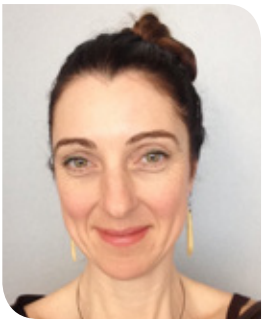
Current Directions In
Women's HEALTH
Winter 2019
A Division of the Canadian Physiotherapy Association

Word from the Chair



I am happy to say that we are experiencing a warm spell here in Saskatoon as I write this. The sun is shining and there are cross-country skiers out in the park just outside my window. I plan to head out there and get some exercise and take advantage of the sun, as soon as I am finished this note!

In the last few months, the WHD executive has been hard at work on various exciting projects. First of all, Hayley, our student representative, is organizing another Valentine's Day Challenge (VDC). If you are not familiar with the VDC, which is now in its fifth year, it is a drive for new, unused toiletries, feminine hygiene products and incontinence supplies which will be donated to local women's shelters. This drive is spearheaded by physiotherapy students and women's health physiotherapists from universities and clinics from across Canada. Want to get involved? Check with your local university physiotherapy program or start your own drive. If you have questions, contact Hayley at *whdstudentrep@gmail.com*.

The WHD annual awards will soon be available. These include travel and new graduate awards, a student bursary to attend Congress and a bursary to attend a conference. New this year is the Jodi Boucher Leadership Award, which was developed to recognize and honour one of our past executive members for her outstanding leadership qualities and countless contributions that she has made throughout her career as a physiotherapist. Lastly, the Physiotherapy Foundation of Canada WHD grant for research in women's health will also be presented this year for an outstanding amount of $10,000! Check our website for details.

Our Research and Education Chairs (with the assistance of two members from PABC) have been hard at work developing an infographic that can be used to share with other health care practitioners, to aid in understanding the scope of pelvic health physiotherapy. We are hoping this will be ready by March. Our Education Chair is also developing templates for client educational resources. We are planning to launch a student competition for these in the spring. Keep your eyes open for details!

Thanks again to all the Executive and sub-committee members for all your hard work! The WHD could not do what we do without these hard-working volunteers.

As always, if you have any questions, please feel free to contact me at *whdchair@gmail.com*.

Stay warm!

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

IN THIS ISSUE

Canadian Physiotherapy Association

Welcome to the winter issue of the WHD newsletter!

Are you enjoying this beautiful season? I know this question is probably getting a lot of eye rolls, but try to think about it from the perspective of having the white, fluffy snow beautifully falling outside, while you are sitting by your window all curled up with a cup of your favourite warm drink in your hands… Not something I personally can relate to, as at the time of writing this, here in Bedford, it is -2 degrees Celsius and sunny, with a lot of slush on the roads.

This issue's main focus is Pelvic Organ Prolapse – It is a condition that affects so many lives (according to WebMD – one third of all women will experience symptoms of POP over their lifetime!) and we, as pelvic health physiotherapists have the tools and skills to help many of them. Leslie, Katie, (newsletter subcommittee) and I are excited to present to you some interesting information we gathered from research, as well as other practitioners, about POP, as well as some practical tools, recommendations, and tips. One of the interviews also has a special treat for you – a view of their courses!

Additional information you will find in this newsletter is a wonderful article about breastfeeding, written by Mercedes Eustergerling, a member of the research subcommittee, as well as my one-on-one interview with Antony Lo, who was gracious enough to answer my questions for the newsletter after a long day of teaching the "Female Athlete" course in Montreal, while still not completely being over his jet-lag.

We hope you enjoy this Newsletter!

Katerina Miller, BSc Psych, MScPT
WHD Newsletter Editor

Pelvic Organ Prolapse – Diagnosis, Assessment, and Management

By Marie-Josée Lord, Physiothérapeute

Pelvic organ prolapse (POP) is a very common reason for consultation in our field of pelvic health physiotherapy and can be found in women of all ages. It is reported in the literature that 50% of parous women are affected by pelvic organ prolapse. (Haya et al. 2018)

WHAT IS PELVIC ORGAN PROLAPSE?

It is the descent (from the normal anatomical position) of one or more of the pelvic structures such as bladder, urethra, rectum or uterus. The terms describing the prolapse are changing from cystocele, urethrocele and rectocele to terms describing the areas affected such as anterior compartment, posterior compartment, middle or apical compartment. After a hysterectomy, the descent of the vaginal apex is referred to as vault prolapse.

