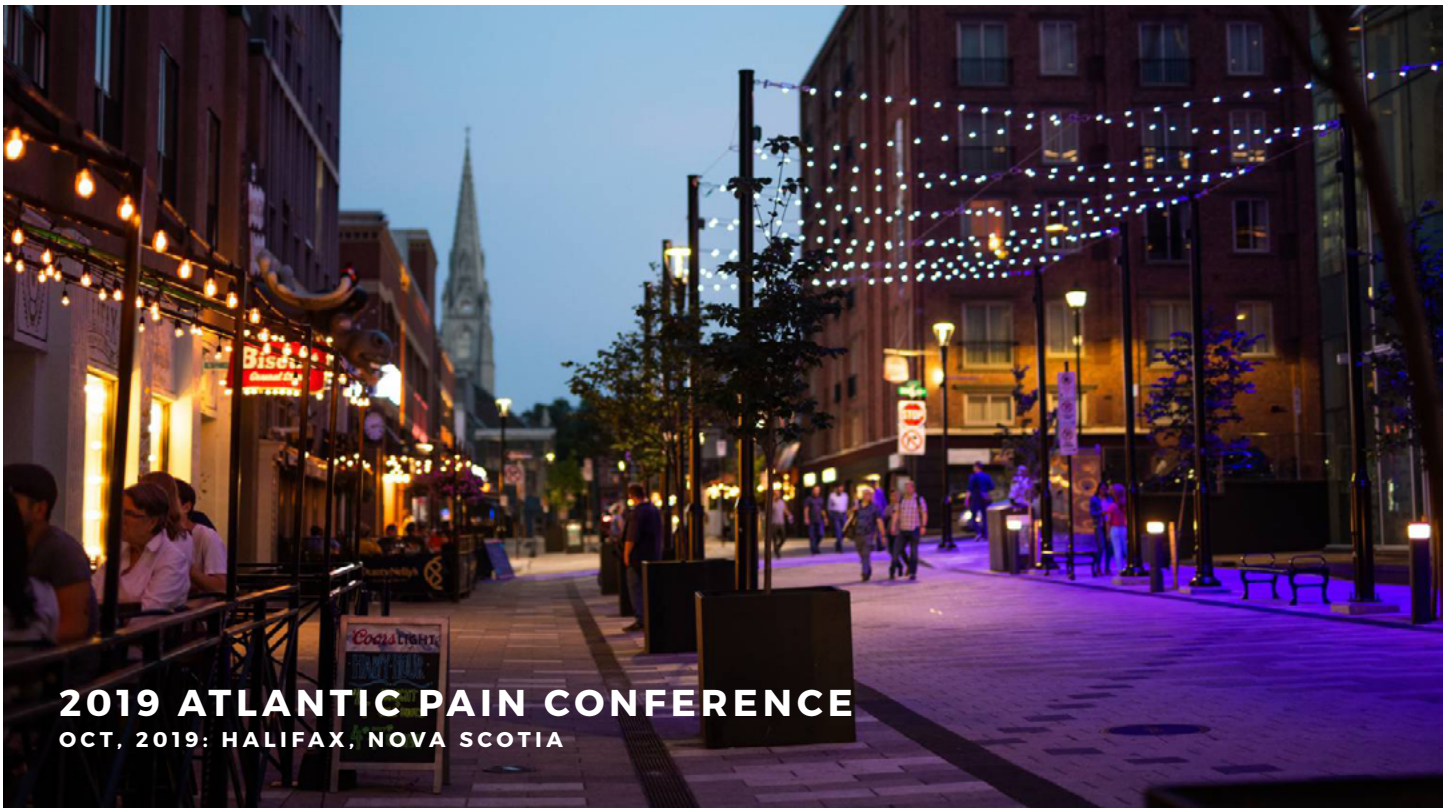


2019 ATLANTIC PAIN CONFERENCE

OCT, 2019: HALIFAX, NOVA SCOTIA

By Katie Kelly PT, member of the Newsletter Subcommittee

In October 2019, I was fortunate enough to be a presenter at the Atlantic Pain Conference, held in Halifax, NS. This is an annual conference of health practitioners eager to advance the discussions around chronic pain, with a focus on the East Coast of Canada. The general public is also invited to the event. This year, the event organizers were making a deliberate effort to highlight pelvic pain and hosted a panel on the topic. Besides myself, Dr. Ashley Cox represented Urology, Dr. Elizabeth Randle represented Gynecology, and a patient representative spoke to her experiences navigating the medical system with chronic bladder pain.

Our patient representative (who is remaining anonymous as I do not have her contact information to request permission to share her identity) opened the panel. It was incredibly brave of her to speak and share the affect of chronic bladder pain on her life – her relationships, her ability to engage in activities, and how she has had to search out practitioners who believe her and can offer help. Her story has likely been echoed in a number of our own patients. Sometimes it is so easy to start lecturing our patients on how we can help them, hammering away at a problem list, and offer them a number of treatment suggestions. However, the benefit of giving a patient uninterrupted time to share their story and experiences is a good reminder of the suffering that they live with on a daily basis, the human on the other side of the treatment and that they are more than just a 'pain patient'. Furthermore, sharing her story brought home the importance of us as practitioners to believe our patients and to really listen to their goals.

Dr. Cox is a co-author of the recently published 'Canadian Urological Associations Guideline: Diagnosis and Treatment of Interstitial Cystitis/ Bladder Pain Syndrome' (2016). The position of the CUA is that first-line conservative treatment should be patient education, dietary modification, sexual counselling, bladder training, and stress management techniques. These are to be followed by physiotherapy and massage therapy specific treatments. While we are an obvious choice for manual based therapies of the pelvis, I feel that pelvic floor physiotherapists are also well-equipped to offed patient education, sexual counselling, stress management and bladder training as well.

Dr. Randle highlighted her recent experience studying endometrial excision surgery at the Ottawa Hospital. Her expertise allows Atlantic Canadian patients to once again have access to excision surgery without having to travel to central Canada. Her presentation highlighted how this can be particularly useful for more complex cases of endometriosis, such as extensive disease in the rectovaginal area. Her surgical images and videos were particularly interesting in demonstrating

From left to right: Dr. Randal, Dr. Cox, Katie Kelly, PT.

assessment of deep endometriosis. When deep endometriosis infiltrates the muscalaris propria of the rectum or rectosigmoid is replaced by adhesions a distinct "moose antler" appearance can be seen on transvaginal ultrasound scan.

After advocating for pelvic floor physiotherapy for almost a decade, where a common response from other practitioners was typically, "I didn't know that physiotherapists could treat that. Is there evidence for it?" I'm happy to report that pelvic floor physiotherapy is openly accepted as an evidence-based treatment for many chronic pelvic pain conditions. Furthermore, health care practitioners seem to be very interested in our role of treatment for central sensitization. Among the 'top-down' treatment methods I highlighted, I included diaphragmatic breathing, meditation, stress management, the use of de-threatening language, non-noxious manual-based therapies, graded motor imagery, catching and correcting negative self-talk, spending time in nature, pain science education and graded exposure to painful activities.

I am happy that the landscape of chronic pelvic pain is changing and that we seem to be moving towards a truly multidisciplinary approach. While limited time seems to be a barrier for interdisciplinary communication, when we do get together to collaboratively treat our patients, innovative treatments methods emerge, the success of our treatments can increase and I believe the patient feels better cared for. I look forward to the future of care in Atlantic Canada.

INTERNATIONAL PELVIC PAIN SOCIETY - 2019 ANNUAL SCIENTIFIC MEETING ON PELVIC PAIN

OCT 17-20, 2019: TORONTO, CANADA

By Suzanne Thompson, PT and Clinic Owner
Suzanne is a physiotherapist and owner of a multi-disciplinary clinic in Cranbrook, BC. She has worked in both private practice and the fitness industry since 1988. Suzanne began her pelvic floor practice in 2005 and has attended many courses and conferences across Canada, the US and Europe. In 2018, she graduated with a Masters of Rehabilitation Sciences (UBC) and presented her systematic review "The Influence of Pelvic Organ Prolapse on Female Sexual Dysfunction and Quality of Life" at the CPA's Congress in Montreal. A life-long learner, she has a keen interest in women's health and enjoys working with her clients in a whole person approach to care. Suzanne also loves time with her 2 kids, travel, and many outdoor pursuits.

For the first time ever, Canada played host to the IPPS Annual Scientific Conference. When it was first announced to be in Canada, I knew I had to go. Sure, England is closer, cheaper and faster to Toronto than Cranbrook, BC … But I wanted to be part of a strong Canadian contingent present at this world class conference. It was sure to be an incredible learning experience as well as a time to connect with new colleagues and old friends. This year, I attended the Pre-Conference Course, Clinical Foundations: An Integrated Approach to the Evaluation and Treatment of Chronic Pelvic Pain. It was a full day of interactive Q & A style information, with a variety of presenters from multiple disciplines. A great clinical overview, topics ranged from urology, gastroenterology, neuro-muscular foundations, pain pathophysiology, behavioural therapy and pharmacology. The afternoon moved into physical assessment demonstrations and group case studies. Overall, it was a very worthwhile day of overview with a few new insights and some good reminders.

The main conference was a Friday - Saturday event. Each day kicked off with an early morning yoga session. Canadian PT Shelly Prosko wakes early to enthusiastically lead a group through a yoga session that will inspire and invigorate the most tired of bodies! Her positivity and enthusiasm is contagious!

Dr. Catherine Allaire, from UBC and BC Women's Center was the 2019 winner of the James E. Carter Pain Achievement Award. She presented the keynote lecture "Endometriosis: Towards Prevention of Chronic Pelvic Pain". Twice, I have witnessed her receive a standing ovation from her world-wide colleagues for her work. She is truly a highly regarded and inspiring leader in her field and it is always a pleasure hearing her present.

Canada and physiotherapy continued to be very well represented, with Carolyn Vandyken and Linda McLean both at the podium presenting on "Pelvic Floor Muscle Dysfunction and Lumbopelvic Pain", and "Evaluation and Monitoring of Pelvic Floor Dysfunction: The Intersection Between Technology and Clinical Evaluation" respectively. Marie-Pierre Cyr, MPT, presented her abstract "Altered Pelvic Floor Muscle Function in Gynecological Cancer Survivors Suffering from Dyspareunia". They were all fantastic presentations and so well received!The presentations throughout the entire conference were varied, with something to address every interest. Research and lectures in pain science, visceral pain syndromes, endometriosis and dysmenorrhea, vulvar-vaginal pain syndromes, musculoskeletal, sexuality and sexual function, psychology and novel treatments were all presented with speakers addressing all demographics of clients.

Unfortunately, I was unable to stay for the post conference session. If you know Carolyn Vandyken, you know it was phenomenal! Along with Alison Sim, their day-long session addressed "Self-Efficacy in Pelvic Pain: From Science to the Clinic".

If you have never been to an international multidisciplinary conference, I would encourage you to bring your technology. Notebooks, laptops, smart phones, rocket books ..... and a pen and paper. Whether answering interactive quiz questions – to downloaded notes and slides – to a fast phone app that has all your presentations right at hand – its slick.

And what conference would be without its social opportunities? Great conversations and lots of laughter was shared over lunch and coffee breaks, between viewing poster presentations and at the trade fair, and at the Thursday evening Welcome Reception and Friday evening "Silent Disco".

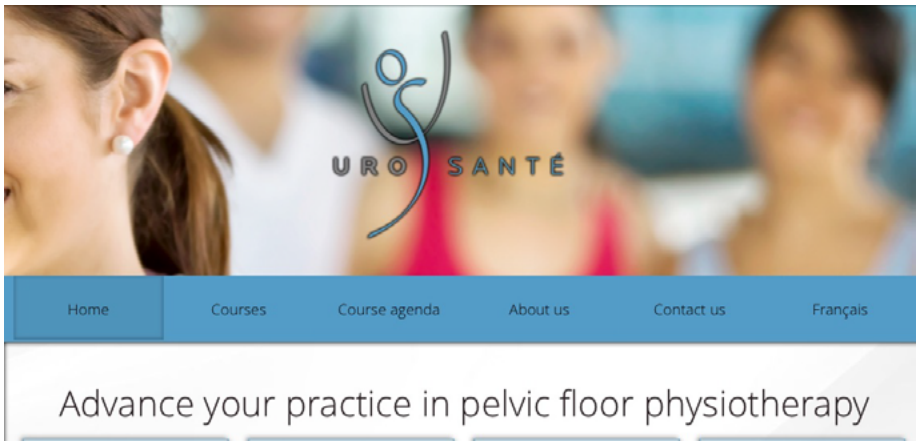
I do have to say that Nelly Faghani from Pelvic Health Solutions sure knows how to throw a cocktail party! While not on the conference agenda, it was a highlight to be sure! So much fun and good food was had – thanks Nelly!

As a physiotherapist, I have always enjoyed learning at hands-on courses. But there is something special about these multi-disciplinary international conferences. I was told early on that if I ever had the opportunity to attend an ICS, IUGA or IPPS conference, I should jump at it. It takes you out of the physio-focused clinical practice and gathers you into a large fraternity of clinicians and researchers coming together and excited at the continuing progress that is being made in the area of pelvic health. The science may seem daunting, however, it is also exciting and reassuring. There is so much we are doing right; and so much more we are learning to do - all to become better clinicians for the people that entrust us with their care.

There are so many great conferences coming up in 2020! Chat it up with your colleagues – perhaps we will meet at one soon!

Pelvic Floor Physiotherapy Courses

www.physiourosante.com



*Courses offered to Physiotherapists only

The Physical Therapy Approach to Female Urinary Incontinence (entry level),
Calgary, AB, Mar. 6-9 2020 AND Halifax, NS, Oct 16-19 2020

NEW! The Physiotherapy Assessment of Breastfeeding Related Conditions:
Maternal & Infant Factors (with Mercedes Eustergerling),
Québec, QC May 1-4 2020 (in English)
No previous experience in breast health or pediatrics is required.
*Labs include breast palpation and manual techniques. (This course is open to **ALL physios**)*

Yoga and the Pelvic Floor (with Diana Perez)
Montreal, QC September 11-12 2020

NEW! The Special Considerations for Caesarean Section:
Preparing for and recovering from belly birth (with Katie Kelly),
Montreal, QC Sept. 26-27 2020 (in English)
No prerequisites required
*(This course is open to **PT's, OT's, Kinesiologists ….see website for complete list**)*

COMBO: Physiotherapy for Ano-Rectal Disorders (2.5 days) AND
The Physical Therapy Approach to Male Pelvic Health (1.5 days)
Calgary, AB, Nov. 6-9 2020

L'approche Physiothérapeutique pour la Dyspareunie
Québec, QC Nov 27-29 2020 (in French)

For course details and registration go to:
www.physiourosante.com **info@physiourosante.com**

Claudia Brown and Marie-Josée Lord

PELVIC FLOOR PHYSIOTHERAPY FOR MALES: THE PATIENT-THERAPIST PERSPECTIVE

By Maria Radelich, PT
*in conjunction with Rick**

Maria Radelich is a Physiotherapist who completed her Masters of Physiotherapy through Dalhousie University. She found a passion for pelvic health in her senior year of school and pursued Pelvic Health immediately upon graduation. She has completed course work in Female and Male Urinary Incontinence, Female and Male Pelvic Pain, and Clinical Skills for Treating Chronic Pain. She has also completed course work in female athletes and return to sport and acupuncture and dry needling for pelvic health. Her passion is the amalgamation between sports medicine and pelvic health and hopes to continue providing services to help patients enjoy physical activity and exercise without pelvic health concerns. Maria can be found at the Bedford Orthopedic Health Centre and you can follow her on Instagram and Facebook under @mariaradelich or contact her through her website www.mariaradelichpt.ca.

I want to share with you the case of my patient Rick*, who has agreed to share his story on how pelvic floor physiotherapy made a difference for him throughout his journey after prostatectomy.

Rick was extremely nervous the day of his initial assessment. He was walking into yet another appointment that was "unknown" and knew it wasn't exactly the place he wanted to be on a Monday morning.

Rick had been followed for many years by Urology due to elevated PSA levels. It came time that the surgeon determined a prostatectomy was the preferred treatment option. Luckily, Rick has a very supportive partner who attended the appointments with him, and he knew that a second pair of ears never hurt when going to consultations that can often feel very rushed. He was told that incontinence and decreased sexual function would be risks but he felt that "it didn't really sink in."

"I KNEW THAT IN STRESSFUL SITUATIONS I WOULDN'T HEAR ALL THE POINTS."

As a PT, this is the number one reason I always allow the patient to bring whomever they want in the room to take part in their care. Bring your team. Asking questions, even if frequently repeated, are always encouraged as I recognize this is a component of solidifying information.

After Rick's surgery he had frequent follow-up appointments with the surgeon, however, these were focused on the surgical procedure and how the healing process was taking place. He was incontinent and he had "no idea how long it may take to stop, or at least reduce the incontinence." He knew he really needed guidance to make sense of when and how he could make progress.

RICK EXPLAINED: "ONE DAY IN THE EARLY STAGES, I WAS SO DISTRAUGHT THAT I CALLED MY SURGEON'S OFFICE. I WANTED TO ASK IF THERE WAS ANYONE WHO I COULD CALL ABOUT ISSUES RELATED TO MY SURGERY. AS MANY TIMES AS I TRIED, I COULD NOT SPEAK WITH ANYONE. I LEFT A MESSAGE, AND NO ONE EVER GOT BACK TO ME."

It was after this experience that his partner, who happens to be an occupational therapist, looked into other methods of help. She came across a PT colleague who suggested to see a physiotherapist with pelvic health training. Sadly, this isn't always a known option, especially for our men. Often, we discuss referrals and how we can make pelvic health physiotherapy more well known but one of the best referral sources we have is our fellow colleagues. They are very supportive of our work.

"I NEEDED SOMEONE TO PROBLEM SOLVE WITH, AND DISCUSS ISSUES NO MATTER HOW SMALL THEY SOUNDED."

On Rick's initial appointment, we did an hour and a half assessment. I listened, we spoke and we asked each other questions. After going through a long spiel (like I always do) about what an exam may entail, he agreed. What Rick heard was "we are going to work on this issue together and you will

improve." That was what he needed to hear.

Generally, I don't make guarantees about functional improvement, but statistically he had good odds of improving and if anything, I was sure we could progress his overall health. My goal was to give Rick confidence that he could have some control regarding his condition. I was also open with him that there are times we can't change everything, and he seemed to understand that, but he just wanted a direction.

Like many men I see, Rick had been given the "handout" after surgery on Kegels. It was stressful for Rick, because he felt like he was following the instructions but noticed no improvement. When we went over them together, he started to realize the significant difference between being taught through a sheet of paper and in-person guidance. It quickly became apparent that the exercises he had been completing were less than ideal and also unrealistic for Rick. The sheet read "Hold for 10 seconds", but Rick's endurance was only 3 seconds at best. This is where we compromised to aim for 4 seconds, which became a huge relief for Rick and seemed a lot more manageable.

"DURING THE INITIAL STAGE, I GRADUALLY BECAME DEPRESSED."

We all noticed it. Rick, myself and Rick's partner. We were open about it. I regularly asked Rick how he was doing, but then dug deep on how he was doing mentally and emotionally. I never used the word depression, because it isn't in my scope of practice to diagnose, yet I could start to recognize the signs and symptoms. We talked about feelings of being down and feeling tired and I encouraged Rick to talk to his doctor about it. At first, he declined medication, but then agreed it may help. This is part of that biopsychosocial approach we all preach. We have a responsibility to watch for these conditions in patients as we are primary health care practitioners. It is our job to help navigate the system and advocate for those in need. It was also helpful to be a point of contact if medications weren't going in the right direction, or undesirable side effects were occurring as we are usually seeing these patients regularly. If something wasn't right, we would know and could help identify new solutions or suggest another referral.

The medication did help. Slowly, we made goals that were realistic and achievable for Rick. Walking with Rick's partner was a motivation for him, but he was exhausted even walking to the bench in his local neighborhood. He was always so worried about the leaking. My response was: "Rick, you're definitely going to leak, but you are also going to leak if you stay at home. This way you get to spend time with Ann* and get to work on those heart and lungs!" He laughed and agreed. Slowly but surely, he was walking 30 to 45 minutes. His mood changed and so did his leaking.

"WE ARE IN THIS TOGETHER. MARIA WAS PREPARED FOR ME. SHE KNEW WHAT WAS NEXT BUT COULD ALSO ADJUST DEPENDING ON THE INFORMATION I PROVIDED. I WAS THE INDIVIDUAL SHE FOCUSED ON."

I'll be honest, I love that he thinks I was prepared. The truth is that I was adaptable. Things don't always go as planned but what makes physiotherapists so great, is that we are okay when something unexpected occurs. I learned this through all of my wonderful mentors. It was humbling to know that many of them didn't always have the answers and weren't sure of the next step either. To me, a great physiotherapist isn't one who knows all the answers or knows every technique, but can be versatile in any given situation.

I was tough on Rick when I felt like he could handle it. "If I was doing an exercise right, I was told. If my approach was wrong, I was told and showed how to do it correctly". There would be days we would both laugh in frustration, but we always adjusted the goal or exercise to allow for a realistic challenge.

To this day, Rick has improved to a point where leakage is only "minor," with few occasional drops during the day and "NO MORE PADS!" When I asked Rick if he would recommend this service to others, his response was:

"I would say it is required. I don't see any way a person could successfully progress in recovering from this type of surgery without the help I received. I vividly remember those months when I was quite down and didn't know what to do. I felt welcome. I needed and received positives and all of my concerns were addressed."

As a final note, I think that Pelvic Health Physiotherapy is so much more than stopping leakage. At first, as much as I wanted Rick to stop leaking, I cared more for his overall health. In some ways, I worked more in the cardiorespiratory realm of physiotherapy than I did on his pelvic floor! I am a huge advocate that pelvic health PTs know more than just the pelvic floor and I think that's what makes us so awesome!

*Names have been changed to keep identities anonymous

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*The above testimonials are provided by users of RepaGyn®. Results with RepaGyn® may vary on an individual basis.

1. Chen, John, et al. Functions of Hyaluronan in Wound Repair. Wound Rep Reg 1999; 7:79-89.

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RESEARCHER'S CORNER

ABHISHEK P. PATEL

ANATOMY & PHYSIOLOGY OF CHRONIC SCROTAL PAIN

Abstract:
This article reviews the anatomy and physiology of the scrotum and its contents as it pertains to chronic scrotal pain. Physiology of chronic pain is reviewed, as well as the pathophysiology involved in the development of chronic pain" (Patel 2017).

Reference:
Patel AP. Anatomy and physiology of chronic scrotal pain. Translational andrology and urology. 2017 May;6(Suppl 1):S51.

Click Here to view the full article.

JOANNE E MILIOS, CERL L ATKINSON, LOUISE H NAYLOR, ET AL.

APPLICATION OF TWO PELVIC FLOOR MUSCLE FUNCTION TESTS IN MEN FOLLOWING RADICAL PROSTATECTOMY: RELATIONSHIP TO URINARY INCONTINENCE

Abstract:
This study examines the impact of posture and measures of urinary incontinence relating to two non-invasive, real-time, ultrasound-based tests. Using real-time ultrasound with transperineal and transabdominal approaches, we previously assessed pelvic floor muscle function in men and found the rapid response and sustained endurance tests possessed strong reliability in both supine and standing postures, and for both ultrasound approaches. However, questions remained pertaining to the relationship of the tests to other outcome variables, including measures of urinary incontinence. Participants (n=95) undergoing radical prostatectomy were assessed to determine the relationship between incontinence and pelvic floor muscle function, as seen on ultrasound. The presence and severity of incontinence was measured via 24-hour pad weight. When related to pad weight, the transabdominal protocol produced weak to moderate correlations between the rapid response test in standing (r=0.43) and supine (r=0.46), and the sustained endurance test in standing (r= −0.56) and supine (r=−0.56). Similar results were found using the transperineal approach. All Bland-Altman analyses showed no significant difference (p>0.05) between the two postures, for either test or scan approach. While the plots also demonstrate no heteroscedasticity or proportional bias, with the bias being close to 0, the magnitude of variation in difference scores suggests different outcomes for tests performed in standing compared to supine postures. We present two simple tests that provide objective, non-invasive, and reproducible assessment of pelvic floor muscle function in men that relate to the clinical outcome of urinary leakage.

Reference:
Millios JE. et al. Application of two pelvic floor muscle function tests in men following radical prostatectomy: relationship to urinary incontinence. Australian and New Zealand Continence Journal. 2019, Vol 25(1), pp 4-8.

Click Here to view the full article.

RESEARCHER'S CORNER

JOANNE E MILLIOS, CERL L ATKINSON, LOUISE H NAYLOR, ET AL.

PELVIC FLOOR MUSCLE ASSESSMENT IN MEN POST PROSTATECTOMY: COMPARING DIGITAL RECTAL EXAMINATION AND REAL-TIME ULTRASOUND APPROACHES

Abstract:
This paper reports three studies. Study 1 assessed the degree of association between traditionally used digital rectal measures, and real-time ultrasound assessments of pelvic floor muscle function in men who report incontinence following prostatectomy. Study 2 compared transabdominal and transperineal approaches to view the pelvic floor using real-time ultrasound. Study 3 explored inter- and intra-observer reliability of two functional tests using realtime ultrasound: a rapid response test requiring participants to perform 10 rapid pelvic floor muscle contractions with elapsed time recorded, and a sustained endurance test wherein participants performed a single sustained pelvic floor muscle contraction with task failure visually confirmed and elapsed time recorded. A modest correlation was observed between the rectal assessment of squeeze pressure and objective perineometer measures ($r=0.51$, $p<0.05$). Rapid response test ($r=0.18$, $p=0.36$) and sustained endurance test ($r=0.18$, $p=0.36$) assessments were unrelated to pelvic floor muscle squeeze pressure measured by perineometry. Strong agreement was found using Bland-Altman analysis for both the rapid response and sustained endurance tests when they were performed using transabdominal and transperineal approaches, or when determining inter- and intra-observer reliability. The two simple functional tests using real-time ultrasound provide objective, non-invasive and reproducible assessment of pelvic floor muscle function that is more acceptable to men than rectal approaches.

Reference:
Millios JE. et al. Pelvic floor muscle assessment in men post prostatectomy: comparing digital rectal examination and real-time ultrasound approaches. Australian and New Zealand Continence Journal. 2018, Vol 24(4), pp 4-11.

Click Here to view the full article.

BECOME PART OF THE WHD COMMITTEE

WE ARE LOOKING FOR SECRETARY, COMMUNICATIONS CHAIR & SOCIAL MEDIA CHAIR

Time commitment:
~1 hour per week
+ 1 hour Zoom meeting per month

These roles come up for renewal in spring of 2020, with the option of staying. Experience is an asset, but not mandatory.

If interested in any of these roles, please contact Devonna Truong at **whdsecretary@gmail.com**.

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RESOURCE: A TOUCHY SUBJECT!

By Victoria Cullen

Victoria Cullen is a Sexual Function Specialist and PhD candidate at RMIT University. She obtained her Bachelors and Masters in Cognitive Psychology from University College London. She works with prostate cancer patients at a private oncology clinic, Cancer Specialists, in Melbourne Australia. In 2015 she co-founded the world's first sex toy design course in an academic setting at RMIT University. This was featured in The Age and on The BBC. In 2017, she partnered with Urology Surgeon, Professor Declan Murphy, to deliver a complimentary consultation to his private radical prostatectomy patients. She delivers free weekly educational videos and articles on sexual recovery through her website: **atouchysubject.com** *where you can also buy products and online courses focused on sexual confidence and education post treatment.*

To learn more about Victoria, please **Click Here.**

My website offers free educational resources for men and their partners experiencing sexual function changes following prostate cancer treatment.

In particular you might find the following useful to pass on to patients and colleagues:

My YouTube channel of how to videos including product comparisons, and the latest penile rehabilitation literature. I post a new video every week.

YouTube: youtube.com/atouchysubject

My video yesterday was on what vacuum devices are best for erectile dysfunction, how they work, what is best for different goals and situations:

Click to View the Video

I have comprehensive and regularly updated guides on pleasure and sensuality, injection therapy and penile rehabilitation, all accessible through my website homepage:

Click to View: Pleasure/Sensuality

Click to View: Injections for Ed

I also sell the Vacurect device through my website, this is my recommended medical grade vacuum device for men after prostate treatment after speaking to hundreds of men about their vacuum pump experiences:

Click to View Vacuum Device

I have a free recovery guide on continence, erections, sexuality and psychology post prostate surgery that you and your patients can sign up to through my homepage by email (this also gives you a weekly free educational resource about sexual recovery).

WHD AWARDS ARE NOW OPEN FOR APPLICATION: UNTIL MARCH 31.

NEWSLETTER ADVERTISING RATES 2020-21

The Women's Health Division has an ever-growing membership of over 700 physiotherapists.

Our quarterly publication is national, reaching physiotherapists from coast to coast.

DEADLINES FOR ADVERTISING SUBMISSIONS

NEWSLETTER ISSUE:	DEADLINE:	PUBLICATION DATES:
Spring 2020	April 15th, 2020	Between May 1 and 15, 2020
Summer 2020	July 15th, 2020	Between August 1 and 15, 2020
Fall 2020	October 15th, 2020	Between November 1 and 15, 2020
Winter 2021:	January 15th, 2021	Between February 1 and 15, 2021

For more information please contact: Marylène Charette, **treasurer.whd@gmail.com**

ADVERTISING RATES 2020-21*

SIZE	PER ISSUE SINGLE ISSUE PRICE	PER YEAR FULL YEAR PRICE (4 ISSUES)
¼ page	$50	$175
½ page	$100	$350
¾ page	$125	$450
Full page	$150	$525
2 pages	$250	$875

E-BLAST ADVERTISING

E-blasts are sent out monthly to our members. Advertising can include upcoming courses and/or job listings.

	WHD MEMBERS	NON-MEMBERS
One listing per blast	$50	$55
Each additional listing per blast	$20	$25

**Please note that these prices are subject to GST/HST according to location of advertiser.*

NEWSLETTER ADVERTISING RATES 2020-21

Course Listings should include the following: Company name, course name, dates, times and location as well as a brief description (max 75 words). Company logo will not be included in the listing.

Job Listings should include the following information: Company name, contact name and email, position available, contact phone number, website, city and province, closing date and a brief description (max 75 words).

WEBSITE ADVERTISING

All job postings and course listings on the website are free and will be posted in our members only section of our website. We offer this service for free so our members can continue to grow, but we encourage all companies to consider giving back to the WHD by creating or sharing resources or patient handouts with us to be added to our Members only section.

Please send all pertinent information to **whdwebsite@gmail.com** as outlined above for the e-blast

- Course postings will remain on the website until the date of the course
- Job listings will remain on the website until the closing date or for two months
- Optional a pdf of a patient handout that you are willing to share with our members.
- Please consider offering a WHD member discount for your courses.

Women's Health

A DIVISION OF THE CANADIAN PHYSIOTHERAPY ASSOCIATION

SPRING 2020 NEWSLETTER

WORD FROM THE CHAIR

> Storms make trees grow deeper roots.
> Dolly Parton

Working from home.

In the midst of this COVID-19 pandemic, I am sure that your practices and lives have all changed in unprecedented ways. I have not been into the hospital to work in about five weeks and have been seeing a few of my private practice clients with telehealth. Perhaps you have been redeployed if you work in the public health sector? Perhaps you are staying at home caring for your children and trying to keep them busy? Although this is a challenging time, it too shall pass. I feel blessed that we are living in a time when there are many opportunities to connect with family, friends and coworkers in a virtual capacity.

With the cancellation of Congress 2020 due to the pandemic and all the activities that we had planned around that, the Women's Health Division (WHD) executive has decided to continue to work through our strategic planning online. We are planning to have a virtual Members Meeting on Tuesday June 23rd. We hope that you attend, as this is a time for you to share with us the ideas and visions that you have for the WHD in the next three to five years. Your input will have a direct impact on our decisions for the strategic plan. The meeting will also include elections for the positions on the executive that are coming up for renewal (Communications Chair, Social Media Chair, Secretary, and Chair).

The WHD will be hosting a couple of webinars this spring: the first one will be brought to us by Katie Kelly (who has been valiantly working on the newsletter subcommittee for the last few years!) will present on May 20 about PT management of women with Cesarean sections. The second webinar is brought to us by our student representative Linnea Thacker on the topic of physiotherapy for the transgendered population. Please join us for it on June 9. Also, if you were looking forward to the WHD post-Congress course presented by our very own Jessica Bergevin (Communications Chair), she recently offered it as an Embodia webinar instead entitled Assessment and Treatment during Pregnancy for the Orthopaedic Physiotherapist. Take a look on the Embodia website and sign up for it!

Finally, it is with mixed emotions that I write this, my last Chair's Address, as my term as Chair of the WHD comes to a close. It has been such a blessing to work with such a driven, intelligent, fun and talented group of women. However, I am really excited that Devonna Truong (currently Secretary) will be taking my place. She is an amazing, energetic and skilled physiotherapist who will take the WHD in some exciting new directions. I can't wait to see her in action!

Juliet Sarjeant
Chair, Women's Health Division of the Canadian
Physiotherapy Association Physiotherapist

> Turn your heart toward what is good by cultivating forgiveness and compassion and mindful presence. See the good in one another. Jack Kornfield

IN THIS ISSUE

EDITOR'S NOTE

Welcome to the spring issue of the WHD Newsletter! We hope that it will provide you with a good distraction and a little sense of normalcy during these crazy times.

Having said that – we chose a "crazy" complicated topic to explore – MENOPAUSE. Why crazy? You ask? Well... It's not just that there are so many different elements to menopause itself, it's also that when you go to the research, there are so many contradicting evidence and findings to read through! The newsletter committee – Katie Kelly, Leslie Spohr, and I did our best to summarize and present to you the best information we could, in the most concise manner.

Speaking of our committee – we are excited to welcome Angelique Montano-Bresolin to our team. You will find a wonderful handout she made (which will become available for you to download on our website), explaining menopause to patients. After chatting about her contribution to this issue, she also agreed to join our team. The four of us will continue working on bringing you high quality information about pelvic and women's health!

If you have any questions you have been wondering about and would like us to look into, please let me know at **whdnewsletter@gmail.com**.

Enjoy the read!

Katerina Miller, PT
WHD Newsletter Editor

WOMEN'S HEALTH DIVISION EXECUTIVE MEMBERS

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Secretary	Devonna Truong	whdsecretary@gmail.com
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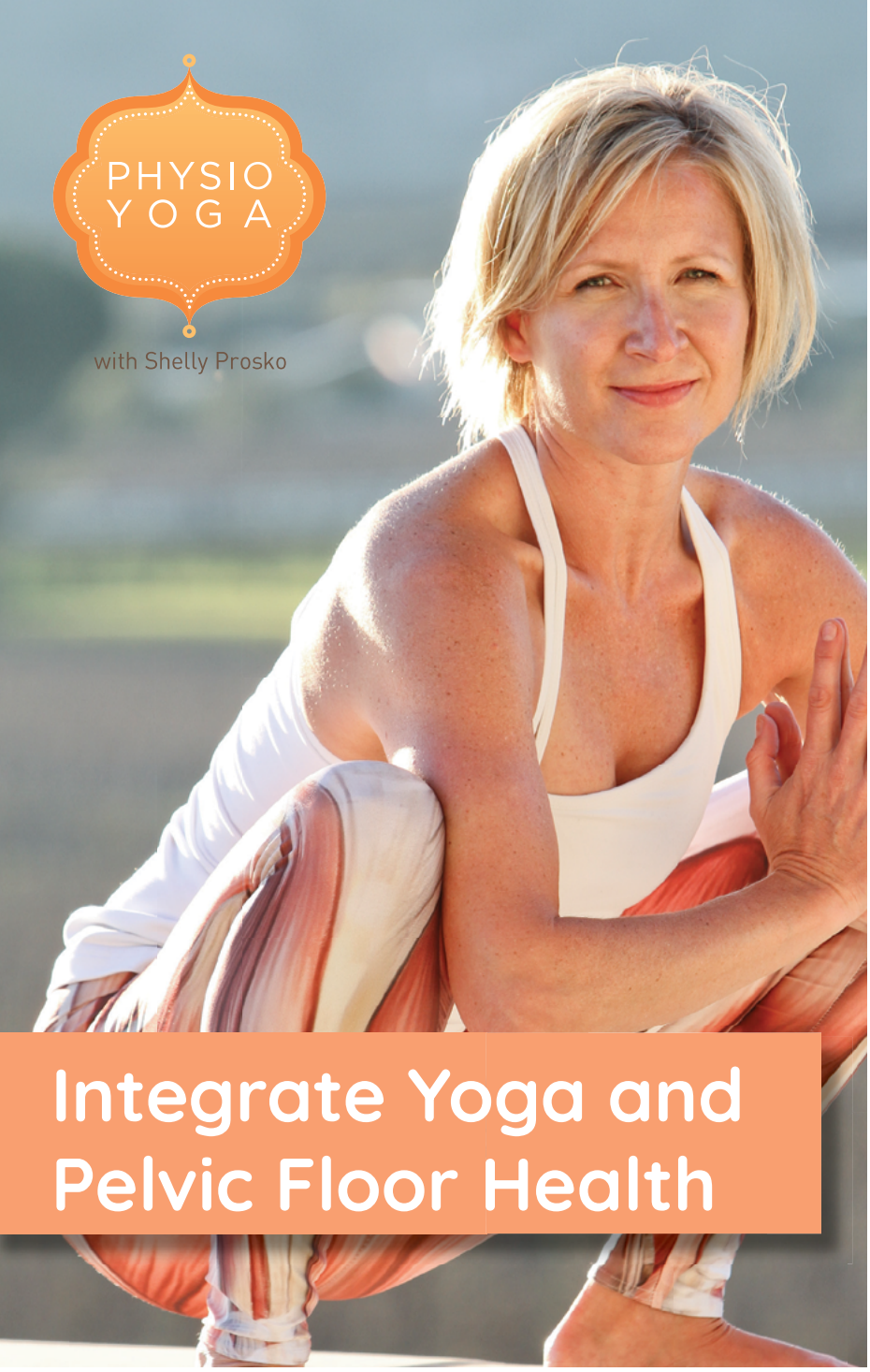

PHYSIO YOGA

with Shelly Prosko

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MENOPAUSE
THE BASICS

By Katerina Miller, PT, WHD Newsletter Editor

This article is a summary of information that is meant to introduce you to menopause. Some things you know, while others might be a good addition to your knowledge. The information provided here is a generalization, based on what most women experience. Please keep in mind that there are many women who have different experiences.

WHAT IS MENOPAUSE?

Menopause is the time in a woman's life when she no longer has menstrual cycles, for a consecutive 12 months. This marks the end of a woman's reproductive years, and usually occurs between ages 45 and 55. [1,2]

SIGNS AND SYMPTOMS OF MENOPAUSE

Signs and symptoms of menopause usually start with simply irregular periods, as the levels of estrogen and progesterone begin to fluctuate (perimenopause), and can last for several years. 1, 2 After menopause (postmenopause), some of the symptoms tend to resolve (such as hot flashes and memory problems). Overall, menopause could last between 7 and 14 years. Please keep in mind that menopause symptoms are vast and complex. There are many hormonal fluctuations at this time of life, and there is no clear clinical picture at this time.

Some of the symptoms many women experience: [1, 3, 4]

- Irregular periods (during perimenopause – pregnancy is still possible)
- Hot flashes
- Urinary incontinence
- Pelvic organ prolapse
- Chills
- Night sweats
- Difficulty sleeping
- Vaginal dryness
- Overall dry skin
- Weight gain and decreased metabolism
- Decreased breast fullness
- Depression
- Anxiety
- Trouble focusing
- Memory problems
- Hair loss from the head
- Hair growth on the face
- Decreased libido
- Increased urination
- Increased instances of urinary tract infections
- Headaches
- Decreased muscle mass
- Decreased bone density
- Painful or stiff joints
- And more...

TESTS THAT CONFIRM MENOPAUSE

*The following tests are used for multiple reasons. The explanation here is in the context of menopause, and may not include other uses. This is not a list of all the available tests; just the most commonly used 4.

- Anti-Müllerian Hormone (AMH) Test – AMH levels are an indication of a woman's fertility, by providing information about her "ovarian reserve" (how many eggs she has left). This test is used to determine the start of menopause, find out the reason for an early menopause, as well as when women have difficulties getting pregnant, amenorrhea, diagnosing Polycystic Ovary Syndrome (PCOS), and more.

- Estrogen Levels Test – in the context of menopause, this test is used to monitor effects of treatments that are being done to treat S&S of menopause.

- Follicle-stimulating hormone (FSH) level test – in women, FSH stimulated the growth of eggs in ovaries and ovulation. Due to this, in a woman in childbearing years, the levels of this hormone will fluctuate based on where she is in her cycle. In women who started menopause, or are in perimenopause, this hormone will be found in high levels.

- Dried Urine Test for Comprehensive Hormones (DUTCH) - This is a relatively new test that is not yet readily available. 5 The DUTCH is able to provide information about how hormones are being metabolized. For example, an analysis of estrogen is pertinent information for estrogen dominance patients where their levels are lowering, but not as fast as progesterone, before causing symptoms.

WHY DOES MENOPAUSE HAPPEN?

In most cases, this is a natural, biological process, which happens in every woman. Women are born with a certain number of eggs in their ovaries, which produce oestrogen and progesterone; these hormones control the menstrual cycle and ovulation during a woman's reproductive years. When eggs are no longer released from the ovaries (for different reasons, discussed later on), menopause happens.[2, 3, 4]

REASONS OTHER THAN NATURAL CHANGES THAT TRIGGER MENOPAUSE:

- Hysterectomy – When only the uterus is removed, but the ovaries are maintained, a woman will stop having periods, but will NOT enter menopause right away, as the hormones estrogen and progesterone are still being made in the ovaries.[3]

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- Total hysterectomy with oophorectomy – When the uterus, cervix, and ovaries are removed, there is no more production of estrogen and progesterone, and therefore meno menopause will begin right away. The S&S of menopause may be more severe than under normal circumstances, as the hormonal change happens abruptly instead of over time. [3]

- Chemotherapy – Women receiving chemotherapy treatment for breast cancer may have damage to their ovaries (ovarian failure). This, in turn, may cause a dysfunction in hormone production, and trigger menopause. The younger the woman, the better are her chances to get her period back once treatment is finished.[6, 7]

- Radiation Therapy – Women who need to go through radiation to their ovaries are at a greater risk of premature menopause. The effect seems to be dose dependent. [8]

- Ovarian Insufficiency (premature/early menopause) – This is when there is a depletion or dysfunction of the ovaries, and therefore a cessation of the period in a woman younger than 40 years of age. There is no known reason for the condition, and it is very important that these women receive both physical and mental support upon diagnosis. [9]

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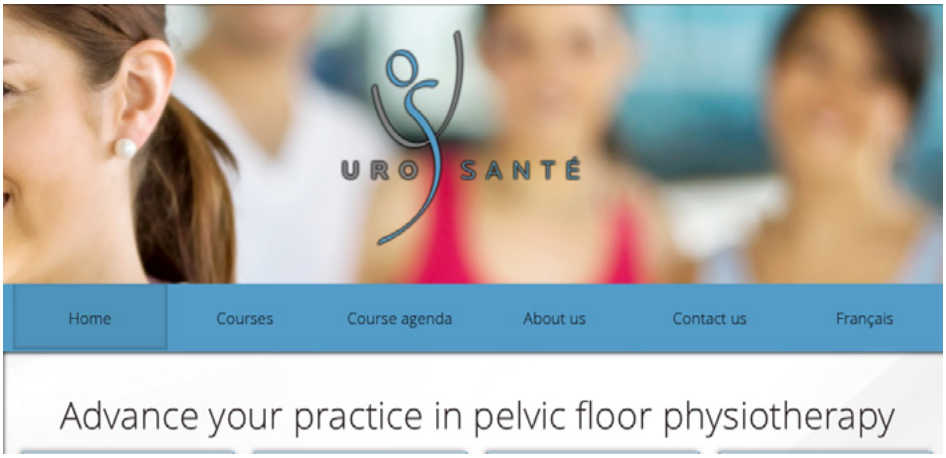

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Claudia Brown and Marie-Josée Lord

THE ROLE OF PHYSIOTHERAPY IN MENOPAUSE: AN INTERVIEW WITH MICHELLE LYONS

By Katie Kelly, PT, WHD Newsletter Subcommittee Member

Michelle Lyons' Biography:
I qualified as a physio in 1994 and started my career in sports medicine, working with one of Ireland's leading football teams. I had my daughter in 2000 and did not have a great obstetric experience, which was really the catalyst for changing career trajectory into women's health. My passion has always been helping women live well, so over the years I've added skills to my toolbox – yoga and Pilates teacher trainings, mindfulness as a therapeutic intervention and nutrition and coaching, all of which, I think, complement our core physio skills. I've spent most of the past decade teaching internationally, and as well as my clinical consulting, I've been delighted to present at conferences including the International Pelvic Pain Society, International Continence Society, the Combined Sections Meeting of the American Physical Therapy Association, the Pelvic Obstetric and Gynae Physiotherapy Association, the British Pelvic Floor Society, the Klose Lymphedema conference and of course the Woman on Fire conference in the UK which I co-curate with Jenny Burrell. Spreading the pelvic health gospel is something I'm deeply passionate about, and I've been privileged to do it all over the world.