It seems that the patient's degree of discomfort or distress is not always proportional to the degree of organ descent. We often have women that have a lot of symptoms from an organ prolapse and yet the descent does not seem significant when objectively tested. You can also have women that have an obvious prolapsed, for example the cervix or bladder is actually protruding outside of the vaginal introitus and in contact with the underwear, but yet these women don't seem to be distraught by this situation. It is in fact quite common for emergency room doctors to have to perform a pelvic exam on a woman that comes in very worried about the fact that she is now noticing a mass coming out of her vagina. Too often these women are sent home being told it isn't anything life threatening but with no further explanation of what is happening and what should be done until they finally get an appointment with their gynaecologist, and hopefully then referred to a pelvic health physio.

POP SYMPTOMS

There is a wide range of POP symptoms reported in the literature.

- Feeling of heaviness or discomfort in the vagina
- Inability to completely empty bladder or bowel
- Inability to sit comfortably
- Constipation
- Need to use finger to empty bowels or splinting during evacuation
- Difficulty wearing tampons
- Pain into perineum, abdomen
- Vaginal noise and/or bath water going into vagina
- Difficulty or pain during sex
- Back discomfort
- Discharge, bleeding from exposed vaginal parts on clothes
- Recurrent UTIs
- Decrease self-esteem and body image

It is important to take a good history e.g. is the patient coughing a lot from asthma, smoking, chronic respiratory disease, or has a higher BMI, is lifting a lot of heavy objects or has chronic constipation. You will need to inquire about the type of physical activities the patient is doing and modify those activities to reduce the pressure on the pelvic floor.

HOW IS POP TESTED?

There are 2 major quantification systems being used to evaluate the degree of prolapse. The Baden-Walker (grades from 0-4) is done with the patient in the supine position performing a Valsalva maneuver while the examiner evaluates the descent of any of the compartments: anterior, posterior or apical.

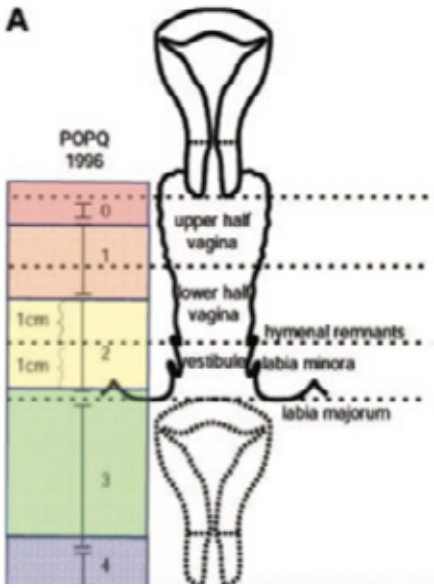
0- Normal position, no prolapse
1- One or more compartments descend halfway to the hymen
2- One or more compartments descend to the hymen
3- One or more compartments descend past the hymen
4- Maximal possible descent of one or more compartments

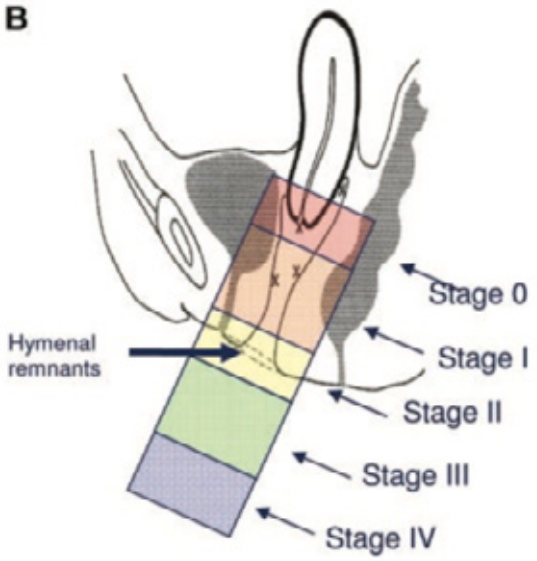
If the prolapse is not evident, but the patient is complaining of a bulge, it may be necessary to evaluate the patient in standing.