Want to learn more about Michelle Lyons? You can follow/reach her here: Website: **celebratemuliebrity.com** *(free resources here, and you can sign up for her newsletter), FacebookGroup: Global Pelvic Physio, Instagram:* **@michellelyons_muliebrity**

COULD YOU TELL US WHAT MOTIVATED YOU TO PRODUCE SO MUCH EDUCATION AROUND PHYSIOTHERAPY FOR MENOPAUSAL WOMEN?

In the world of women's health, the focus has been on either specific issues, such as urinary incontinence or the peri-natal year, and although these are hugely important individual topics, what I wasn't seeing in our world of pelvic health, was an awareness of how the menopausal transition (and life beyond) impacts women. I realised that menopausal women were a hugely under served population and there wasn't enough awareness of how menopause and ageing affects not only pelvic health, but also heart, brain, bone and metabolic health.

For example, many of the pelvic health issues we see at menopause, such as bladder, bowel, sexual or prolapse dysfunctions, can often be traced back to previous obstetric events but with a changing hormonal profile (oestrogen alone has approximately 300 separate functions in the female body!), these pelvic health issues can be an impediment to leading a full rich life, with issues ranging from sexual health to a reluctance to exercise because of fears around continence or prolapse. Too many women are directed towards medical or surgical interventions as a first line, when often education can be helpful (for example around lubrication/ sexual ergonomics/ exercise prescription) which we as physiotherapists can provide.

> "We need to take an overview of the whole person – and not be too 'vagina-centric'! How is she sleeping? Are hot flashes/night sweats disturbing her rest?"

Sometimes, we can zoom in on a person's 'problem' or dysfunction, but I think that as physios, we can zoom out and see the big picture too – so for example – a peri-menopausal women who is having pain with sex – is it because of vulvo-vaginal issues? Or pelvic floor muscle dysfunction?Or an ortho issue like gluteal tendinopathy, which affects 1 in 4 women in their 50's?

We need to take an overview of the whole person – and not be too 'vagina-centric'! How is she sleeping? Are hot flashes/ night sweats disturbing her rest? (We can then discuss strategies like sleep hygiene, or guided imagery/ CBT which has been shown to decrease hot flashes by up to 46%) Is it a partner-based issue? If she has a male partner in the same age range, it's worth remembering that the prevalence of erectile dysfunction in men in their 50's is around 50% and increases approximately 10%/decade.

When we realise how lucky we are, as physios, to have the gift of time with our clients (never enough, I know, but more than many of our healthcare colleagues!) and we can couple that with knowledge of the specific issues that peri and post menopausal women may be dealing with, then we can take a whole woman overview and ask specific questions that are relevant to a particular life stage – really having that depth of knowledge and a commitment to a truly biopsychosocial approach – that is often the missing link in menopausal wellness.

CLINICALLY, WHAT ARE YOU SEEING AS SOME OF THE GREATEST CONCERNS THAT PRE/POST-MENOPAUSAL WOMEN HAVE THEMSELVES? DO YOU HAVE ADDITIONAL CONCERNS FOR THESE WOMEN ABOUT THINGS THAT THEY MIGHT NOT BE AWARE OF?

Generally, what I hear from women going through menopause, is a list of concerns about mood, sleep and weight gain – all of which are responsive to behavioural change. What I would like to see, is more awareness about heart health and brain health in women as we age.

Whenever I do a community-based talk, to non-healthcare professionals, and I ask: 'what is the biggest killer of women after the menopause?' Almost inevitably, the answer is breast cancer. Breast Cancer is undoubtedly a huge issue for millions of women worldwide, but it isn't the biggest killer of women – that would be heart disease. Allowing for some minor international differences, generally in the Western world, 1 in 9 women will be diagnosed with breast cancer, and 1 in 36 will die from it.

Contrast that to 1 in 3 women dying from a cardiovascular event. Women have different symptoms of a heart attack, are lesslikely to be responsive to the standard (male) treatment approaches and are more likely to be sent home from hospital with an affective diagnosis like anxiety or depression. For too many women, the first time their heart attack is diagnosed is after it kills them. Similarly, dementia, especially Alzheimer's, affects disproportionately more women than men. Is this because up until menopause, oestrogen has a huge cardio-protective and brain protective function? Probably.

Do we have a magic bullet for these diseases? No…but we do know that lifestyle changes, especially exercise, sleep and stress management are key factors in managing and hopefully reversing these issues. That is where I would love to see a re-emergence of physiotherapists – as confident prescribers of bespoke and advanced exercise strategies, tailored to accommodate pelvic health, bone health and any other issues a woman may be facing!

AS PHYSIOTHERAPISTS, WHAT IS OUR ROLE IN THE MANAGEMENT OF MENOPAUSE IN OUR PATIENTS?

When I was a baby physio, our anatomy lecturer would always remind us that 'a good physio is her voice and her two hands'. I would amend that to include, 'and her two ears as well'. I think one of the ways we can really help women going through menopause is as Educators – which means listening to her concerns, asking the right questions and listening to her answers and then collaborating with her to come up with problem solving strategies, involving exercise, lifestyle and empowerment.

> "Do we have a magic bullet for these diseases? No…but we do know that lifestyle changes, especially exercise, sleep and stress management are key factors in managing and hopefully reversing these issues. That is where I would love to see a re-emergence of physiotherapists..."

WHICH OTHER HEALTH PRACTITIONERS DO YOU FIND VALUABLE FOR COLLABORATION WITH YOUR MENOPAUSAL CLIENTS?

I work closely with a crack team of fitness professionals – I'm clinical consultant for the Holistic Core Restore coaches, and I think working with well educated fitness professionals, who understand (to quote Dr Nieca Goldberg) 'that women are not small men'!

I also think working with ob/gyn's and gp's who are aware of the research supporting a combined approach to menopausal pelvic rehab is fantastic – the evidence shows that topical hormone therapy in conjunction with pelvic rehab works better than either approach individually.

THERE ARE SO MANY MYTHS AROUND MENOPAUSE. ARE THEIR ANY PARTICULAR MYTHS ABOUT SYMPTOMS OR CURES THAT YOU CARE TO COMMENT ON? ALTERNATIVELY, ANY PET PEEVES?

One of the key messages to get across would be that hormone therapy at menopause is not a cure all, and doesn't get you off the hook if you aren't making good choices in terms of exercise, food, alcohol, sleep hygiene or stress management. It can be so easy to blame everything on the menopause – but we do have to acknowledge that we are also ageing as we transition through menopause; that we can probably no longer get away with the lifestyle choices we were making in our 20's now that we are in our 50's!

> "...we play a huge role in educating women about how their bodies work, and in strategies for regaining quality of life when bumps in the road happen."

But also, that if we show our bodies some care and attention and listen to the messages we are being sent, we can live well during and especially after the menopause! If we remember that the average age for menopause around the world is 51, and the average life expectancy for women is 80...there is a lot of living to be done after menopause and we have a huge amount of information and skills to help women live well!

DO YOU BELIEVE THAT THERE IS A ROLE FOR PHYSIOTHERAPISTS TO PLAY IN HORMONE EDUCATION?

Absolutely! I firmly believe that 'Knowledge is Power!' and that we play a huge role in educating women about how their bodies work, and in strategies for regaining quality of life when bumps in the road happen. I'm quite fond of saying that many women know more about their phones than they do about their own bodies...and that we can motivate women to make good lifestyle choices if they know why we are making recommendations.

For example, if central weight gain is an issue, we can talk about how cortisol, adrenaline and progesterone interact, and how looking at stress management and sleep hygiene might be as important as good food choices. The days of women accepting medical advice unquestioningly has passed (I hope!) so we need to have confidence in discussing menopausal changes at both a macro and a micro level.

WE KNOW THAT YOU LOVE TO TALK ABOUT CONSTIPATION! WHY IS THIS SUCH AN IMPORTANT TOPIC WITH RESPECT TO MENOPAUSE?

Constipation may just be the answer to everything! It's how we excrete excess oestrogen (many of the 'symptoms' of meno-pause are due to an imbalance of oestrogen relative to progesterone). Constipation is also linked to bladder urgency, prolapse, back pain and mood disorders. Our gut and bowel function changes as we age, and we have to take that into account when we are looking at menopausal health issues – foods that we used to tolerate well may become problematic.

We all have our own bowel- based stress responses – some favour constipation, others veer towards diarrhoea. Our enteric nervous system and the role of the vagus nerve are only just beginning to be fully explored. Constipation in particular, can also be driven by pelvic floor muscle dysfunction or slow transit through the intestines, or dehydration, or lack of exercise...

Ultimately, I am a subscriber to the belief that not only you are what you eat, but you are what you eat, absorb and don't poop out! (Disclaimer: I am moderately obsessed with good bowel function!)

WOULD YOU CARE TO SHARE YOUR TOP TIPS FOR MANAGING MENOPAUSE SYMPTOMS?

Prioritise self care. Movement is non- negotiable. Alcohol is not your friend if you are having hot flashes, night sweats, disturbed sleep, weight gain or mood swings. Aim to eat a primarily plant-based diet, with a goal of 30 different plants per week. Make sleep a priority. Make sure you have joy and fun in your life. And if you have any pelvic health issues, bladder or bowel or prolapse or sexual problems, go and see a good women's health physio!

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HORMONES, MENOPAUSE AND DIETARY INFLUENCES: AN INTERVIEW WITH JESSICA DRUMMOND

By Leslie Spohr, PT, WHD Newsletter Subcommittee Member

Jessica Drummond Bio:
Dr. Jessica Drummond, DCN, CNS, PT, NBC-HWC is the founder and CEO of The Integrative Women's Health Institute and the author of Outsmart Endometriosis. She is passionate about caring for and empowering people who struggle with women's and pelvic health concerns. She is equally passionate about educating and supporting clinicians and wellness professionals in confidently and safely using integrative tools to transform women's and pelvic healthcare.

Dr. Drummond has two decades of clinical experience as a licensed physical therapist, licensed clinical nutritionist, and board certified health coach working with women with pelvic pain, including endometriosis, vulvodynia, and bladder pain syndrome. She brings a unique, conservative and integrative approach to supporting women to overcome hormonal imbalances, and chronic pain conditions. She is a sought after international speaker on topics such as integrative pelvic pain management, natural fertility options, optimal hormone health, menopause, and female athlete nutrition.

She loves farmer's markets, art museums, eating great food, and having girls movie nights with her daughters. She lives and works from her home and offices in Fairfield, Connecticut and Houston, Texas reaching thousands of clients and professional students in over 60 countries through her virtual practice and educational programs.

Dr. Drummond was educated at the University of Virginia, Emory University, Duke Integrative Medicine, and Maryland University of Integrative Health.

PLEASE TELL US A LITTLE BIT ABOUT YOURSELF, YOUR TRAINING AND HOW YOU ENDED UP WHERE YOU ARE IN YOUR CAREER.

I began my career as a physical therapist in 1999. I focused my practice on orthopedics, sports medicine and women's health. I loved working as a clinical physical therapist, and worked for many years in a women's health specialty hospital. Then, in 2003, after the birth of my first daughter, I got sick myself. Likely, I had a reactivation of the Epstein Barr Virus, and had significant endocrine symptoms. I struggled for years with anxiety, fatigue, and other challenging symptoms. I had to quit my job, move, and focus entirely on my health for several years. Since that time, I decided to learn more about nutrition because it was so essential to my recovery. I found that nutrition was such a valuable tool, not only for my healing but for my patients who struggled with chronic pelvic pain conditions.

WHAT ARE THE MAJOR HORMONES INVOLVED THROUGHOUT A WOMAN'S LIFESPAN?

There are many. The hormones that I most commonly need to address in my practice are insulin, cortisol, thyroid hormones, estrogen, progesterone, and testosterone.

WHAT ARE THE TYPICAL HORMONAL CHANGES THAT OCCUR PRE- AND POST-MENOPAUSE.

In peri and post-menopause, the key factor is low estrogen, which does affect insulin sensitivity as well. And, many women struggle with cortisol imbalances, low stress resilience and low progesterone and testosterone.

DO YOU SEE (AND IF SO, CAN YOU DESCRIBE) A RELATIONSHIP BETWEEN CERTAIN HORMONAL CHANGES AND SOME OF THE SIGNS AND SYMPTOMS WOMEN EXPERIENCE DURING MENOPAUSE?

Yes, here they are:

- Pelvic pain: Often associated with cortisol and insulin dysregulation and high or low estrogen.
- Bowel function: not specifically related, though bowel changes can be seen premenstrually with hormone dysregulation.
- Urinary/Fecal Incontinence/Urgency: Generally not related to hormone imbalance.
- Pelvic Organ Prolapse: Can be related to low testosterone, and low pelvic floor muscle strength due to the lowered testosterone.
- Libido: Related to low estrogen and testosterone.
- Weight changes: Thyroid and cortisol dysregulation.
- Sleep: Cortisol and insulin dysregulation, and declining estrogen.
- General energy/Mood: Any endocrine dysregulation.

IN YOUR OPINION, ARE THERE "NORMAL" AND "ABNORMAL" MENOPAUSAL SYMPTOMS?

Not really, ideally there are few menopause symptoms beyond irregular periods and eventually the periods stopping. It's common, but not optimal to experience hot flashes, heavy periods, abdominal weight gain, hair loss, and vaginal dryness/atrophy, and low libido.

CAN YOU HIGHLIGHT THE MAJOR CONTRIBUTING FACTORS TO SYMPTOMS ARISING FROM HEIGHTENED HORMONAL CHANGES (SUCH AS PROLONGED HOT FLASHES, POOR SLEEP, ETC.) AND BRIEFLY DESCRIBE HOW YOU GO ABOUT TREATING THEM?

This is a vast question, but all of the common symptoms of perimenopause can be related to endocrine shifts. However, I find that clinically addressing digestive, immune and nervous system health first often allows the endocrine imbalances to resolve on their own.

> "All health professionals should offer preventative nutrition advice - since all of our patients eat every day."

WHAT IS YOUR CLINICAL OPINION REGARDING THE LINK BETWEEN FOOD AND MENOPAUSAL SYMPTOMS?

The key driver of perimenopausal symptoms when it comes to food is associated with the insulin resistance shifts that happen in perimenopause. Thus, the key foods to remove are sugar, alcohol, and processed grains. And, it's essential to add foods high in fiber, fat and antioxidants - primarily vegetables, herbs and spices, and healthy fats like avocado and olive oil.

CAN YOU DISCUSS SOME OF THE FOODS THAT MIGHT IMPACT MENOPAUSAL SYMPTOMS NEGATIVELY? POSITIVELY?

Negatively: Sugar, alcohol, processed grains, and in some cases - factory farmed meats.

Positively: High quality sources of animal protein, vegetables (the more the better), low sugar fruits like berries and citrus, healthy fats like avocado, olives and olive oil, nuts, and seeds, and herbs and spices, especially oregano, garlic, cinnamon, turmeric (curry), ginger, rosemary, and others.

CAN YOU COMMENT ON THE IMPORTANCE OF TIMING FOR NUTRIENT INTAKE (MORE SPECIFICALLY, ARE THERE ANY NUTRIENTS THAT ARE BETTER TAKEN AT CERTAIN TIMES OF THE DAY)? DO YOU HAVE ANY OPINIONS ON WHETHER INTERMITTENT FASTING PLAYS A ROLE IN HORMONAL MANAGEMENT?

Intermittent fasting can be helpful for people with stable blood sugar, and those still cycling just before ovulation. Ideally until blood sugar is stable, it's best to eat within 30-60 minutes of waking, and then every 6 hours or so, three times daily. Breast cancer recurrence can be significantly reduced with a nightly 12 hour fast (stop eating at 7pm and don't start again until 7am). For immune support, optimizing blood sugar balance and then doing a longer fast - such as 7pm to 11am is ideal.

WHEN WOMEN START TO ALTER THEIR DIET TO HELP WITH MENOPAUSE, WHAT IS THE TYPICAL TIME FRAME NEEDED TO NOTICE AN EFFECT?

Usually around 3 months, but often changing the diet is not enough. We often need to do lab testing to look at digestive function, and support that with supplements. Plus, most women also need to address their stress, sleep, and movement practices.

IN YOUR OPINION, WHAT IS THE ROLE OF PHYSIOTHERAPISTS IN TREATING WOMEN GOING THROUGH MENOPAUSAL CHANGES? IF APPLICABLE, DO YOU HAVE ADVICE FOR PHYSIOTHERAPISTS WITH REGARDS TO OFFERING DIETARY ADVICE WHILE STAYING WITHIN THEIR OWN SCOPE OF PRACTICE?

I think physiotherapists have a major role to share. All health professionals should offer preventative nutrition advice - since all of our patients eat every day. And, PT's can also address sleep, stress, and exercise, which are also key to optimizing perimenopausal health.

IS THERE ANYTHING ELSE YOU WOULD LIKE TO SHARE?

For more information on perimenopause and nutrition and other topics, check out our blog: **integrativewomenshealthinstitute.com/blog/**

Thank you so much for sharing your knowledge with our readers, Jessica. We really appreciate your time!

RESEARCHER'S CORNER

SHERYL A. KINGSBERG, MICHAEL KRYCHMAN, SHELLI GRAHAM, BRIAN BERNICK, AND SEBASTIAN MIRKIN

THE WOMEN'S EMPOWER SURVEY: IDENTIFYING WOMEN'S PERCEPTIONS ON VULVAR AND VAGINAL ATROPHY AND ITS TREATMENT

INTRODUCTION: Vulvar and vaginal atrophy (VVA) affects up to two thirds of postmenopausal women, but most symptomatic women do not receive prescription therapy.

AIM: To evaluate postmenopausal women's perceptions of VVA and treatment options for symptoms in the Women's EMPOWER survey.
Methods: The Rose Research firm conducted an internet survey of female consumers provided by Lightspeed Global Market Insite. Women at least 45 years of age who reported symptoms of VVA and residing in the United States were recruited.

MAIN OUTCOME MEASURES: Survey results were compiled and analyzed by all women and by treatment subgroups.

RESULTS: Respondents (N = 1,858) had a median age of 58 years (range = 45–90). Only 7% currently used prescribed VVA therapies (local estrogen therapies or oral selective estrogen receptor modulators), whereas 18% were former users of prescribed VVA therapies, 25% used over-the-counter treatments, and 50% had never used any treatment. Many women (81%) were not aware of VVA or that it is a medical condition. Most never users (72%) had never discussed their symptoms with a health care professional (HCP). The main reason for women not to discuss their symptoms with an HCP was that they believed that VVA was just a natural part of aging and something to live with. When women spoke to an HCP about their symptoms, most (85%) initiated the discussion. Preferred sources of information were written material from the HCP's office (46%) or questionnaires to fill out before seeing the HCP (41%).The most negative attributes of hormonal products were perceived risk of systemic absorption, messiness of local creams, and the need to reuse an applicator. Overall, HCPs only recommended vaginal estrogen therapy to 23% and oral hormone therapies to 18% of women. When using vaginal estrogen therapy, less than half of women adhered to and complied with posology; only 33% to 51% of women were very to extremely satisfied with their efficacy.

CONCLUSION: The Women's EMPOWER survey showed that VVA continues to be an under-recognized and under-treated condition, despite recent educational initiatives. A disconnect in education, communication, and information between HCPs and their menopausal patients remains prevalent.

REFERENCE: Kingsberg SA, Krychman M, Graham S, Bernick B, Mirkin S. The women's EMPOWER survey: identifying women's perceptions on vulvar and vaginal atrophy and its treatment. The journal of sexual medicine. 2017 Mar 1;14(3):413-24. **Click Here** to view the full article.