The Pelvic Organ Prolapse-quantification system (POP-Q) is an internationally (IUGA and ICS) accepted evaluation system. It consists of several measurements at predetermined anatomical points. This system is more reliable but more complex and more time consuming so does not seem to be used as much in clinics as it is in research evaluations. This may be due to a lack of time physicians have to do their physical exams.
The results go from stages 0 – IV: (Haylen et al. 2010)

0- No prolapse
I- Most distal portion of the prolapse is more than 1 cm above the level of the hymen
II- Most distal portion of the prolapse is 1 cm or less proximal to or distal to the plane of the hymen
III- The most distal portion of the prolapse is more than 1 cm below the plane of the hymen
IV- Complete eversion of the total length of the lower genital tract

There may be a need to do further testing such as 3D ultrasounds, anal manometry or defecography if the patient is dealing with difficulty emptying the bladder or any stool evacuation difficulties.





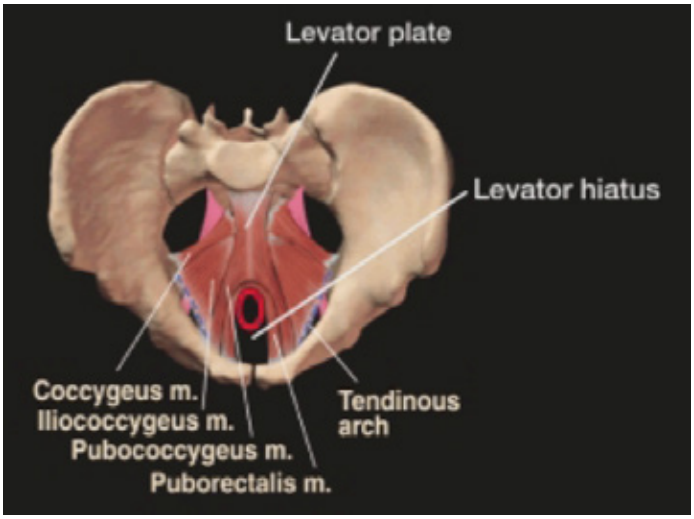
POP-QHaylen, 2010

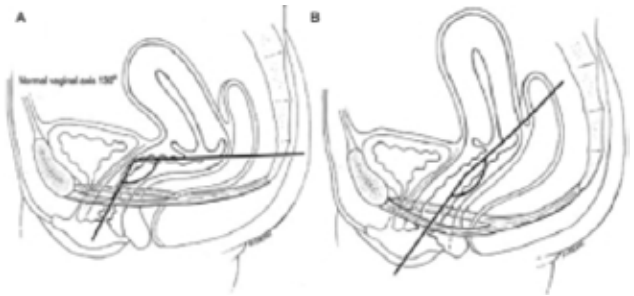
The medical management of POP will depend on its severity, but also on the degree of the patient's discomfort and complaints. Usually women feel their discomfort later in the day, after being up against gravity for a while and having done some physical activities, including carrying young children or doing household chores. There are several validated questionnaires directed specificially to prolapse: Pelvic Organ Prolapse/Urinary Incontinence Sexual Questionnaire (PISQ-12), Prolapse quality of life questionnaire, Pelvic organ Prolapse Distress Inventory, Pelvic Organ Prolapse Impact questionnaire. Those may help you determine the level of concern or distress of the patient.

PELVIC HEALTH PHYSIOTHERAPY FOR POP

When the prolapse is asymptomatic or mildly symptomatic, the medical management is often observation and lifestyle modifications such as weight management, smoking cessation and constipation management. A referral to pelvic health physiotherapy would be appropriate to help the patient acquire strategies against any increases of abdominal pressure such as when coughing, lifting, jumping, etc.

The first part of pelvic floor muscle training (PFMT) would consist of making sure the patient is able to perform a good contraction with minimal co-contraction of abdominal muscles. The training of the abdominal core muscles will come later after the patient has improved her pelvic floor muscle contractility and tone. The organ support in the pelvis comes mainly from proper tone of the pelvic floor muscles (PFM), more specifically at the levator plate, but also from the pelvic fascial/connective tissue. The levator plate is the area of the pelvic floor that is just posterior to the rectum and anterior of the coccyx and, as described by Herschorn in his 2004 article on Female Pelvic Floor Anatomy, if there is good tone of the pelvic floor muscles, and the levator plate remains horizontal during an increase of intra-abdominal pressure, the organs won't be pushed down as far and will be stopped by the levator plate. However, if the tone of the PFM is not good, and the levator plate becomes more vertical during an increase of intra-abdominal pressure, then the internal organs are being pushed into the vagina and support has to come from the fascia. Over time, this connective tissue cannot keep supporting this pressure and starts failing, thus resulting into some pelvic organ prolapse.



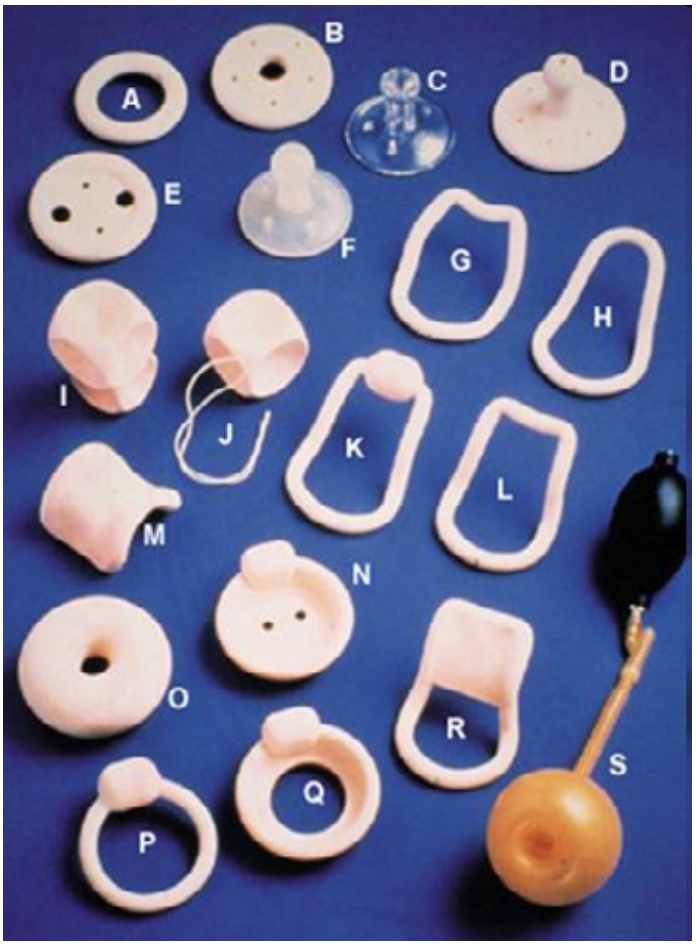


Herschorn, 2004

The pelvic health physiotherapist will help the patient improve the PFM contractility and tone, as well as get the patient to learn to do an automatic contraction when doing any effort that increases intra-abdominal pressure. This is referred to as 'The Knack'. Proper abdominal training will also help improve the pressure generated on the pelvic floor and reduce the likelihood of POP symptoms. Often with physiotherapy treatments, we see an improvement of the symptoms but don't always see a significant change of the position of the prolapse. In a recent study, Resende et al. 2019, compared PMFT and hypopressive exercises. Their results showed improvement of POP symptoms, quality of life, prolapse severity and PFM function in both groups with more significant improvement in the PFMT group.

Also, as part of the physiotherapy treatments, we should not forget to help our clients manage constipation, teach the proper evacuation technique starting with good position, breathing, PMF relaxation, adequate pushing using TA and maybe splinting to better evacuate stool from the rectocele as well as decreasing the symptoms of heaviness post evacuation.

The next option for POP is one that may change a woman's life if the POP symptoms persist even though she has done some PFMT and/or if she wants to pursue some sports that will constantly put a pressure on her pelvic floor. The option of wearing a pessary seems to scare off many women at first. If the pessary is well fitting and is the proper type for the prolapse, then the support it brings to the patient will allow her to continue her activities without worrying about making the organ descent worse and increasing her symptoms. Pessary fitting is done by urogynaecologists, gynaecologists, nurse practitioners, and can also be fitted by trained physiotherapists with the approval of the patient's physician. There are many different types of pessaries and will need to be tried while the patient is doing some physical straining such as coughing, jumping, running, picking up heavy objects, etc. Pessaries can be worn all the time and only removed to clean it, or can be worn only when doing a sport or physical activity that causes the symptoms to increase. When the pessary fits properly, it is an excellent option instead of surgery.



Milex-CooperSurgical

The last medical treatment option would be surgery. So much has already been written and studied about different surgical techniques; mesh vs. native tissue graft, abdominal vs laparoscopy approach, and of course, surgery cure-rate, symptoms recurrence rate, and complications. The type of surgery proposed to the patient will greatly depend on the surgeon's training and experience, the types of prolapse, the age and degree of physical activity of the patient as well as the patient's complaints.