MENOPAUSE AND VAGINAL DRYNESS HANDOUT *(Next Page)*

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Angelique received her training in the area of pelvic floor rehabilitation both in Canada and the United States through the Herman and Wallace Pelvic Rehabilitation Institute, Uro Sante, Pelvic Health Solutions, and the American Physical Therapy Association. She has acted as a Clinical Internship Supervisor and Guest Lecturer for the University of Toronto Physical Therapy Program and the Ryerson University Midwifery Program. Angelique also acts as a teaching assistant for the educational company, Pelvic Health Solutions. In 2012, she founded Proactive Pelvic Health Centre, Toronto's first private multi-disciplinary clinic in Toronto devoted to pelvic health rehabilitation for people of all genders, ages and stages of life.

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Women's Health
A DIVISION OF THE CANADIAN PHYSIOTHERAPY ASSOCIATION

MENOPAUSE AND VAGINAL DRYNESS

Menopause is a normal physiologic event in the lives of women and transmales. Some may see it as 'the end of the road' or even a disease or disorder, but perhaps we should be shifting our perspective and viewing this stage of life as a transition, just like many of the other natural transitions we go through.

What is Menopause?

An individual has reached menopause when a period of twelve consecutive months has passed without menstruation. The average age one goes through menopause is ~52, however the range can vary widely from approximately 40-58 years of age.

What is Peri-Menopause?

Peri-menopause is the time period leading up to menopause. During this phase, individuals will experience fluctuations in hormone levels (primarily estrogen and progesterone) which may contribute to a vast number of menopausal symptoms. Peri-menopause may last on average for 6-8 years and some of these changes usually begin in one's mid-to-late 40's or early 50's.

Common Symptoms

Systemic symptoms such as: night sweats, hot flashes, fatigue, insomnia, weight gain, mood swings, and memory issues.

Local symptoms within the pelvis and vulvovaginal area may include: irregular menstrual cycles, changes in vaginal health such as - vaginal dryness, a decrease in muscle and collagen tissue flexibility, changes in vulvar skin texture and appearance, burning, itching or skin irritation.

Other Pelvic Health Changes

- urinary incontinence (bladder leakage)
- increased urgency or frequency of urination
- an increase in urinary tract infections as the pH balance of the vagina changes with a decline in hormone levels

If you, a friend or family member is struggling with vaginal dryness or other menopause related symptoms, please seek out medical advice. Let's keep the conversation going and reduce the stigma associated with this natural transition in life.

What about Sex?

Changes in sexual function and loss of sexual desire can act as a negative influence on a person's self-esteem and personal relationships. This is in part due to how prevalent vaginal dryness is in the peri to post-menopausal population. Literature supports that ***50% of post-menopausal women will have symptoms of vaginal discomfort within three years of menopause.***

What the Statistics show:

A North American Menopause Society (NAMS) study discovered the following findings post-menopause:

- 58% of women avoided intimacy due to vaginal discomfort
- 64% of women experienced loss of libido due to vaginal discomfort
- 64% of women experienced pain associated with sex
- 30% of men & women ceased having sex altogether due to vaginal discomfort

We can see how the local symptom of vaginal dryness associated with menopause can cause such drastic changes to one's relationship and quality of life.

How do I treat Vaginal Dryness?

NAMS suggests a stepwise (non-hormonal to hormonal) approach for treating vaginal dryness which includes:

1. Vaginal Moisturizers and Lubricants
2. Low Dose Vaginal Estrogen
3. Oral or Transdermal Hormone Therapy

Non-hormonal options such as lubricants and vaginal moisturizers can easily be obtained over the counter.

Vaginal lubricants are more immediate-acting and provide temporary relief from vaginal dryness and pain related to sexual activity. They are not well absorbed by the skin but come in a variety of forms and textures (water, oil or silicone based).

Vaginal moisturizers such as RepaGyn, Gynatrof or Replens are quite helpful to reduce pain and friction but also play a role in healing damaged tissue and helping maintain vaginal moisture and acidity. If applied regularly, the effects are more long lasting.

Created by: Angelique Montano-Bresolin, PT

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Symptoms	Change	Symptoms	Change
Dryness	71.0%	Fissures	78.3%
Dyspareunia	50.5%	Inflammation	86.7%
Burning	66.0%	Redness	78.5%
Itching	85.0%	Tension	79.5%

The majority of symptoms showed a highly significant improvement ($p<0.005$) after 20 days of treatment

‡ 95 breast cancer patients suffering from vaginal dryness (induced by chemotherapy or hormone treatment) were assessed after receiving RepaGyn® (once daily for 20 days, followed by a maintenance period of twice per week for 10 weeks)*

RepaGyn® is a hormone-free, natural health product.

The recommended dosage is one vaginal ovule daily, preferably at bedtime, for at least 2-3 weeks. Each box contains 10 ovules.

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* RepaGyn® is also known as Cikatridina®, Cicatridine®, Cicatridina®

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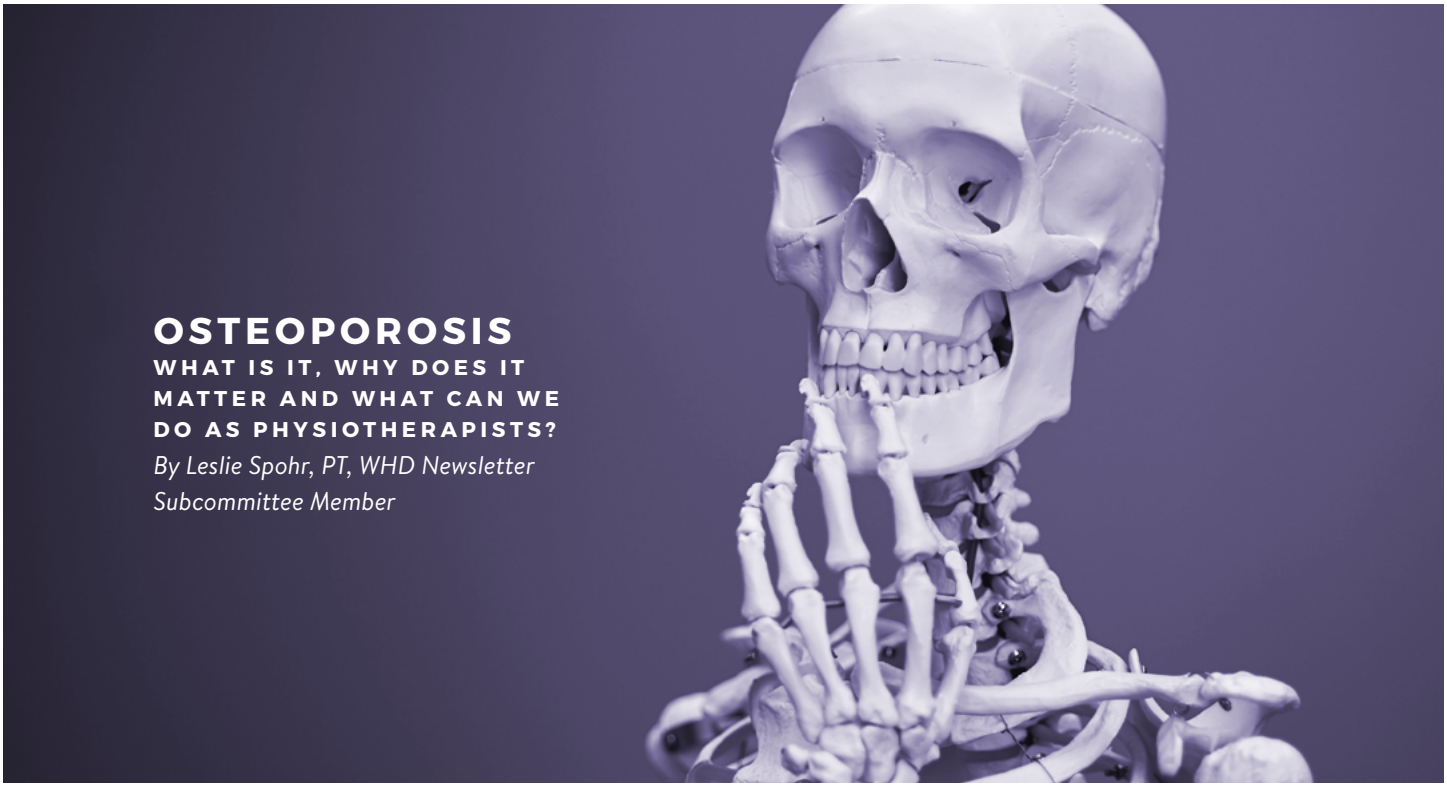

OSTEOPOROSIS

WHAT IS IT, WHY DOES IT MATTER AND WHAT CAN WE DO AS PHYSIOTHERAPISTS?

By Leslie Spohr, PT, WHD Newsletter Subcommittee Member

WHAT IS OSTEOPOROSIS?

Osteoporosis, a disease characterized by low bone mass and deterioration of bone tissue which can lead to an increased risk of fracture, is thought to affect more than 70% of postmenopausal women.1 The underlying mechanism is an impairment of the micro-architecture of the trabecular bone structure. Osteoporosis resulting from another disease or condition, or from the treatment of another condition, is known as secondary osteoporosis. [1,2,3]

The most common areas for fractures related to osteoporosis are the spine, wrist, hip and shoulder. Since the deterioration of bone can occur gradually over time with little to no symptoms, it is often known as the "silent thief". By the time a fracture occurs, the disease is often so advanced that treatments are less favourable.[1]

Approximately 40% of women diagnosed with osteoporosis will experience a fragility fracture at some point in their life.4 After an initial fracture, the risk for subsequent fracture more than doubles in the following 6-12 months. Evenmore, research has shown that within 12 months of a hip fracture, 1 in 3 people will die, 40% will be institutionalized or unable to walk independently and 60% will still require some level of assistance a year post-fracture.4 Osteoporosis is considered a global health concern because of its association with pain, disability, loss of functional independence and increased morbidity and mortality.[4]

WHO IS AT RISK?

Over 2 millions Canadians are impacted by osteoporosis and approximately 1 in 3 women and 1 in 5 men will experience an osteoporotic fracture in their lifetime. As life expectancies rise and lifestyles shift to favor less daily physical activity, it is projected that the number of osteoporotic fractures will increase globally.[5]

There are several well known risk factors for osteoporosis: [1, 5, 6]

- Age
- Genetics
- Gender
- Low Calcium/Vitamin D intake
- Smoking
- Low body weight
- Menopause status
- Bedrest/immobilization

Major risk factors for osteoporotic fracture are:[1,5]

- Advanced age
- Low bone mineral density
- Previous fracture as an adult, or a parent with a history of a fractured hip
- Increased Falls risk

One of the well known predictors of a potential fracture is Bone Mineral Density (BMD), which is often described by either

a T- score or a Z-score (both are units of standard deviation (SD)).

- T-score: the number of SDs an individual's BMD differs from a mean value expected in young healthy individuals of the same gender. For each SD decrease there twice as much risk for a fracture.

By this measure, osteoporosis is defined as a T-score (of the femoral neck) that is 2.5 SDs below the young female adult mean.[7]

- Z-score: is the number of SDs an individual's BMD differs from a mean expected value of those of similar age, gender and ethnicity. This measure is often used in severe cases only.

Although BMD is a decent measure of risk, limitations in bone densitometry (DXA) (in accuracy of reading as well as the information provided) means many low impact fractures (80%) still occur in those with "normal" BMD.[7]

TREATMENT AND PREVENTION OF OSTEOPOROSIS

The primary goal in treating osteoporosis is to slow down bone loss and prevent fractures. Bone loss in postmenopausal women occurs at a rate of 0.6% - 2/1% per year after the age of 60, typically ~1.5% in the first 4-5 years.[7]

Management for osteoporosis focuses first on nonpharmacologic measures, including:[5]

- Physical Activity/Exercise
- Strength Training
- Balance exercises
- Postural exercises
- Nutrition
- Eating a balanced diet
- Having adequate calcium and vitamin D intake
- Lifestyle Changes
- Smoking cessation
- Avoidance of excessive alcohol intake
- Fall Prevention

Pharmaceuticals, directed toward bone mineral density, have shown to be 20-60% effective (depending on the medication used, patient population and patient adherence), and is often a first line of treatment for this population.4 If pharmacologic therapy is indicated, options include:[1,5]

- Bisphosphonates (ex. Fosamax ® , Actenol ®)
- Denosumab (ex. Prolia ®)
- Selective estrogen-receptor modulators (SERM) (ex. Evista ®)
- Parathyroid hormone (ex. Forteo)
- Hormone Therapy (ex. estrogen/progesterone, Calcitonin)
- Romosozumab (Evenity™)
- Physical Activity

While pharmaceuticals can have positive effects on bone mineral density, they do not have any effect on risk factors such as muscle strength, muscle power, dynamic balance, coordination and overall functional performance.[4] When it comes to modifying risk factors of osteoporosis (bone strength, fall risk, fall impact) an appropriately prescribed and adhered to exercise program is the only available strategy.[4]

Bone is a dynamic tissue. It has the ability to respond to changes in mechanical loads by changing its mass, structure and/or strength. This dynamic nature allows it to withstand future loads to prevent a fracture.[4] Bone cells become desensitized to repetitive loading and, over time, it loses its ability to adapt under continual loading or increasing repetitions. Bone responds to: (1) dynamic intermittent versus static loads; (2) loads of high magnitude applied rapidly; (3) loads applied in random, diverse directions/patterns; (4) few repetitions if the appropriate load intensity is used.[4]

The American College of Sports Medicine recommends that programs intending to optimize bone health should follow the following:[4]

1. **Principles of Specificity:** skeletal adaptations are site specific. Therefore programs must include exercises that target sites of interest (ie. hip, spine, wrist).
2. **Principles of Progressive Overload:** Loads/strains must exceed the typical loads of everyday activities.
3. **Principle of Reversibility:** Positive skeletal adaptations will be progressively lost if the program is stopped.
4. **Principle of Initial Values:** The greatest change in bone, as a result to loading, will typically occur in those with the lowest initial mineral density.
5. **Principle of Diminished Returns:** Subsequent gains are anticipated to be slow and modest with a similar loading regime

It is important to note that the response time for bone adaptations is slow, as the typical bone remodelling cycle lasts 3-8months. For this reason adaptation must last, ideally, 12-24months in order to detect change.[4]

Therapeutic exercise is commonly recommended in the treatment and prevention of osteoporosis and associated fractures. However, the effect of certain exercises on bone is controversial, especially in an older population, and clinically it is unsure if exercise can actually prevent fragility fractures.[4,6] Simply put, the question left unanswered is, "Does training-induced improvements in areal BMD result in improvement/maintenance of whole bone strength, particularly at common fracture sites?"[4]

Regardless, exercise training is considered an effective approach to reducing risks. Research suggests that therapeutic exercises and balance exercises need to be individualized to the person in order to minimize harm and maximize results. [6,7]

Current reviews of literature summarize the following:[4, 5, 6]

1. **Walking:** As a stand alone intervention does not modify BMD loss (but still good for overall health)
2. **Aerobic training (especially of high intensity and speed (jogging, stairs)):** This form of exercise is able to limit a loss in BMD. However these forms of exercise may not be suitable for the typical osteoporotic population (due to projected falls risk).
3. **Strength training:** Results in an site specific increase in bone density with 3x/week sessions for a year. Progressive resistance training in the lower limb is the most effective intervention on BMD of the neck of the femur. Programs that have been shown to improve or maintain BMD in older women often use moderate to high intensity loads (2-3 sets of 8-12 repetitions at 70-85% of maximal muscle strength) that progress over time, target muscles that cross the hip or spine and are carried out 2-3 times/week.
4. **High-Velocity Power Training:** More studies are needed to confirm, but findings suggest this form of activity has the ability to improve functional performance and possibly lessen the risk of fall.
5. **Weight-Bearing Impact Exercise:** There is inconsistent evidence that short periods of weight-bearing activities with moderate to high magnitudes (ie: 3-5 sets of 10-20 jumps 4-7 days/week, 2-3 times body weight) and multidirectional movement patterns maintain or prevent bone loss. Despite the positive changes, again the safety, efficacy and feasibility of this form of exercise is inconclusive for the general osteoporotic population.
6. **Tai Chi:** Potential positive effect if performed regularly for 12 months minimum.
7. **Pilates/Yoga:** Both show ability to increase BMD. Research suggests avoiding end range flexion, extension and rotation of the spine as well as internal/external rotation of the hip when participating.
8. **Combined exercises/Group classes:** (mix of iaerobic, strength, balance, etc.): Have been shown to maintain and possibly increase BMD. Unfortunately the specifics of a protocol (frequency, duration, etc.) has not been agreed upon.
9. **Vibration Platforms:** Show positive results on muscle strength, balance and reducing fall risk. Inconsistent findings on positive changes in BMD and additionally, once again, safety for this population has been questioned.

For more information: Osteoporosis Canada offers a downloadable booklet called "Too Fit to Fracture". You can find it **here.**

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SAVE THE DATE AND KEEP YOUR EYES OPEN!

Members' meeting is scheduled for JUNE 23, 2020, at 8PM EST.

This will be a virtual meeting, and the link will be posted in an E-blast closer to the date.

TIPS FOR MANAGING HOT FLASHES

WHAT DO WE REALLY KNOW?

By Katie Kelly, PT, WHD Newsletter Subcommittee Member

While menopause is a normal part of aging, roughly 25% of menopausal women suffer from hot flashes and night sweats severe enough to impair quality of life, and require treatment. In a recent article of non-hormonal ways to reduce vasomotor response (hot flashes and night sweats), the North American Menopause Society (NAMS) published a review of the evidence1. Levels of evidence range from Level 1 (high quality randomized trials and systematic reviews), Level 2 (lesser quality randomized studies, and RCTs), Level 3 (uncontrolled trials, case studies), level 4 (case series, case-controlled studies) and Level 5 (expert opinion).

LIFESTYLE RECOMMENDATIONS

We often hear about suggestions to either improve or reduce the frequency of hot flashes. But what does the North American Menopause Society think about these suggestions?

• **Cooling Techniques:** These are common suggestions that women are given about ways to lower their core body temperature in an effort to decrease hot flash and night sweat occurrence. Examples include – wearing layers, wearing natural fibers, thin pajamas, drinking cold beverages, putting an ice pack inside the pillow case, keeping the bedroom cool at night, using a fan, using a temperature-controlled mattress cover, etc. And while anecdotally it is easy to see why some of these suggestions might bring comfort during a hot flash, no research seems to exist proving these as effective treatments for hot flash prevention and has been labeled as level 5 evidence[1]. So, while we might suggest these as measures for comfort, it seems we have no evidence to support that they reduce the frequency of vasomotor symptoms.

• **Dietary Trigger Avoidance:** Many things have been suggested as dietary triggers for hot flashes. These include alcohol, caffeine, spices, dairy, hot foods or beverages. Very little research has been done on this topic, and the NAMS authors propose the recommendation of avoiding dietary triggers as level 5 evidence. However, in a recent study of 302 Iranian women, a relationship was found between higher amounts of dairy and solid fats consumption, and lower amounts of vegetable consumption in regards to more hot flashes[2]. Tobacco and alcohol use were not studied in this cohort. However, research is emerging demonstrating a link between moderate/heavy alcohol consumption and vasomotor symptoms[3,4]. The relationship between dietary triggers and hot flashes remains complex due to the potential relationship between dietary

intake and obesity, as well as alcohol consumption and anxiety/depression, all of which have been proposed as contributing factors for hot flashes as well.

• **Cardiovascular Exercise:** Evidence exists for and against the notion that regular exercise can help reduce the frequency of hot flashes1. A Cochrane review in 2014 notes that there are flaws with most of the research and the treatment parameters for 'cardiovascular exercise' vary greatly[5]. However, they come to the conclusion that cardiovascular excise does not reduce the occurrence of hot flashes. A review in 2018, reports similar findings[6]. The NAMS, while acknowledging the general health benefits of exercise, suggests level 1 evidence that cardiovascular exercise does NOT reduce vasomotor symptoms.

• **Yoga:** In the NAMS review the authors report level 1 evidence that yoga does not reduce vasomotor symptoms. They cite previous reviews where no significant results were demonstrated between yoga and hot flashes. They do note of one study, where women were to do one weekly 90-minute yoga session, versus health and wellness education[7]. Both groups noted reduced vasomotor symptoms after 10 weeks, with the yoga group having marginally better results. Since the NAMS review, however, a 2018 systematic review and meta-analysis has found significant improvement of vasomotor symptoms in menopausal women after yoga interventions when compared to no treatment and compared to exercise controls8. The authors did note bias in some of the studies, and recommended more research.

• **Relaxation Techniques:** These include activities such as mindfulness-based stress reduction, paced breathing, meditation and relaxation. The evidence seems to be very mixed. For example, in the NAMS review, mindfulness-based stress reduction (which includes acceptance, yoga and meditation practiced daily) was found to significantly improve vasomotor symptoms after 20 weeks of treatment[9]. There was some evidence that applied relaxation techniques might be beneficial as well. Both of these techniques received level 2 evidence rankings. However, paced-breathing was lacking in any supporting evidence and was rated as level 2 evidence for not reducing hot flashes. A more recent meta-analysis review was conducted in 2017 that examined the effect of paced respiration, mindfulness or hypnosis all of which had no effect on vasomotor symptoms10. It is likely that the variety of methodology between the activities termed as "relaxation techniques" makes it difficult to determine their effectiveness.

• **Cognitive Behavioural Therapy:** CBT for menopause symptoms as administered by a clinical psychologist, includes psycho-education (the physiology of hot flashes, stress as a trigger, negative beliefs and sleep hygiene), paced-breathing, and relaxation training. In research cited in the NAMS review, both the usual care group and treatment group had improvements, though the CBT group had better results in reducing the vasomotor symptoms problem ratings, but not frequency[11]. Another study in 2019 found similar findings, where CBT was effective in reducing the "bothersomeness" of hot flashes[12]. Interestingly, many of the techniques used in CBT were also studied in the "Relaxation Techniques" section above. This might be an indication that these relaxation techniques are effective but perhaps only in conjunction with other behavioural therapy techniques, or perhaps, guided by a professional psychologist. This further strengthens the arguments of the NAMS authors when they reported that more stringent methodology is required when studying "relaxation techniques". The NAMS authors suggest level 1 evidence that CBT improves the management of vasomotor symptoms.

• **Weight Loss:** The NAMS review cites one RCT and 3 other studies examining weight loss and vasomotor symptoms. Taken together, the results suggest that weight loss can improve severity and bother of hot flashes. They suggest level 2 evidence that weight loss may be associated with reduction or elimination of vasomotor symptoms. But recent research suggest it might not be the act of losing weight that determines number and severity of hot flashes. In a 2017 longitudinal study examining 1546 women over a year, they found that current BMI and waist circumference were the larger determinants of vasomotor symptoms, and not % body weight change or weight loss[13]. The authors suggest that perhaps greater amounts of weight loss are necessary to see significant change in symptoms. The study of obesity and menopause symptoms is certainly complex, and perhaps the connection between the two is not correlational. More than one study has found that obesity has a greater bearing on vasomotor symptoms in the perimenopause phase, and inversely related to vasomotor symptoms in the post menopause period [13,14]. Likely, more research is necessary to determine the true relationship between weight and hot flashes.

This is by no means a complete review for symptomatic vasomotor lifestyle modification treatments. Many of the above suggestions might bring relief to our patients, even if they do not reduce the frequency and severity of hot flashes. We must be clear about the discrepancies in the research when suggesting these recommendations, but building patient self-efficacy, promoting stress reduction and encouraging exercise are all beneficial to the general health and well-being of our menopausal patients. What is encouraging, is the volume of research emerging investigating menopausal symptoms, which will hopefully, bring us closer to better understanding this life stage.

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SAVE THE DATE FOR OUR WEBINARS!

WEBINAR 1

CONSIDERATIONS FOR CAESAREAN REHABILITATION

DATE: MAY 20, 2020
TIME: 7PM EST
KATIE KELLY

The aim of this webinar is to introduce some concepts around caesarean-section rehabilitation. With roughly 30% of North American births occurring via caesarean, this is a patient population that you
will encounter as a pelvic health or orthopedic practitioner. A caesarean birth presents its own unique set of challenges for practitioners. Rehabilitation techniques addressing the complications that can occur following a major abdominal surgery while simultaneously acknowledging the challenges associated with early motherhood are necessary for a well-balanced approach to recovery. In recognizing that mothers who delivery via belly-birth are worthy of their own birth preparation, education, and rehabilitation plan we can begin to change the dialogue around caesarean birth, and in doing so, hopefully develop happier and healthier mothers.
Keep an eye on the upcoming E-blast for the link to use for attending it.

About Katie: Katie Kelly, Pelvic Floor Physiotherapist
Following graduation from Dalhousie University in 2010, she completed her first post-graduate pelvic health course in 2011 and has been treating pelvic floor patients ever since. Katie opened her own practise in 2017, and is now happy to be expanding to her co-owned multidisciplinary clinic at Reconnect Health Centre, in Moncton NB. Katie is often a guest lecturer for the School of Physiotherapy at Dalhousie University, with a focused knowledge on pregnancy and pelvic health. She is an active contributing author to the Canadian Physiotherapy Association's Women's Health Division Newsletter. Katie has formed a relationship with Mount Allison University's Sexual Health Laboratory to research chronic pelvic and genital pain conditions. Her latest goal is to help expand the knowledge of her peers. Since undergoing a C-section delivery, she has been passionate about furthering the discussion around cesarean rehabilitation.

For more information, see: **www.katiekellypt.ca.**

WEBINAR 2

PELVIC HEALTH PHYSIOTHERAPY IN THE TRANS COMMUNITY

DATE: JUNE 9, 2020
TIME: 8PM EST
CELESTE CORKERY

As the social landscape changes for Canadian trans folk, more people are feeling comfortable living in a gender role congruent with their gender identity. The trans population has traditionally been undeserved and underrepresented within our health care system. There is a huge role for pelvic physiotherapy in trans health, whether a trans person is undergoing surgery or not. This webinar will provide an overview of this role, an opportunity to ask questions as well as provide resources for patients and physiotherapists. Keep an eye on the June E-blast for the link to use for attending it.

About Celeste: Céleste Corkery earned her Physiotherapy degree from the University of Ottawa in 2008. She is passionate about advancing her knowledge base and expertise through continuing education leading her to pelvic health physiotherapy. Céleste works at Women's College Hospital with both the Toronto Academic Pain Medicine Institute and the Transition Related Surgeries program.

FIND A PELVIC HEALTH PHYSIO!

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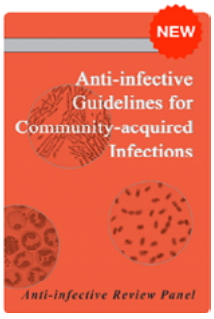
Dr. Colleen McDermott
Urogynecologist, Mount Sinai Hospital



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VULVOVAGINAL TREATMENT OPTIONS

By Katerina Miller, PT, WHD Newsletter Editor

WHAT IS VULVOVAGINAL ATROPHY?

Vulvovaginal Atrophy is one of the most disruptive symptoms of menopause. During menopause, a woman's hormones fluctuate greatly, especially estrogen.[1] With the decrease in estrogen, the vaginal and vulvar tissue becomes thinner, dryer, and less flexible, and there is a significant decrease in lubrication. This condition is called vulvovaginal atrophy.

COMMON TREATMENTS FOR VULVOVAGINAL ATROPHY

The most important way to help our menopausal clients is education, proper diagnosis, and appropriate management of vulvovaginal atrophy (VVA). [2] Treatment depends of the severity of the condition, and may include one or a combination of treatments, such as: non-hormonal lubricants and moisturizers, pelvic floor physiotherapy, low-dose vaginal estrogen therapy, vaginal dehydroepiandrosterone, and oral ospemifene.[3] For both the physical and emotional health of women who are going through menopause, it is vital to start treatment as soon as VVA is detected, and those treatments must be highly individualized, as there are many treatment options, and different presentations of symptoms. [4]

FIRST LINE THERAPY:

Nonhormonal lubricants: Used to increase comfort and pleasure during sexual activity. The recommended lubricants should not contain irritants such as glycerin, parabens, and propylene glycol, and can be water, silicone, or oil-based.[3, 5] Examples of lubricants: Water based: Slippery stuff, YES, Good Clean Love, Sliquid. Silicone based: JO, Pink, Uberlube.

Vaginal Moisturizers: Typically used on a regular basis (several times per week, depending on severity) to maintain vaginal tissue health by helping it retain water. [6] Some lubricants have shown to be comparable to estrogen in their ability to reduce itching, irritation, and dyspareunia.[7] It is important that the chosen moisturizer does not irritate the skin, as some may not be a good match to the body's pH and osmolality. [3] Examples of moisturizers: Replens, RepHresh, Sliquid Satin, and Hyalo Gyn. [5]

Physiotherapy: Education about the condition, development of awareness and control over the pelvic floor, pelvic floor relaxation, manual therapy, biofeedback, and training and teaching the use of vaginal dilators can be very helpful in treating severe VVA. [3, 5]

SECOND LINE THERAPY:

Hormonal Therapy:

Topical low-dose vaginal estrogen therapy: Usually used to help with comfortable sexual intercourse, or to prepare the tissue for surgery.8 It is the first line of therapy if VVA is not relieved by non-prescription therapies. [5] This treatment option has a known risk of thromboembolism and stroke.[9] Examples: Premarin vaginal cream, Estragyn vaginal cream, Estring, Vagifem, Yuvafem, Intrarosa, and Osphena.[3]

Vaginal dehydroepiandrosterone (DHEA): This is a good option for women who have contraindications to hormone therapy. [10] This intravaginal hormone was found to be beneficial for the treatment of VVA symptoms.[3] The main difference between estrogen therapy and DHEA is that while the prior is applied a few times per week, DHEA must be applied daily.

Oral ospemifene: The advantage of this medication is that it does not have a proliferative effect on the endometrium or breast tissue.[8] It is a chemical classified as a selective estrogen receptor modulator (SERM).

OTHER TREATMENTS:

LASER therapy: This method was introduced to treat vaginal atrophy in 2013, yet remains controversial.[9] The principal of its benefit lies in making small holes in the thin most superficial layer of the skin, with the purpose of increasing circulation, by that affecting epithelial morphology and alleviating VVA symptoms.

Sexual activity: Sexual activity on a regular basis through menopause is important to help with symptoms of VVA. 1 It was shown to help maintain the vaginal tissues thick and moist, as well as maintaining its length and width. If intercourse is avoided, the condition will worsen.

Recommendations for Clinical Care from the North American Menopause Society [11]

1. Over-the-counter topical progesterone cream should not be used to provide endometrial protection with estrogen use, and any benefit for menopause symptoms is unproven. (Level III)
2. The role of oral DHEA in improving mood, sexual function, and general well-being remains unproven. (Level III)
3. Melatonin supplementation may have a role for circadian-rhythm sleep disorders, including shift work and jet lag. (Level II)

sleep hygiene, or guided imagery/ CBT which has been shown to decrease hot flashes by up to 46%) Is it a partner-based issue? If she has a male partner in the same age range, it's worth remembering that the prevalence of erectile dysfunction in men in their 50's is around 50% and increases approximately 10%/decade.

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POSITIONS IN THE WHD

There are a few volunteer positions coming up for re-election in the Women's Health Division's committee, and you are welcome to apply!

THE POSITIONS ARE:
SECRETARY,
COMMUNICATIONS CHAIR
&
SOCIAL MEDIA CHAIR

Each position is for 2 years, and voting will be held during our members' meeting in June.

The deadline for application submission is May 15, 2020.

If you would like to apply, please send your CV and letter of intent to Devonna Troung, at **whdsecretary@gmail.com**.

2020 VALENTINE'S DAY CHALLENGE RESULTS

By Linnea Thacker, WHD Student Representative

Cindy Thibodeau of MOOV Physiotherapy

This year marked the 6th annual WHD Valentine's Day Challenge, during which women's health physiotherapists and PT students across the country collected donations of toiletries, feminine hygiene products, and incontinence supplies for local women's shelters. This annual collection drive provides a great way of celebrating Valentine's Day, while encouraging community engagement amongst physiotherapists and physio students. Participating clinics and schools connect with local women's shelters to learn about their unique donation needs, and deliver the collected items at the end of the drive. Given that the Valentine's Day Challenge is in its sixth year, many schools and clinics are recurrent participants, deepening their relationships with their community partners over the years, and generating wonderful stories of collaboration!

This year's participants came from 19 clinics and three universities across British Columbia, Alberta, Saskatchewan, Ontario, Quebec, and Nova Scotia. Together, participating clinicians and students collected over 1000 toiletries, feminine hygiene products, and incontinence supplies, along with $250 of financial gifts, to donate to women's shelters in their communities.

Women's shelters serve a variety of roles, which can include providing safe housing, counselling, and educational programming to women (and sometimes their children) experiencing homelessness and/or domestic violence. Donations of supplies, along with financial gifts, are often relied upon for shelters to continue offering consistent support and programming for women in their communities. Sadly, the current demand for women's shelters in Canada far exceeds the existing supply. In early March of this year, the CBC launched an investigative reporting series on domestic violence in Canada, and reported that in November 2019, an average of 620 women and children were turned away from domestic violence shelters across Canada each day! As a result, many women and their children are left in precarious environments without safe alternatives.

Willow Health Physio's Lindsay Brown and Administrative Assistant Meggan MacKenzie

The current pandemic further highlights health inequities within our country. As trends emerge demonstrating worse outcomes in certain populations, we are reminded of the importance of recognizing and addressing social determinants of health. Likewise, while many of us shelter in place, we are reminded of those for whom a safe home is not an option. The far-reaching effects of the virus place us in a unique position to re-evaluate the systems at work in our communities and explore how we can improve the health of all members of our communities moving forward. Engaging with our local shelters is one such way. Thank you to all who participated in this year's Valentine's Day Challenge and helped support organizations across the country who are actively addressing health inequities. We look forward to your participation again next year!

NEWSLETTER ADVERTISING RATES 2020-21

The Women's Health Division has an ever-growing membership of over 700 physiotherapists.

Our quarterly publication is national, reaching physiotherapists from coast to coast.

DEADLINES FOR ADVERTISING SUBMISSIONS

NEWSLETTER ISSUE:	DEADLINE:	PUBLICATION DATES:
Summer 2020	July 15th, 2020	Between August 1 and 15, 2020
Fall 2020	October 15th, 2020	Between November 1 and 15, 2020
Winter 2021:	January 15th, 2021	Between February 1 and 15, 2021
Spring 2021:	April 15th, 2020	Between May 1 and 15, 2021

For more information please contact: Marylène Charette, **treasurer.whd@gmail.com**

ADVERTISING RATES 2020-21*

SIZE	PER ISSUE SINGLE ISSUE PRICE	PER YEAR FULL YEAR PRICE (4 ISSUES)
¼ page	$50	$175
½ page	$100	$350
¾ page	$125	$450
Full page	$150	$525
2 pages	$250	$875

E-BLAST ADVERTISING

E-blasts are sent out monthly to our members. Advertising can include upcoming courses and/or job listings.

	WHD MEMBERS	NON-MEMBERS
One listing per blast	$50	$55
Each additional listing per blast	$20	$25

**Please note that these prices are subject to GST/HST according to location of advertiser.*

NEWSLETTER ADVERTISING RATES 2020-21

Course Listings should include the following: Company name, course name, dates, times and location as well as a brief description (max 75 words). Company logo will not be included in the listing.

Job Listings should include the following information: Company name, contact name and email, position available, contact phone number, website, city and province, closing date and a brief description (max 75 words).

WEBSITE ADVERTISING

All job postings and course listings on the website are free and will be posted in our members only section of our website. We offer this service for free so our members can continue to grow, but we encourage all companies to consider giving back to the WHD by creating or sharing resources or patient handouts with us to be added to our Members only section.

Please send all pertinent information to **whdwebsite@gmail.com** as outlined above for the e-blast

- Course postings will remain on the website until the date of the course
- Job listings will remain on the website until the closing date or for two months
- Optional a pdf of a patient handout that you are willing to share with our members.
- Please consider offering a WHD member discount for your courses.

Women's Health

A DIVISION OF THE CANADIAN PHYSIOTHERAPY ASSOCIATION

FALL 2020 NEWSLETTER

WORD FROM THE CHAIR

Dear Members,

Welcome to all our new members who have joined our division this year, we're excited to have you! Happy late Fall to all - I hope everyone has been able to continue to enjoy the outdoors despite the change in seasons and of course, challenging times we're in.

Our executive team has reconnected a few times since our summer recharge. We met for a September zoom social and had several productive meetings over the past couple of months to finalize the action items of our strategic plan. We hope to have a working document to share with you all soon and we are excited to be discussing exciting projects we will be working on over the next several years. I would like to take this opportunity to thank the amazing group of women that I have the privilege of working with, for their energy and dedication to the division and our strategic planning process.

A special, heart-felt thank you to Katerina Miller, our outgoing Newsletter Chair, who took the reins of the newsletter and made it spectacular. Kat and her wonderful newsletter subcommittee members, Lesley Spohr and Katie Kelly, have worked hard to deliver a newsletter that we hope you have found inspiring and helpful for your practice. We are excited to announce that Hayley O'Hara, who has been on our executive for two years now, will be taking over as Newsletter Chair to continue Kat and her team's amazing work. I am excited to see the new wonderful additions that Hayley will contribute to our already awesome newsletter!

I hope you were able to attend the CPA Virtual Summit and enjoyed the informative women's health session with Ms. Mercedes Eustergerling who spoke about "Mastitis and Breast Inflammation: Etiology and Physiotherapy Management" on Friday evening. Things were a bit different this year, but hopefully you were all able to get a good laugh watching Arthur, Chair Elect of the Pain Science Division, and I play with the Empathy Toy in the keynote session with Ilana Ben-Ari! We loved learning and experiencing the importance of empathic communication while having lots of fun.

Stay tuned for our upcoming yearly event!
Valentine's Day Challenge: Our 6th annual VDC - an event organized by our student representative, Nicole Ivaniv, to encourage PT students (and PTs) to collect menstrual products for local women's shelters. Contact Nicole at **whdstudentrep@gmail.com** for questions or to get involved!

Sending my best to all our division members during these challenging times. Thank you for your ongoing support of the WHD.
Best,

Devonna Truong
Women's Health Division Chair,
Candian Physiotherapy Association

IN THIS ISSUE

NOTE FROM THE EDITOR

Dear Readers,

After two years of working with the WHD team in various roles, I am now stepping into this reputable role of Newsletter Chair. Our previous Newsletter Chair, Katerina Miller, is leaving us, but not without making an immense impact on the lives and practices of our members over the years.

I have been entrusted with a rich archive of articles, research, interviews, book reviews, and more, all surrounding topics in pelvic and women's health. From one pelvic health therapist to another, I feel as though I have been granted access to the most exclusive journal club ever. To top it off, I have the honour of working with the incredible minds of our Newsletter Subcommittee: Leslie Sophr, Katie Kelly, and Angelique Montano-Bresolin.

I have always loved the Autumnal equinox and its ability to bring about new beginnings, and so it is only fitting that this transition comes about as the leaves change colour. With all that this year has presented us with, I would like to think that I am also stepping into this role with an open heart... and the perspective that anything-goes-in-2020.

I do hope you enjoy my very first edit of our Fall Newsletter.

With love,

Hayley O'Hara, PT
WHD Newsletter Editor

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Our services are available in both official languages | Services disponibles en français et en anglais

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PLEASE JOIN US FOR THE 7TH ANNUAL WOMEN'S HEALTH DIVISION

Valentine's Day CHALLENGE!

Up until February 14th 2021, physiotherapy students and practicing women's health physiotherapists from across Canada will be organizing a collection drive for new, unopened, and unused toiletries, menstrual hygiene products, and incontinence supplies for local women's centres. This may include tampons, pads, hair/skin products, laundry detergent, and dental hygiene products. **We are currently recruiting physiotherapy students and clinicians who would like to represent their school/workplace for the challenge.**

If you would like to participate, please contact Nicole Ivaniv at whdstudentrep@gmail.com for more information.

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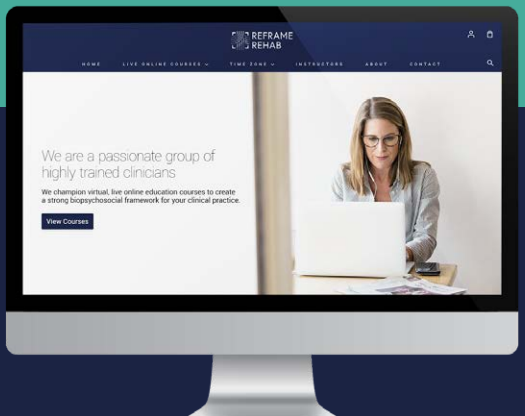

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ADDRESSING RACISM IN WOMEN'S HEALTHCARE

By: Regan Haley, MScPT (student)

The original goal of this article was to create an academic piece of writing to publish in the Women's Health Division newsletter highlighting the cause and effects of racial disparities in women's healthcare. My intentions behind this project stem from me wanting to learn more about the racial disparities in women's health in order to inform my practice moving forward as I transition into a practicing physiotherapist. While reading an article published by the Charlatan (Carleton University's independent newspaper) I came across a message from the Vice-President of the Carleton University Students' Association, Tinu Akinwande, who said that being an active ally means using your "privilege to speak without being silenced" (1). I wanted to use this platform to share what I had learned with other physiotherapists who could actively advocate to provide equitable healthcare services to all patients.

When trying to make sense of racism within healthcare and its impact on Black women, find myself in an uncomfortable space of unknown where I have more questions than answers. Although slavery was abolished in Canada, and all the British colonies, in the 1830's racial segregation and institutional and systemic racism still informs today's social, economic, and political systems. In 2017, the UN reported that Canada's history of racial segregation and structural racism provides the foundation for many of our systems, manifesting itself in the form of high rates of unemployment, poverty, lack of adequate education, limited access to healthy food, the overrepresentation of Black Canadians in the criminal justice system, lack of access to physical and mental healthcare resources, implicit biases, and generational trauma impacting the psychological, emotional, and physical wellbeing of Black, Indigenous, People of Colour (BIPOC) (2). The systemic racism deeply rooted in our North American institutions is so intricately woven and interconnected that it becomes almost impossible to untangle this web of racism in order to find one specific cause behind the racial disparities in women's health. The more I researched, the clearer it became that it would be impossible to write about the "cause" of racial disparities in our healthcare system.

While immersing myself in this search for knowledge and understanding, I spent a lot of time debating whether this information should be coming from me, a white woman. I do not have the formal education or the personal experiences to be able to educate others on systemic racism. This process of revision and self-doubt has highlighted the safety net that my white privilege provides. Although the thought of living in a truly equitable country and world is a beautiful dream, if it never happens, I will still be safe. At the end of the day, I can close my laptop and dissociate from the research I have done. Although I have not forgotten what I have read, I was reading it, and not experiencing it. I want to express that this topic of discussion amongst white people and those of us in the healthcare system is long overdue and while I am just beginning to educate myself, Black activists across North America have been doing this work for years while personally experiencing the systemic racism within our institutions. Those are the women we should be listening to and learning from.

> "The systemic racism deeply rooted in our North American institutions is so intricately woven and interconnected that it becomes almost impossible to untangle this web of racism in order to find one specific cause behind the racial disparities in women's health."

There is an abundance of research highlighting the true impact of systemic racism on the lives of Black Canadians, yet there is very little being done to address it. We claim to be an evidence-based profession, yet we continue to ignore the research, contributing to a system that creates and maintains poor health outcomes for our racialized patients. We all have work to do. To start the conversation amongst WHD members, I have summarized some of the things I have learned from the research and from leaders in the Black community on ways we can take action and implement change within our profession. I have also created a document categorizing some of the resources I turned to on my search for answers. My hope is that you will use these resources to learn more about systemic racism and racial disparities within women's healthcare.

WHAT CAN WE DO TO ADDRESS THE RACIAL DISPARITIES IN WOMEN'S HEALTHCARE?

1. Educate yourself. Read, listen, and learn from Black voices. Dedicate time to reading research, watching documentaries, and listening to podcasts with the intention to establish a safer and better world for Black women.

2. Dedicate time to self-reflection. Ask yourself questions about your childhood and what you were taught, explicitly or implicitly, about Black People of Colour (BPOC). Recognize and be aware of your own prejudices, stereotypes, and implicit biases. Think about times you have been complicit and did not speak up when you witnessed racism. Reflect on how you might benefit from an oppressive system that was created by people like us, for people like us, at the expense of BPOC. This will be uncomfortable - create space for the discomfort and allow yourself to feel all the feelings that arise. Write about some of the mistakes you have made and the lessons you learn as you move forward. You will make mistakes. Hold yourself accountable - when someone calls you out, listen, learn, apologize, and do better the next time. Be grateful for the lesson. Furthermore, if you are in a position to hire, be aware of prejudices based on name or appearance and always provide equal pay and equal opportunities for promotions.

"This will be uncomfortable - create space for the discomfort and allow yourself to feel all the feelings that arise...Hold yourself accountable - when someone calls you out, listen, learn, apologize, and do better the next time."

3. Be present with each patient and take the time to recognize that their lived experiences may differ from your own. Experiencing racial discrimination, either covertly or overtly, is a stressor that induces frustration, anger, distress, confusion, and anxiety. Racial trauma is the cumulative effects of racism on the psychological, emotional, and physical wellbeing of racialized individuals. Experiences of racism, discrimination, and racial violence often exceed the coping abilities of humans leading to the development of unhealthy coping strategies and chemical changes such as substance abuse, violence, depression, and social anxiety, all of which have the ability to affect future generations. The biopsychosocial model of healthcare can address and recognize some of these manifestations of racial trauma. Therefore, understanding racial trauma and practicing within the biopsychosocial model of care is imperative as these symptoms can affect pain and the ability to heal which can impact treatment outcomes (3). Recognizing that if you are not Black, you will never understand or relate to the struggles experienced by BPOC, but you can be compassionate, educated, and supportive.

4. Practice patient-centered care. "To understand the illness perspective of a particular patient, the therapist must enquire about and attempt to understand the cultural explanatory model of health that the patient brings to the encounter" (4). This requires investigation into the "patient's understanding of the meaning and cause of their condition" (4). Believe your patients when they tell you about their symptoms. Evidence suggests that healthcare professionals have similar implicit biases to the general public, one of these being a largely false and harmful belief that Black women are physically stronger and are not as susceptible to pain as white women (5). If you notice a patient struggling to get the help they need - whether it be funding, resources, support, or programming within communities - ask them what they feel they need and how you can help. Use your position and voice to advocate for them. We cannot claim to support women if we are not supporting ALL WOMEN. Offer virtual assessments and treatments whenever possible. Providing telehealth sessions may increase racialized groups' access to healthcare services by reducing travel and childcare costs, increasing patient comfort and safety, and reducing the likelihood of cancellations or no shows, thereby ensuring women are receiving the care they need.

5. Think about your workplace and the diversity amongst your coworkers and the leaders within the organization. Contemplate how the leaders of the organization have encouraged, created, and maintained culturally safe practices. Have they made intentional efforts to create and actively dedicate time to diversity and inclusion trainings and committees? If yes, are the leaders or senior people within the organization taking part in these trainings and committees? Does it feel performative? Does the training/committee foster real change, or does it feel like it has been created just so that the leaders can say that they have them? Are the members of the committees compensated for their work? Does the committee set realistic and achievable goals leading to concrete action?

6. Provide a safe, inclusive, and accepting environment for bothcolleagues and patients with a zero-tolerance policy for racist actions, comments, and microaggressions. Challenge racism when you see it; do not be a passive bystander and understand that remaining silent is not a form of anti-racism and contributes to racism within the workplace.

7. Provide culturally safe and responsive healthcare and encourage your colleagues to do the same. Culturally responsive healthcare is "an extension of patient-centred care, [and] ensures that attention is given to social and cultural factors during therapeutic encounters by exploring the beliefs and values that underpin the illness experience" (6). Cultural competency/cultural safety is "the attributes required by health professionals to engage effectively with health consumers from culturally diverse communities" (6). I have referenced both cultural competence and cultural safety because, although cultural competence is the more frequently used term in the literature, it suggests the expectation that we be experts in other cultures, which is an unattainable goal. Cultural safety reflects the importance of becoming acquainted with and learning to appreciate and celebrate the norms and values of different populations.

8. Encourage physiotherapy university programs and physiotherapy organizations, including hospitals and private practices, to embed cultural safety training within all aspects of education and care. The Canadian National Physiotherapy Advisory Group's (NPAG) Competency Profile for Physiotherapists in Canada 2017 (CPPC 2017) does not describe or cite "cultural competence" in any of the 7 essential competencies for physiotherapists and only mentions "diversity", which they define as the "variation among people, including but not limited to, variation based upon factors such as race, ethnicity, colour, religion, age, sex, sexual orientation, marital status, family status, and disability", in 2 of the 7 competencies (7).

9. Be aware of ethnocentrism. Ethnocentrism is the evaluation of other cultures using one's own culture, often perceived as the norm, as a frame of reference, causing judgements regarding others' practices, behaviors, and beliefs. Research suggests that healthcare practitioners (HCPs) "tend to subconsciously gravitate toward ethnocentric attitudes and stereotypical behaviors when caring for patients who hold cultural values and beliefs different from their own. In addition, ethnocentrism by HCPs has led to less-the-adequate treatments, misdiagnosis, and mistreatment of culturally diverse individuals" (8). However, as we learn about other cultures and begin to appreciate and celebrate cultural differences, we decrease ethnocentric attitudes and stereotypical behaviors. The disparities in health outcomes for patients from culturally diverse communities and racialized groups are exacerbated by "culturally insensitive practices, such as inadequate communication, limited ethnocultural knowledge, prejudice, and practitioner ethnocentrism" (9).

10. Finally, we need to continue practicing allyship and anti-racism even when the "trend" or "hype" dies down and things appear to be returning to "normal". Continue having hard conversations with family, friends, and colleagues. Teach everyone, especially those who look like you, about what you are learning and share resources from Black leaders with your peers. Continue donating and signing petitions. Continue educating yourself through books, scholarly resources, documentaries, webinars, and podcasts by Black authors. Examine where your money goes - research Black-owned companies and local businesses to support and boycott massively complicit or harmful corporations. Follow Black leaders and activists on social media platforms (see suggestions below) and pay for their educational content. Hold yourself, friends, family, and coworkers accountable, and remember that accountability is something we offer to people through understanding, partnership, and support.

"Hold yourself, friends, family, and coworkers accountable, and remember that accountability is something we offer to people through understanding, partnership, and support."

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If you are looking for resources to begin learning more about racism and health care please click **here** for a list of resources.
Article references on page 19.

EDUCATION CORNER

ASSESSMENT AND TREATMENT OF AXILLARY WEB SYNDROME

By Tania Obljubek, PT

Tania is a women's health physiotherapist who is passionate about breast cancer rehabilitation and aging well. With over 24 years of experience, she inspires her clients to bring balance into their lives, supports their path to recovery, and assists them in achieving value-based goals for improved function, strength, and mobility. Tania received a Bachelor of Physical Therapy from University of Western Ontario and a Bachelor of Science from Lakehead University. For the past 22 years she has worked at Women' College Hospital. She has covered all areas of women's health, but has expertise is in pelvic health, senior's health, breast cancer and breast reconstruction rehabilitation, and lymphedema management. She has co-authored a booklet, with the support of the Peter Gilgan Center and Canadian Cancer Society, on Pelvic Health and Breast Cancer. She provides leadership in the physiotherapy community by teaching workshops to both the public as well as professional colleagues, including the development of a two-day post graduate breast cancer and rehabilitation course. Tania is also a mother, wife, aunt, sister, daughter, colleague and friend. She is an avid knitter and cross stitcher, reads 2-3 books or articles at any one time, and always drinks from a mug made in her hometown of Thunder Bay to ground her spirit. Most importantly, she stays inspired each day by the strength and power of her clients.

In Canada, it is estimated that 1 in 8 women will be diagnosed with breast cancer. Survivorship rates are improving each year, with earlier diagnostics and the development of novel treatments. Survivorship, however, comes with its own set of hurdles, including lymphedema, cardiovascular issues, loss in strength and upper extremity range of motion (ROM), chronic fatigue, and chronic pain. Of these is a lesser known, but equally significant, issue relating to the removal of axillary lymphatic nodes: Axillary Web Syndrome (AWS). The purpose of this article is to describe AWS and the role of physiotherapists in the assessment and treatment of AWS. AWS, also known as "cording", refers to the visible and palpable cords of tissue superficial to the axilla (armpit) and upper extremity following mastectomy and lymphatic node removal. These cords are likened to ropes or guitar strings in the axilla that can radiate down the arm into the antecubital fossa and anterior compartment of the forearm. It usually presents 3-5 weeks following surgery and may pose as a risk factor for lymphedema. Occurrence rates vary quite broadly from 6-72% as there is no one complete definition of cording[3, 4, 5].

To diagnose AWS, look for one or more of the following key findings:

- Presence of visible and palpable cords in the axilla and/or antecubital fossa and/or volar surface of the forearm with shoulder abduction
- History of lymph node dissection
- Presents 3-8 weeks after lymph node dissection
- +/- Pain in the region
- +/- Decreased shoulder ROM, particularly abduction and combined abduction/internal rotation/extension (hand behind back)[7]

The risk factors for AWS include lower BMI, younger age, and axillary lymphatic node dissection (versus sentinel lymphatic node dissection). Differential diagnosis might include deep vein thrombosis (DVT) in the upper extremity, cellulitis, thrombophlebitis, and Mondor's disease. DVT presents with sudden swelling, warmth, and intense pain in the upper extremity. Cellulitis presents with signs of infection, redness and warmth, around the skin and incision. Thrombophlebitis appears as a vein that is thrombosed, swollen, and tender and warm on palpation. Mondor's disease presents with cords at the inferior aspect of the breast and extend downwards. It is unclear whether the cords are lymphatic or venous thrombosed vessels[2].

There are several theories about the underlying pathology to AWS. Well established is the presence of thrombosed lymphatic vessels that have been injured from the node dissection. Secondary to surgical tissue injury and ruptured red blood cells, there is an increase of hemoglobin in an affected area. Hemoglobin inhibits the pumping of lymphatic fluid, resulting in lymphatic fluid stagnation in the lymphatic vessel and subsequently thrombosis (Miles Johnston). Another theory is that lymphatic fluid coagulates at a faster rate due to increased thrombokinase. Lymphatics can regenerate – known as "lymphangiogenesis" - and may re-establish lymphatic flow. During this process, the regenerating tissue can adhere to underlying tissues. This tethering of fibrous tissue to adipose tissue may produce the cord-like structures characteristic of AWS. It has been difficult to understand the underlying pathology of AWS but physiotherapy can play an essential role in pain management and restoring function[5, 6, 7].

The assessment of AWS may involve one or more of the following:

- Observe any swelling in or around the chest wall, breast, axilla, and upper extremity.
- Abduct the shoulder an observe the axilla for any "guitar-like" strings, following the length of the cord into the chest wall and/or down the arm.

- Assess ROM of shoulder flexion and abduction for any limitations.
- Measure horizontal abduction in side-lying by measuring the distance from fingertip to bed while the shoulder is at 90°, 120° and 180° degrees of abduction.Assess upper limb tension with median nerve bias.
- Note any soft tissue restrictions around the incisions and surrounding tissues of the upper extremity.
- Have the client complete the Axillary Web Syndrome Self-Assessment Questionnaire[1].

According to research, cording typically resolves within 12 weeks; however, the pain and limited range of motion that results can leave clients susceptible to frozen shoulder and pain sensitization, and may also delay their access to cancer treatments such as radiation therapy. Physiotherapy treatment has been shown to help manage pain and facilitate faster resolution of the cord[2]. The goals of treatment may include reducing pain, restoring lymphatic circulation, lengthening the cord adhesions, and improving movement and mobility. Treatment should be gentle to minimize disruption of the growing lymphatics. It may include:

- Soft tissue techniques on the cord and surrounding tissues
- Skin/cord traction at end-range followed by gentle active ROM of the shoulder
- Median nerve mobilization
- Stretching and postural exercises
- Manual lymphatic drainage if swelling is present and if increased redness occurs secondary to aggressive treatment[3].

Axillary Web Syndrome is a relevant, but often misunderstood, condition affecting breast cancer patients who have undergone breast surgery. If left untreated, AWS may result in significant pain and functional limitations that can become chronic and delay access to necessary cancer treatment. Physiotherapy intervention can assist with early recognition, pain management, and restoration of function, helping to facilitate a timely return to meaningful activities.

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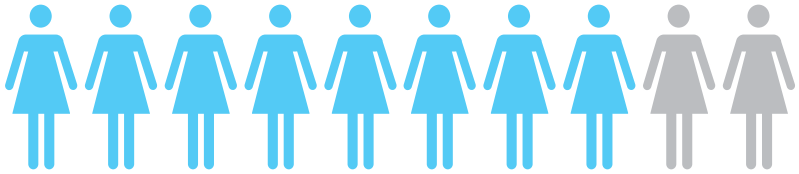

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CERVICAL CANCER AND LYMPHEDEMA

By Ann DiMenna, PT (CDT)

Ann is a graduate of the University of Waterloo, where she received a degree in Biochemistry, as well as the University of Toronto, where she received a degree in Physiotherapy. In 2008, Ann completed post-graduate training in Combined Decongestive Therapy (CDT), making her fully certified to treat patients with lymphedema. She serves on the Board of Directors of the Lymphedema Association of Ontario and is a popular speaker on the topic of lymphedema at various conferences in Canada and the US. She is also the co-author of "The Complete Lymphedema Management and Nutrition Guide: Empowering Strategies, Supporting Recipes and Therapeutic Exercises" - a must-have resource for lymphedema patients.

Did you know that over 1350 women in Canada will be diagnosed with cervical cancer this year? Most women diagnosed with cervical cancer will be between the ages of 35 and 44. The standard course of treatment depends on the stage at which the cancer is detected. Fortunately, with the advancement of diagnostic screening methods, survival rates are on the rise, and so is the need for treatment. Treatment for gynecological cancer often involves surgery followed by radiation and/or chemotherapy, which may result in one of many complications. One of the most misdiagnosed chronic complications of treatment is lymphedema. Lymphedema is the abnormal accumulation of a protein-rich fluid called lymph. Lymph fluid accumulates due to blockage of the lymphatic drainage system. The risk factors that predispose women to developing lymphedema include having a high number of nodes removed, radiation to the abdomen, post-operative complications, and a high body mass index (BMI).

SIGNS AND SYMPTOMS

Signs and symptoms of lymphedema include heaviness, aching, pins and needles, and a measurable girth difference. It can present as unilateral or bilateral, and it may affect the lower abdomen and the genitals. You may also see pitting edema and a positive stemmer sign. A positive stemmer sign is when the assessor is unable to pinch and lift the skin at the base of the second toe. A negative sign does not rule out lymphedema, as the swelling may exclude the foot. Differential diagnoses include liver failure, kidney failure, heart failure, DVT, cellulitis, venous insufficiency, or metastatic cancer. Good history taking can help to identify individuals with lymphedema.

COMBINED DECONGESTIVE THERAPY

The treatment for lymphedema is known as Combined Decongestive Therapy (CDT). Special certification in CDT is required to effectively deliver treatment. CDT involves skin care, manual lymphatic drainage, exercise, and compression therapy.

SKINCARE The skin is our barrier against infection, and those at risk of lymphedema are at significant risk of infection due to lymph node damage. Applying a lotion that is between the pH of 4-6 is essential for maintaining skin integrity, while protecting the skin against damage is crucial to keeping its barrier intact.

MANUAL LYMPHATIC DRAINAGE Manual lymphatic drainage is a gentle skin stretching technique that stimulates contraction of lymphatic vessels to enhance movement of lymph from the extracellular space to the intracellular space within lymphatic vessels. As fluid moves out of the congested area, skin stretch will improve, and a visible and measurable decongestion of the tissues may occur.

EXERCISE Exercise is a very important component of CDT. It is often divided into 2 phases: active decongestive phase and maintenance phase. In the active decongestive phase of treatment, when bandaging is being used, exercises are simple. These include joint range of motion and gentle muscle contractions to stimulate fluid movement. In the maintenance phase, resistance training and more rigorous types of exercise may be performed, with emphasis being placed on finding balance so as not to overwhelm the lymphatic system and cause more swelling.

COMPRESSION THERAPY Compression therapy can also be divided into two phases: the intensive phase and the maintenance phase. In the intensive phase, multilayer compression bandaging, using padding and short stretch compression bandages, is applied after manual lymphatic drainage and worn for 23 hours per day. This phase is to reduce limb girth until swelling plateaus. Once a plateau is reached, compression garments can be ordered either over the counter or in custom-made fabrics. The Assistive Devices Program (ADP) is available in most provinces to help provide coverage for lymphedema garments.

WHAT CAN YOU DO TO HELP? Connect your clients with your local lymphedema association to find a certified lymphedema therapist. Remember that knowledge is power and, when patients find resources early, many of the complications due to lymphedema can be prevented. Prevention is the key to helping individuals at risk of lymphedema understand how to better help themselves. **Article references on page 12*

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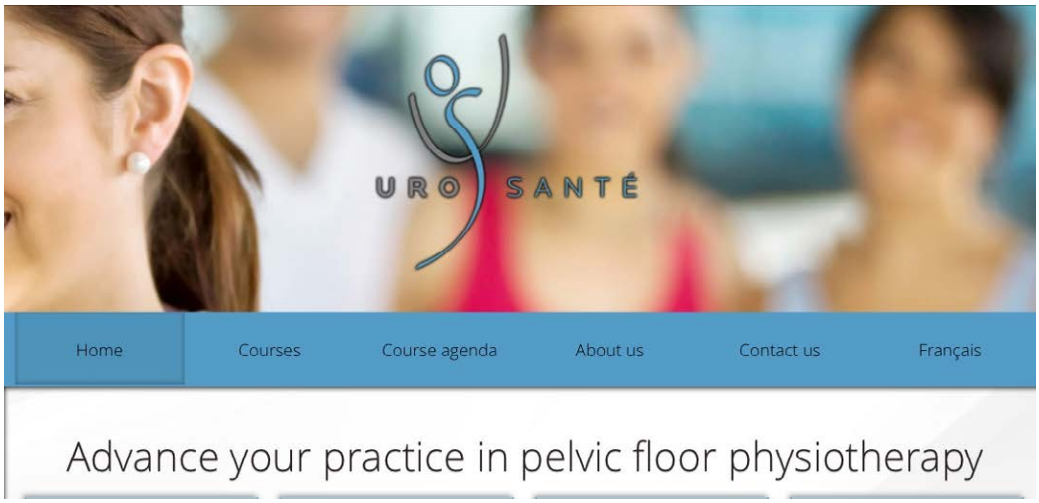

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LYMPHEDEMA MANAGEMENT AND NUTRITION GUIDE:

EMPOWERING STRATEGIES, SUPPORTING RECIPES AND THERAPEUTIC EXERCISES

Written by: Jean Lamantia, RD & Ann Dimenna, PT/CDT
Reviewed by Leslie Spohr, PT

Lymphedema is a type of swelling that occurs when there is an abnormal buildup of lymphatic fluid in the skin. Burns, injuries, surgery, radiation therapy, obesity and circulatory problems are some of the common causes of lymphedema but cancer patients are of highest risk following surgical and radiation treatments.

According to the National Cancer Institute in 2015, "Lymphedema is one of the most poorly understood, relatively underestimated and least researched complications of cancer or its treatment." This is one of the few books that brings all relevant and up to date information regarding lymphedema all in one place.

Ann DiMenna, a certified lymphedema therapist, and Jean LaMantia, a registered dietician, joined forces, experience and expertise in this area to create an easy to follow guide to managing lymphedema. This book is evidence-based, comprehensive and illustrated with helpful tables and charts to help patients and health-care providers develop a better understanding of lymphedema and to empower patients to take part in the decision making process. From explaining the condition, diagnostic measure and treatment options they provide a well rounded, easy to understand, information to help manage life with lymphedema.

The book runs about 146 pages including all diagrams, charts, tables and appendices. It is well illustrated with helpful charts and tabs to highlight key information. Divided into 4 main parts, this well-structured book discusses a variety of topics regarding lymphedema.

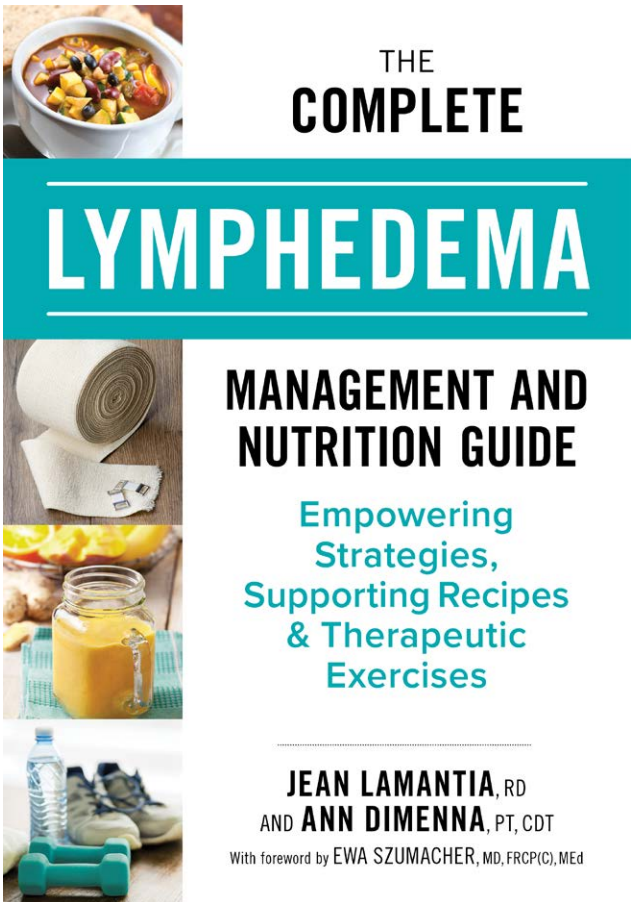
The first part of the book dives into the pathophysiology and causative factors of lymphedema, discussing risk factors and risk-reduction techniques. It is in this part that readers are taught how to measure and chart relevant data of affected limbs for proper measurement collection and follow-up care.

Clearly outlined therapeutic procedures, that are commonly used to treat lymphedema, are covered in the second part. Topics such as skin care, Manual Lymphatic Drainage (MLD), compression bandaging, pneumatic compression pumps, exercise and lymphatic taping are thoroughly discussed. The authors break down each topic into clear and concise descriptions and easy to follow instructions. Large, easy to follow pictures and diagrams further supplement the readers ability to carry these techniques out with confidence and efficiency.

The third portion of the book explains the important role of nutrition and supplements in managing lymphedema. Specific dietary recommendations (of things such as protein, fluids, sodium and more) and the importance of weight management are explained in a way that illustrates how these areas can complement traditional treatment options discussed in part two.

The book wraps up with a portion dedicated to meal plans and recipes that showcase all of the nutritional recommendations highlighted in part three. With over 57 pages of recipes, from appies to mains, the authors provide a solid glance into the recommended dietary intake for those managing lymphedema.

I found this book to be a fabulous educational tool and resource for managing lymphedema. From providing an in-depth explanation of the condition to thoroughly breaking down multiple treatment options I walked away with an understanding of how to manage lymphedema and maximize one's quality of life with this condition.



LYMPH: WHAT IS IT ALL ABOUT?

LESLIE SOPHR INTERVIEWS DR. PERRY NICHELSTON OF STOP CHASING PAIN

Perry Nickelston, DC, NKT, FMS, SFMA, is a Chiropractic Physician with a primary focus in Performance Enhancement, Corrective Exercise, and Metabolic Fitness Nutrition. He is a 1997 graduate from Palmer Chiropractic University and a master fitness trainer with over 25 years experience in the health industry. Perry is a member of the Board of Directors and Medical Staff Advisor for AIMLA (American Institute of Medical Laser Application) and the Director of clinical protocols and training for LiteCure Medical Lasers, specializing in Myofascial Laser treatments.

Dr. Perry is a regular columnist for Dynamic Chiropractic, Practice Insights, Chiropractic Economics, To Your Health Magazine, Advance Physical Therapy, PT on the Net, LiveStrong, StrengthCoach, and other industry publications for health and fitness. He is currently publishing several books on health, fitness, laser therapy, and business success. You can find more of his work on his website, including his Core 4 RRTT Recovery and Regeneration Program for maximum pain relief. A self treatment program whose sole purpose is to empower you to take back control of your life from chronic pain.

Q. WHAT STARTED YOUR JOURNEY LEARNING ABOUT THE LYMPHATIC SYSTEM?

A. Five years ago, I became very sick with an autoimmune disease and traditional medical approaches were not helping. In fact, they were making me worse. Out of necessity, I needed to look at different approaches and how the systems of the body work together. I found my answer in Lymphatics. Suffering has a way of teaching and revealing things we would not normally see.

> "Out of necessity, I needed to look at different approaches and how the systems of the body work together. I found my answer in Lymphatics."

Q. HOW DID YOU LEARN ABOUT LYMPH AND THE LYMPHATIC SYSTEM?

A. Incessant learning and studying of many disciplines. [I] learn from others and then bring [my] own unique perspective and approaches.

Q. CAN YOU BRIEFLY DESCRIBE THE LYMPHATIC SYSTEM AND ITS ROLE IN THE HUMAN BODY?

A. The lymphatic system is known as a sewage system of your body. It's part of your immune system and cardiovascular system. Its job is to remove bacteria/toxins/viruses/cancer/metabolic wastes/parasites from the body. Basically, anything that you don't want inside your body, its job is to get it out.

Q. WHAT ARE SOME OF THE MOST COMMON PROBLEMS THAT CAN OCCUR IN THE LYMPHATIC SYSTEM? ARE THERE KNOWN CAUSES/RISKS ASSOCIATED WITH THEM?

A. The lymphatic system can become overwhelmed and overloaded leading to fluid stagnation. That means poor lymphatic flow. Too much exposure to toxicity, lack of movement, and [lack of] efficient breathing is associated with lymphatic issues.

Q. WHAT TYPES OF CONDITIONS CAN ARISE FROM DYSFUNCTION IN THE LYMPHATIC SYSTEM?

A. Lymphedema is the most well-known, [with] excess swelling and inflammation in an area. However, you can have many symptoms with a dysfunctional lymphatic system. Some examples are chronic fatigue, systemic inflammation, tiredness, brain fog, chronic pain. If your lymphatic system completely stopped working, you would die within 24-hours.

Q. WHAT TREATMENTS EXIST FOR THE LYMPATHIC SYSTEM?

A. [The] most common are directed manual therapeutic lymphatic release and massage. You also have different types of compression devices, and there is now some promising research on the use of light therapy to help lymphatics.

Q. DO YOU SEE A CONNECTION BETWEEN DYSFUNCTIONS IN THE LYMPHATIC SYSTEM AND PELVIC CONGESTION? WHAT ABOUT WITH PELVIC PAIN CONDITIONS?

A. Yes, to both questions. [There are] a significant number of

lymphatics in the abdominal region, lumbar region, pelvis and groin. When they become congested, they can compromise blood flow and increase nerve sensitivity. No system in the body works alone, [no system] gets injured alone, and [no system] heals alone.

> "No system in the body works alone, [no system] gets injured alone, and [no system] heals alone."

Q. CAN YOU DISCUSS HOW THE LYMPHATIC SYSTEM IS IMPACTED BY RADIATION FOR CANCER TREATMENT (PARTICULARLY OF BREAST AND PELVIC CANCERS)? DOES (YOUR) TREATMENT DIFFER IN THESE CASES?

A. That all depends on the type of radiation and chemotherapy someone is receiving. You have to remember; those therapies are designed to destroy cancer tissue and they do not just bypass healthy tissue. You can have tissue surrounding the cancer cells affected. Lymphatic vessels included. All lymphatic treatments are highly individualized based on the combination of existing therapies and the timeline of the therapies. No two people receive the exact same treatment program.

Q. IN YOUR OPINION, WHY DO MANY HEALTH CARE PROFESSIONALS NOT LEARN MUCH (IF ANYTHING) ABOUT THE LYMPHATIC SYSTEM?

A. Great question. I ask myself this every day. They should. It's the most important and neglected system in the body. I hope this changes in the next few years. I call lymph the new fascia. Medicine didn't really concentrate on fascia either at one point. It was disregarded. Now it's everything. My mission is to share the importance of lymph with them all.

Q. IS THERE ANY RESEARCH OR EDUCATIONAL OPPORTUNITIES YOU WOULD RECOMMEND OUR READERS LOOK INTO FOR MORE INFORMATION (RESEARCH PAPERS, VIDEOS, WEBSITES ETC)?

A. Yes, there is more research every year on lymphatics and a simple search on PubMed will get you started. The new research on the brain and lymphatic system is very exciting. You can also attend our "Body Aquarium: Lymphatic Mojo" courses or purchase our online self-help video.

Q. IS THERE ANYTHING ELSE YOU'D LIKE TO SHARE WITH OUR READERS?

A. Yes. Love your lymph and work on it every day - it's counting on you.

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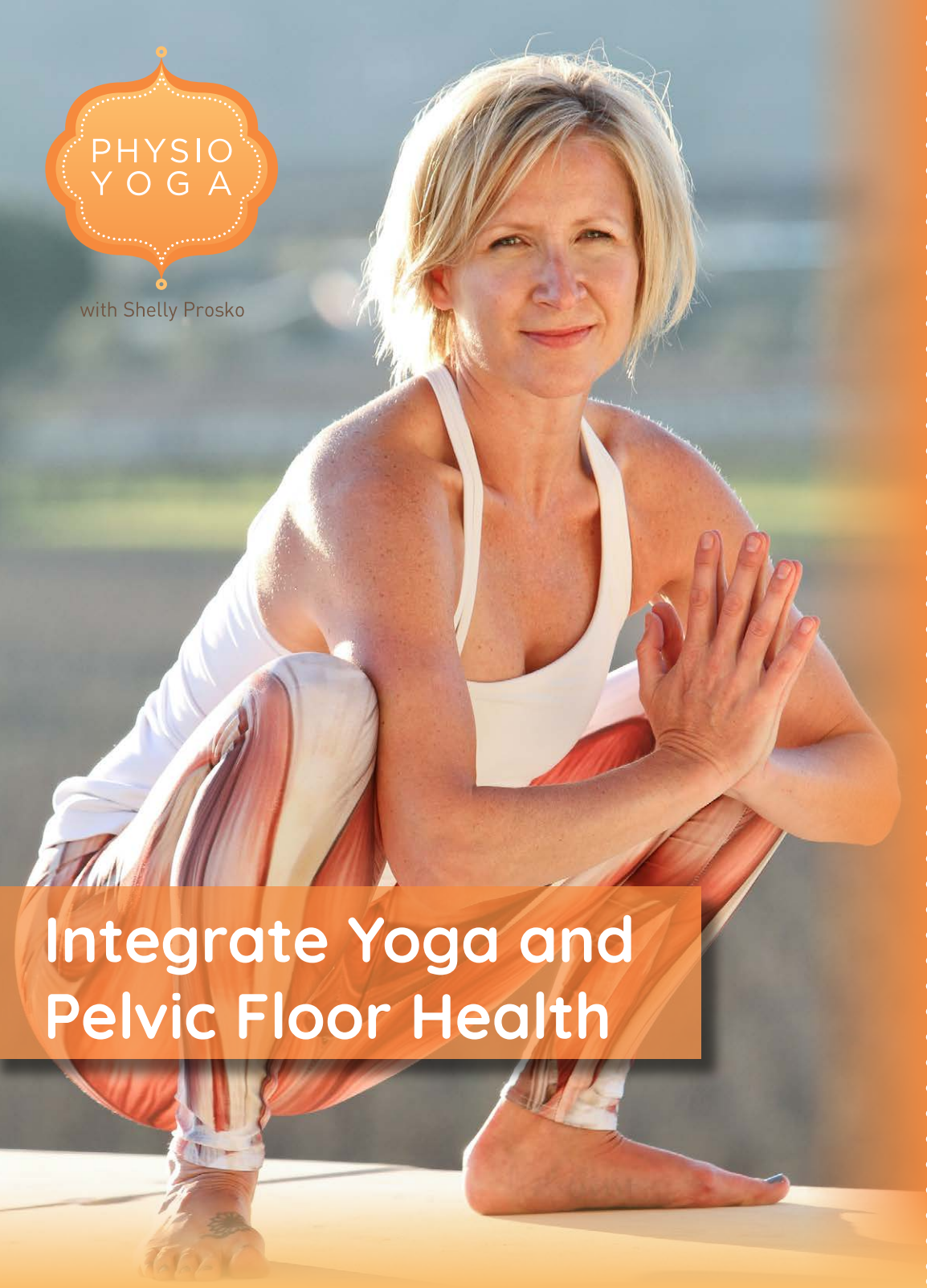
with Shelly Prosko



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Shelly Prosko, PT, C-IAYT
physiotherapist, yoga therapist

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Winter 2021:	January 8th, 2021	Between February 1 and 15, 2021
Spring 2021:	April 8th, 2021	Between May 1 and 15, 2021
Summer 2021:	July 8th, 2021	Between August 1 and 15, 2021
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For more information please contact: Marylène Charette, **treasurer.whd@gmail.com**

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Women's Health

A DIVISION OF THE CANADIAN PHYSIOTHERAPY ASSOCIATION

SUMMER 2020 NEWSLETTER

WORD FROM THE CHAIR

It is with great honour that I am writing to all our members through the Chair's address of our amazing newsletter! I hope that you and your loved ones are staying healthy and resilient during these unprecedented times. Since I am new to most of our members, I would like to formally introduce myself. My name is Devonna Truong and I have been a part of the Women's Health executive team for the past 4 years, first as the Public Relation's Chair and most recently, Secretary. I have my own private practice in Toronto, Ontario and am involved as a facilitator at the University of Toronto physiotherapy program and previously, McMaster University. I am passionate about advocating for evidence-based practice in women's and pelvic health and the indispensable role of exercise and empowerment within the biopsychosocial approach to healthcare. Through my several terms on the executive, I have been able to establish a thorough understanding of governance and develop a new and exciting direction for the division as a whole and we have initiated several collaborations and projects given the feedback from the members over the years (stay tuned)! I am dedicated to leading our executive team and members by inspiring everyone to dream, learn and achieve together

With all the extra time that the changes in the world have provided, I have been working hard during my time as Incoming Chair, and now Chair, to re-evaluate how we can make improvements and explore how we can make an impact as a division. I am truly humbled by our incredible and passionate executive team who is devoted to optimizing your member experience. We have been meeting as an executive for several hours every couple of weeks to develop our new strategic plan that will guide our division over the next 3-5 years. We would like to thank our consultant, Dave Bennett, for all the support and guidance he has provided our executive through the comprehensive process. Dave is a wealth of knowledge as he comes with extensive experience in working with several boards and associations, including the CPA. We are happy to announce that we have finalized our strategic priorities and activities this past week and are excited to share it with our members! We are taking a break from our regular meetings for the rest of the summer to allow our executive to re-charge and spend time with our loved ones. In September, our time will be devoted to the fun part - developing the operational aspects of the strategic plan by creating actionable items within our strategic priorities that align with our vision! We hope that you join our enthusiasm and welcome the opportunity to provide any feedback or interest in involvement as a subcommittee member to our Secretary, Linnea Thacker at **whdsecretary@gmail.com.**

Thank you to all that attended our virtual member's meeting and provided your feedback on what you would like to see as our members, it is always great hearing from you. A special welcome to both our new Student Representative, Nicole Ivaniv from McMaster University and our French Resource Person, Carolane Chevrier from Vancouver, BC! We are excited to have such enthusiastic voices brought to the table.

Finally, I would like to express a heartfelt thank-you to all of our members who continue to support the WHD and of course, to our hardworking executive and subcommittee members who dedicate countless hours volunteering their time year-round to promote our profession and to advance our division. Happy Summer everyone!

Devonna Truong
Chair, Women's Health Division of the Canadian Physiotherapy Association
Registered Physiotherapist

IN THIS ISSUE

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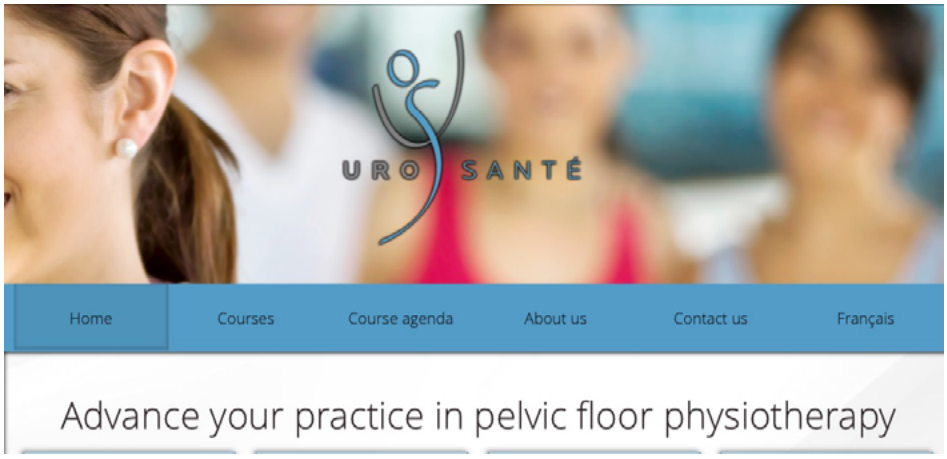

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Yoga and the Pelvic Floor (with Diana Perez)
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NEW! The Special Considerations for Caesarean Section:
Preparing for and Recovering from Belly Birth (with Katie Kelly),
ONLINE - Oct. 3-4 2020 (in English)
No prerequisites required

The Physical Therapy Approach to Female Urinary Incontinence (entry level),
Halifax, NS, Oct 16-19 2020

The Physical Therapy Approach for Dyspareunia
ONLINE - Nov. 7-8 2020

NEW! The Physiotherapy Assessment of Breastfeeding Related Conditions:
Maternal & Infant Factors (with Mercedes Eustergerling),
Québec, QC Nov. 20-23 2020 (in English)
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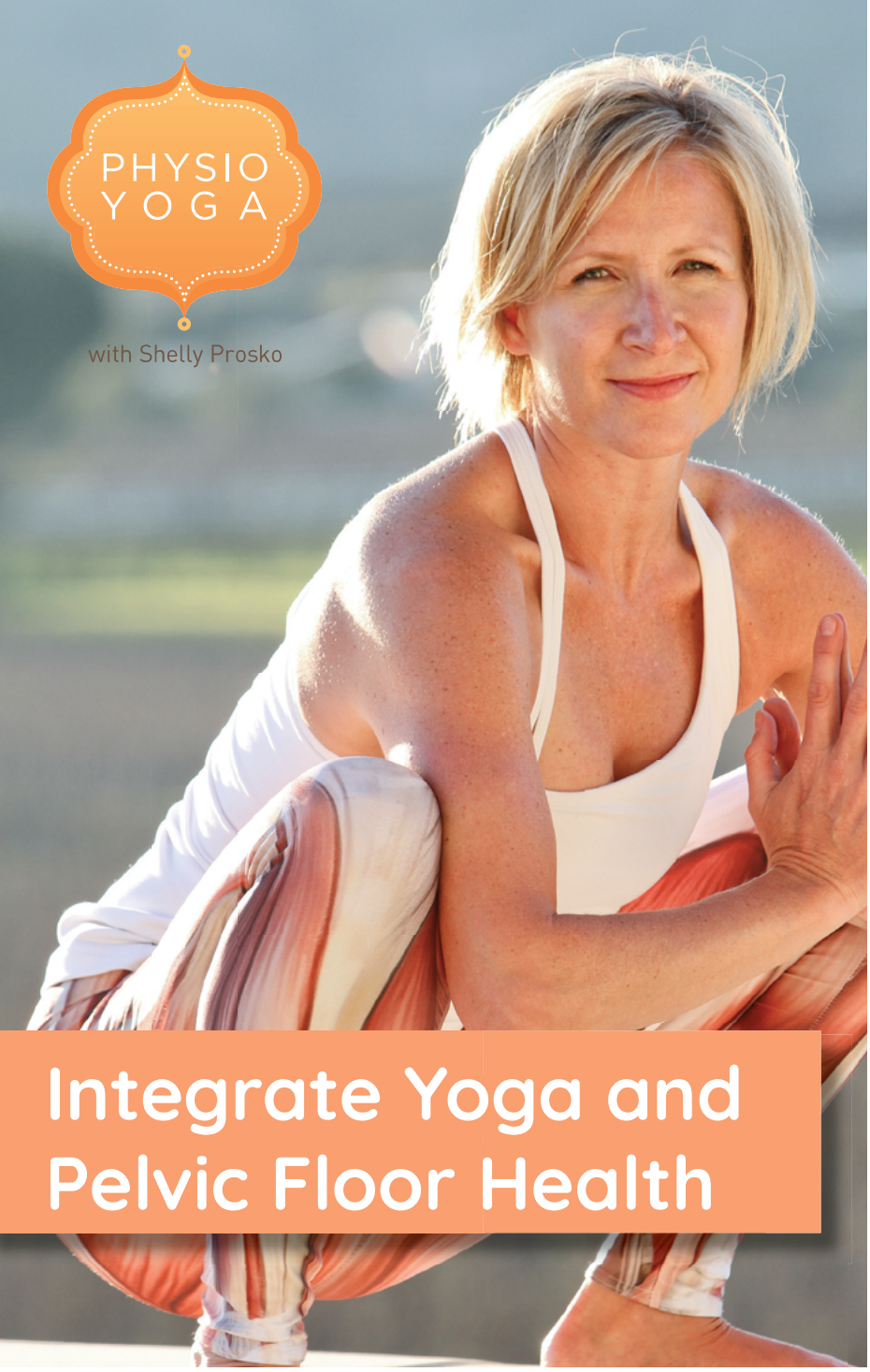
with Shelly Prosko



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Shelly Prosko, PT, C-IAYT
physiotherapist, yoga therapist

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EDITOR'S NOTE

Hello dear readers!

It is impossible for me to know who actually reads my note, but I like to pretend that everybody does. This is why I am choosing to pretend that everybody reads this newsletter from cover to cover, without skipping a word!

This very well might be the last Editor's Note I write for this wonderful newsletter. I have been in this role for 3 years now, and I am ready to pass the torch on.

My time with the newsletter, as well as with the WHD in general has been phenomenal! I got to work with AMAZING people, interview some of the greatest minds of our field, and read articles written by innovators, researchers, and overall such knowledgeable people, that I am always humbled by their knowledge, while at the same time motivated by them to keep on learning and developing my skills.

I hope you are enjoying what my team and I are presenting to you! And I am confident that the person who will take my place will be as passionate about it as I am.

Wishing you all for the rest of 2020 to bring only good news and lots of laughter, and overall a beautiful future!

With all my heart,
Katerina Miller, PT
WHD Newsletter Editor

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2019-2020 ACTIVITY SUMMARY

CHAIR *Juliet Sarjeant*

In the last year, we had been working hard to provide exemplary content for the centennial CPA Congress in Ottawa. Sadly, as we all know, that did not come to pass, but we are excited that some of the content will be presented live at the virtual Congress in November 2020. While the executive was to be gathered in Ottawa, we were meant to spend a few days creating the strategic plan that will guide us through the next three to five years. Due to the fact that we were not able to meet face-to-face, this process has been happening online. While this is not the easiest way to communicate and share ideas about such an important document, the executive has been extremely committed to the process and we now have a draft strategic plan with which to work.

We are also excited because we have been in discussions with the Orthopaedic Division to create a collaborative course for 2021, so keep your eyes and ears open about this! I have been blessed to work with such an amazing WHD executive. This group of volunteers has an astounding amount of passion, knowledge and commitment, which makes the job of chair so much easier and enjoyable! Thank you also to the sub-committee members who have been instrumental in helping us produce content for our members via the newsletter, social media and for Congress.

SECRETARY *Devonna Truong*

As Secretary this past year, I have lead communications amongst the team (meeting agenda, meeting minutes, strategic planning, etc.) and implemented changes in organizational and communication structure to improve group function and meeting effectiveness. I have also supported the role of Chair through collaboration and continuous communication and other executive roles in their initiatives and navigating project barriers. More recently, I have engaged and supported communication with our consultant on the division's ongoing strategic planning process and reviewed documents and had discussions for role handover for Chair. The immediate goal is to finalize an awesome strategic plan and I am looking forward to executing it with our fabulous executive team in the role of Chair!

NEWSLETTER *Katerina Miller*

This year brought great changes to the Newsletter, and the result is this fresh, modern new look you have in front of you. Over the past year the newsletter subcommittee and I have been working hard on making more high quality connections in the field of WH/PH physiotherapy, so that we could bring you the best information possible. This effort is a continuous effort. Additionally, I am very proud of one of our subcommittee members – Katie Kelly, who presented an evidence based webinar about our role in c-section care. We continue working hard on bringing you high quality, interesting information, and we hope you are enjoying it!

TREASURER *Marylène Charette*

As the new treasurer and new member of the executive for the past 6 months, my activities were primarily to become familiar with my role and responsibilities. In regards of a more efficient transition/succession in the future, I put into writing the different procedures and protocol of my tasks while learning them. Like the rest of the executive team, I also helped with the development of the new strategic plan for the next few years. Lastly, as an initiative of the division to offer resources/service in French, I participated in the recruitment and supervision of a translation studies intern. My goals moving forward are, but not exclusively:

1. Develop the 2021 budget following the new strategic plan
2. Develop a PayPal account for more efficient payment for our advertisers and
3. Implement a new tracking system for the division expenses and revenues.

SOCIAL MEDIA *Alison Pethrick*

Over the past year, I have worked to revamp the WHD Social Media presence to ensure that our posts are accurately reflecting and representing the priorities of the WHD. This has included activity promotion, information distribution, content creation, and networking with other professional divisions via post-sharing, tagging, likes, and comments. I see social media as the voice of the WHD, and have truly enjoyed beginning to interact with our members on our platforms. Moving forward, I hope to continue to be able to highlight WHD activities, our subcommittee volunteers, and the great work of our members as well as provide valuable content for our followers (members or not!) to expand the reach of the WHD's work.

Follow Along and Comment!

INSTAGRAM: womenshealthdivision **FACEBOOK:** WHDCPA **TWITTER:** CPAWHD

COMMUNICATIONS *Jessica Bergevin*

An initial accomplishment was to reframe the role of PR Chair into Communications Chair and Social Media Chair to better organize interactions with division members. Ongoing activities include producing and circulating e-blasts, website management, congress planning and strategic planning. Goals moving forward for this role are streamlining communications in sync with the Social Media Chair and the Newsletter Chair, producing high-quality e-blasts, website review and updates, and advocacy efforts

EDUCATION *Samantha Doralp*

The WHD continues to support multiple education initiatives, demonstrated through our listing and advertising of upcoming courses, ongoing webinars provided by both our executive and member community and sharing of online resources. The WHD has offered 5 webinars this past year with great attendance. The WHD has shifted from developing additional resources to connecting you to content through our various platforms (website, newsletter, eblasts). The WHD was looking forward to connecting with all of you during Congress this year, and sadly with the cancellation, we lost an exciting opportunity to learn from each other and connect in person. Our very own Jess Bergevin still hosted the Congress course on Embodia, a testament to the commitment of the Division. Exciting new initiatives include focusing on education across Canada and the WHD is currently completing an Environmental Scan of Women's and Pelvic Health programs and courses. As we develop and plan our Strategic Priorities for the next few years, we are excited to highlight education and witness the momentum building both in our executive and our member community. Thank you for a wonderful year.

KNOWLEDGE TRANSLATION *Nicole Beamish*

We have been working hard to connect our members with knowledge and research through different projects. Below is a snapshot of what we have been working on over the course of the year.

- The WHD team was actively working on getting ready for Congress 2020 in Ottawa, where we were planning on having a women's health stream. Unfortunately, Congress was cancelled but the CPA is planning a virtual summit for November 2020, (keep an eye on our social media platforms for more information).
- The research reading list has been up and running on our website for the past three years now. Every quarter we provide links to open access research that may be relevant to your women's and pelvic health practice. **Check it out here.**
- The WHD has been working with Physiopedia to help improve and updated the current women's and pelvic health content on Physiopedia to help ensure that physiotherapists from across the globe have access to up-to-date women's and pelvic health resources. If you are interested in volunteering to help with this project, please email me at **whdresearch@gmail.com.**
- Through the Physiopedia initiative, we were able to provide three outstanding physiotherapy students from Queen's University a non-patient contact placement. Victoria Geropoulos, Michelle Walsh, Regan Haley, spent four weeks this summer improving content. We can not thank these students enough for their commitment to improving global access to physiotherapy resources. Check out our **Physiopedia Page** to read their work.

The research team's goal for 2020-2021 is to continue to build connections with women's health researchers and clinicians. We will achieve this by building the research subcommittee, engaging with women's health PTs on a global scale and helping to facilitate the transfer of knowledge gained from women's health research to our members.

NEW GRADUATE REPRESENTATIVE *Hayley O'Hara*

"Over the past year, I have transitioned into a new role on the Women's Health Division executive: New Graduate Representative. This role gave me the opportunity to work closely with our Student Representative, Linnea, on initiatives relating to pelvic health education and philanthropy amongst Canadian Physiotherapy students. Recently, I have participated in regular meetings to help develop the WHD Strategic Plan. This process has been exciting and I look forward to seeing how the WHD evolves over the coming years with this strong new focus."

STUDENT REPRESENTATIVE *Linnea Thacker*

My main task this year involved organizing the 2020 Valentine's Day Challenge, which engaged women's health physios and physio students from 19 clinics and 3 universities across Canada in collecting donations for women's shelters in their communities. Together, participants donated over 1000 toiletries, feminine hygiene products, and incontinence supplies, along with $250 in financial gifts. Additionally, I organized a webinar on trans pelvic health, and am currently in the process of arranging another webinar for later this summer. I have been actively involved in the strategic planning process and am excited by where the Division is headed! I look forward to transitioning the next Student Representative into the role for the coming year as I shift into the role of Secretary.

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Diastasis Rectus Abdominis & the Implications for Low back & Pelvic Health: What's the Solution? - September 26 & 27

Motivational Interviewing & Coaching Tools for Physiotherapists - October 2

Pregnancy, Pelvic Girdle Pain & The Pelvic Floor - October 16-17

Trauma & The Pelvic Floor in the Age of COVID-19: Treating Survivors of Childhood Sexual Abuse, Sexual Assault and Birth Trauma - October 21 & 28

Introductory Electrical Stimulation for Pelvic Health - November 6

Nutrition and Lifestyle Medicine for Endometriosis - November 7-8

Pelvic Floor Therapy & Sex: What is Our Role? - November 7-8

Introductory Pelvic Health Care for Trans and Gender Diverse People - November 21

Cesarean Birth: The Role of Physiotherapy in Preparation & Recovery - November 23

Ultrasound Imaging for Male & Female Pelvic Health Physiotherapy - November 29

In-Person Courses

Pediatric Incontinence & Pelvic Floor Dysfunction - October 3-4

The Assessment and Treatment of Breastfeeding Conditions - Oct 30- Nov 2

CBT Skills For Distressing Physical Symptoms - November 28-29

The Use Of Pessaries For Pelvic Organ Prolapse (POP) In Pelvic Floor Rehabilitation - Dec 5-6

Out Of Provinces Courses

The Assessment and Treatment of Breastfeeding Conditions - Oct 1-4 / Calgary, AB

Mobilization of Visceral Fascia: GI System - October 23-25 / Calgary, AB

The Use Of Pessaries For POP In Pelvic Floor Rehabilitation - November 7-8 / Abbotsford, BC

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Women's Health

A DIVISION OF THE CANADIAN PHYSIOTHERAPY ASSOCIATION

STRATEGIC PLAN

INTRODUCTION

The Women's Health Division (WHD) is a not-for-profit division of the Canadian Physiotherapy Association (CPA) that is managed, operated, and advanced by volunteers with a passion for women's and pelvic health. We are a dynamic organization, national in scope, that effectively facilitates communication, education and service delivery for physiotherapy practitioners on topics specific to women's and pelvic health.

VISION STATEMENT

To be the national leader in women's and pelvic health physiotherapy through community, advocacy and knowledge translation.

STRATEGIC PRIORITIES

The fulfilment of Women Health Division's vision over the next five years calls for strategizing in four key areas to achieve success. These include Governance, Member Experience, Knowledge and Education, and Advocacy.

STRATEGIC PRIORITY 1
GOVERNANCE

STRATEGIC PRIORITY 2
MEMBER EXPERIENCE

STRATEGIC PRIORITY 3
KNOWLEDGE & EDUCATION

STRATEGIC PRIORITY 4
ADVOCACY

STRATEGIC PRIORITY 1

GOVERNANCE

Establish an efficient, organized and productive governance structure that will allow us to maximize our resources and member services.

ACTIVITIES

A. Develop clearly defined roles and responsibilities for each executive and subcommittee members.
B. Conduct an annual review of the activities within the Strategic Plan and adjust the Operational Plan as required.
C. Conduct an annual review to update the Terms of Reference for the Division
D. Provide governance and leadership education to the executive.
E. Implement an effective Succession Plan for the executive.

STRATEGIC PRIORITY 2

MEMBER EXPERIENCE

Provide an exceptional member experience.

ACTIVITIES

A. Facilitate professional development and promote evidence-informed practice for all WH/PH clinicians/educators/researchers via access to resources, research, and courses.
B. Assist WH/PH clinicians to navigate a wide range of practice-based challenges, such as use of PPE, national regulations, etc..
C. Provide professional development guidance for new grads and aspiring WH/PH clinicians.
D. Nurture an active and engaged community for WH/PH clinicians.
E. Improve delivery of member experience in French.
F. Review and evaluate member services on an annual basis to ensure the WHD's resources are being appropriately used according to members' values.

STRATEGIC PRIORITY 3

KNOWLEDGE & EDUCATION

Foster excellence in WH/PH physiotherapy practice by supporting research, facilitating education, and encouraging evidence informed practice.

ACTIVITIES

A. Develop a set of advanced practice competencies for WH/PH clinicians across Canada.
B. Collaborate with Canadian Physiotherapy programs to support entry-level and elective WH/PH curriculum.
C. Connect and support WH/PH researchers across Canada.

STRATEGIC PRIORITY 4

ADVOCACY

Champion the advancement of women's and pelvic health.

ACTIVITIES

A. Revisit renaming the division to re-evaluate if our name represents the population we serve.
B. Advocate for the role and value of WH/PH physiotherapy across the health disciplines.
C. Collaborate with professional regulating bodies to support the standardization of WH/PH continuing education.
D. Improve access to WH/PH care for diverse and underserved populations.
E. Support our members as advocates in their communities.
F. Promote the presence of the WHD on the international stage.

POST-GRADUATE MICROPROGRAM IN PELVI-PERINEAL REHABILITATION, SCHOOL OF PHYSIOTHERAPY, AT UNIVERSITY OF MONTREAL: A 9TH COHORT IN CANADA!

The School of Rehabilitation at the University of Montreal, would like to congratulate the ninth cohort of physiotherapists, who graduated from the Microprogram in pelvi-perineal rehabilita-tion, this May, despite the actual Covid-19 situation. The graduates, from all corners in the province of Quebec, Ontario, Manitoba and New-Brunswick, are practicing with various clients in both the public and private fields (ex: men, women & children, as well as clienteles with on-cological, anorectal or neurological issues.)

This Post-graduate Program of 6 courses, 15 credits (250 hours), began in January 2010 and is the first of its kind in Canada. It aims to enable physiotherapists to develop the unique exper-tise and the skills needed to evaluate and treat various problems pertaining to the perineal, pelvic floor and pelvic regions.

This Post-graduate Microprogram in pelvi-perineal rehabilitation, based on an evidence-based and ethical approach, is given by modules (2 per semester) on weekends thru scientific read-ings, lectures, workshops, clinical reasoning sessions, practical sessions, clinical observership and multidisciplinary exchanges. It is offered every year and the deadline for admission is No-vember 1 of every year. The number of admissions has been increased from 25 to 36, due to its popularity!

For more information **click here.**

MICROPROGRAMME DE 2E CYCLE EN RÉÉDUCATION PÉRINÉALE ET PELVIENNE EN PHYSIOTHÉRAPIE DE L'UNIVERSITÉ DE MONTRÉAL: UNE 9E COHORTE AU CANADA!

Le programme de physiothérapie de l'Université de Montréal tient à féliciter les physiothérapeutes de la neuvième cohorte du microprogramme en rééducation périnéale et pelvienne et ce, malgré les circonstances actuelles. Ces diplômées pratiquent avec diverses clientèles dans le réseau public et au privé, dans plusieurs régions du Québec, de l'Ontario, du Manitoba et du Nouveau-Brunswick.

Ce microprogramme de 15 crédits (250 heures), le premier au Canada, a vu le jour en janvier 2010. Il a pour but de permettre aux physiothérapeutes de développer une expertise unique et d'acquérir les compétences nécessaires à l'évaluation et aux traitements physiothérapeutiques des diverses problématiques périnéales et pelviennes auprès des clientèles variées (ex : hommes, femmes et enfants ainsi que les clientèles neurologique, oncologique et gériatrique).

Le programme de 2e cycle, basé sur les données probantes et une pratique éthique, se donne par modules de fins de semaine sous forme de lectures scientifiques, de conférences, d'ateliers de raisonnement clinique, de sessions pratiques, de stages d'observations cliniques et d'échanges multidisciplinaires.

Ce programme en rééducation périnéale et pelvienne est offert à chaque année et la date limite d'admission est le 1er novembre de chaque année. Fait à noter est que nous avons augmenté le nombre d'admissions de 25 à 36 par année!

Pour plus d'information **cliquez ici**.

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Itching	85.0%	Tension	79.5%

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‡ 95 breast cancer patients suffering from vaginal dryness (induced by chemotherapy or hormone treatment) were assessed after receiving RepaGyn® (once daily for 20 days, followed by a maintenance period of twice per week for 10 weeks)*

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- ✔ **Convenient and easy-to-use vaginal ovules**

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1. Tea, MKM, Priemer, V, Kubis,E, Efficacy and safety of hyaluronic acid suppositories (Cikatridina®) in the treatment of vaginal atrophy in breast cancer patients induced by hormone treatment or chemotherapy, Fertility and Reproduction Journal, 2006, 16 (2) (Austrian edition), 17-19.

* RepaGyn® is also known as Cikatridina®, Cicatridine®, Cicatridina®

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NEW GRADUATE AWARD
EMMA CONRON

I am honoured to be the recipient of the 2020 New Graduate Award in Women's Health and/or Pelvic Health. I have taken two continuing education courses in pelvic health since graduating in September 2019. In school I received only a brief introduction to women's/pelvic health. The WHD award has allowed me the opportunity to expand my knowledge in this field, and subsequently better my overall practice as an entry level physiotherapist. The knowledge I gained on these courses has really highlighted the importance of the role of physiotherapists as educators. Being able to understand pain and the role of the central nervous system in contributing to pain mechanisms has been particularly impactful on the way I practice physiotherapy, not only with the patients I see for pelvic health but for all individuals struggling with chronic pain. I am very proud to be a member of the women's and pelvic health community and am excited to continue to learn and grow in the next stages of my career.

ADVANCED PRACTICE AWARD
FRANCESCA AMBROCICHUK

In February I had the fortune to attend Ramona Horton's Mobilization of the Visceral Fascia: Urinary System course held in Toronto, Ontario by Pelvic Health Solutions. This course was a remarkable learning experience. I recommend this course to anyone seeking to advance their pelvic health practice and further their knowledge and manual skills in the nervous system and fascia. Ramona Horton is a physiotherapy gem. The course material has been developed with countless hours of study and research and is presented with a solid evidence base, firmly rooted in embryology and anatomy. We had two wonderful and talented lab instructors and there was no shortage of instruction and advice from them during our practical labs. This course has enhanced my palpation skills. I can consider more critically the role of the fascia and the nervous system in my assessment and treatment and I have learned effective and rewarding manual techniques to interact with these systems. This has helped my patients in remarkable ways, which is such a rewarding experience!

Continuing education is an investment for yourself as a clinician, for your patients' health, and for the future of our profession. As a senior clinician, I can share this knowledge and experience with new physiotherapists beginning their pelvic health journey. The financial support from the Women's Health Division to encourage continuing education is an investment toward a rich future of women's health physiotherapy in Canada. I am so grateful for this award to support my lifelong passion for learning. Thank you WHD!

CONFERENCE BURSARY AWARD
LARISSA TUTERT

The physiotherapy community has grown to understand that pain is multi-factorial. Pain tends to be the driver behind why many patients seek help in the first place. This reality was the impetus behind my attendance at the 2019 International Pelvic Pain Society (IPPS) Annual Scientific Meeting in Toronto, Canada. By expanding one's knowledge of the multi-faceted components of pelvic pain, one can provide a truly comprehensive and holistic approach to patient care.

While working at the Dovigi Orthopaedic Sports Medicine Clinic at Mount Sinai Hospital, my patients have demonstrated how pain has the potential to affect us all in various ways. The most current evidence-based research was presented at the IPPS conference and this allowed me to immediately translate this knowledge to my clinical practice. Following the conference, I was able to more seamlessly integrate techniques to screen for endometriosis and adolescent dysmenorrhea in my paediatric patients. I was also able to incorporate new contemporary medical acupuncture techniques in male and female chronic pelvic pain populations. Poster presentations and group breakout sessions at the conference highlighted how differently sexual pain is interpreted across cultures. As a result, I have since sought out opportunities to learn from leaders in various healthcare fields in order to further enhance how I provide trauma-informed care.

I have recently had opportunities to incorporate the knowledge I acquired at the IPPS conference outside the clinical setting. I developed and delivered a Prenatal Pelvic Floor Workshop at Mount Sinai Hospital, which incorporates the most current information on chronic pelvic pain in order to empower workshop participants. To further my community outreach efforts, I have presented to the Obstetrical health care providers at Mount Sinai Hospital and disseminated the latest research from the IPPS Conference.

TRAVEL AWARD
TRYNA DEGAGNE

First and foremost I'd like to thank the Women's Health Division (of the Canadian Physiotherapy Association), for selecting me as the gracious recipient of the 2020 Travel Award for Members Practicing in Remote Areas. My name is Tryna DeGagne and I live in Brandon, MB, with my husband and two young children. I am the owner and sole physiotherapist at my clinic, Element Physiotherapy. This is my 9th year as a physiotherapist and 6th year practicing in the area of Women's Pelvic Health Physiotherapy. I have a special interest in the area of perinatal physiotherapy and pelvic girdle pain, as well as returning postpartum women to physical activity.

In the spring of 2019, I flew to Ontario, to attend a course organized by Pelvic Health Solutions entitled Pregnancy, Pelvic Girdle Pain & The Pelvic Floor. What I valued most about the course is the biopsychosocial approach to pain and the incorporation of pain science for treating perinatal pelvic girdle pain. This model is substantiated by vast research, including research from one of the course instructors, physiotherapist Sinead Dufour. While we learned many extremely useful internal and external manual therapy techniques at the course, we were encouraged to incorporate many other aspects of treatment. This ranged from an abundance of education regarding the central mechanisms and physiology of pain, acknowledging physical environmental stressors, as well as self techniques and exercises for our clients to manage their own symptoms. Ultimately it enables them to have a very active role in their physiotherapy and pain management.

This has been integral to my practice for the last year, even more so as COVID-19 has forever changed the delivery of physiotherapy services and promoted the expansion of telehealth physiotherapy. I have been able to effectively provide therapy services for rural clients 2-4 hours away from my hometown who wouldn't otherwise have access to a pelvic health physiotherapist and/or techniques that clients can use immediately following their delivery to manage their pain. Many thanks to the course instructors, my fellow colleagues at the course and again to the Women's Health Division for enabling rural physiotherapists with the chance to expand our education and help clients also living in remote areas.

NEWSLETTER ADVERTISING RATES 2020-21

The Women's Health Division has an ever-growing membership of over 700 physiotherapists.
Our quarterly publication is national, reaching physiotherapists from coast to coast.

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Summer 2021:	July 8th, 2021	Between August 1 and 15, 2021

For more information please contact: Marylène Charette, **treasurer.whd@gmail.com**

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