A 2017 Cochrane review reported that:

- Permanent mesh resulted in lower rates of awareness of prolapse, recurrent anterior wall prolapse and repeat surgery compared to native tissue
- Native tissue repair had reduced risk of new SUI, reduced bladder injury and complications from mesh erosion vs mesh repair

Surgery may be a viable option to treat the prolapse, but the patient should be well informed of the risk of complication and should have been directed first to more conservative types of treatments before choosing this treatment.

WILL THE FUTURE BRING US NEW TREATMENTS FOR POP? LASERS, PLASMA RICH PLATELETS (PRP) INJECTIONS, RADIOFREQUENCY TREATMENTS?

Certainly, more research will be needed to determine the efficacy of these treatments. For now, we have to remember that we often make the most improvement with education. Knowledge is power. Knowing that having a prolapse isn't life threatening, knowing what to do to improve it or reduce the symptoms is quite reassuring for the women. Don't minimise your patients' symptoms or their concerns vis-à-vis their prolapse, and start educating them!

References:

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www.ics.org

Message from CPA

The Canadian Physiotherapy Association is thrilled to announce that our 2019 awards program is accepting applications as of December 21st. Our program will fund physiotherapy research grants, scholarships, and continuing education bursaries. Thank you so much to our 2019 Division award partners: the Orthopaedic, Neurosciences, Cardiorespiratory, and Women's Health Divisions.

Applications will be reviewed after our February 24th deadline by our Scientific Awards Committee (SAC). Please share our awards program with your Divisions via your communications channels, we would really appreciate it!

In order to help our Foundation continue to support our profession, please consider a donation from your Division during the holiday season; every dollar counts.

Interview: Assessment and Treatment of Levator Ani Muscle Tear

By Leslie Spohr, PT and Newsletter Subcommittee Member

Levator Ani muscle (LAM/LA) injuries occur in 13–36% of women who deliver vaginally[1]. Injury to the LAM is attributed to vaginal delivery resulting in reduced pelvic floor muscle strength, enlargement of the vaginal hiatus and pelvic organ prolapse[1]. We connected with Tamarah Nerreter, of Diane Lee and Associates, for insight on assessment and treatment of LAM injuries.

Schwertner-Tiepelmann, N., Thakar, R., Sultan, A.H., & Tunn, R, (2012). Obstetric Levator Ani Muscle Injuries: Current ststus. Ultrasound in Obstetrics and Gynecology,39 (4), 372-383. Retrieved January 26, 2019, from https://obgyn.onlinelibrary.wiley.com/doi/full/10.1002/uog.11080.

Q: HOW DO YOU PREFER TO ASSESS FOR LEVATOR ANI MUSCLE (LAM/LA) TEARS? WHY DO YOU PREFER THIS METHOD?

A: Preference is to do internal palpation examination for LA tears. This is due to the difficulty with diagnosis using external examination. Further MRI imaging can be difficult to get and expensive, and is difficult to distinguish partial or complete tear. Often LA tears are missed post-partum because physicians/midwives are not assessing internally for them. Most commonly we see the puborectalis tear/avulsions, the extent varying greatly within the incomplete realm (muscle thinning to partial avulsion which is often not thought to be a factor in prolapse but rather incontinence; avulsions are often associated with prolapse symptoms and/or signs as well as poor contraction of PFM).

Q: ARE THERE OTHER METHODS COMMONLY USED TO ASSESS AND, IF SO, IN YOUR OPINION, WHAT ARE THEIR LIMITATIONS?

A: I am not currently aware if there are other methods of examination, other than imaging MRI or diagnostic ultrasound that would confirm or negate a levator ani tear.

Q: IF ABLE, CAN YOU DESCRIBE HOW YOU MANUALLY ASSESS FOR LEVATOR ANI TEARS? HOW DID YOU LEARN?

A: I learned this in a level 3 and 4 pelvic floor course. Further, I learned from my mentors early on in my practice. Assessment is performed intravaginally using digital palpation. The superficial pelvic layers should be assessed appropriately for function/dysfunction first and then deep to this the LA can be assessed with palpation to determine the grade of tear or avulsion. As per Dietz's description in his article (a good resource):

Hans Peter Dietz (2010) Pelvic floor muscle trauma, Expert Review of Obstetrics & Gynecology, 5:4, 479-492

Muscle morphology (e.g., holes, gaps, ridges and scarring), muscle integrity, scarring and the width between the medial borders of the PFMs with palpation is noted.

Specific to the puborectalis:

To assess morphological integrity the palpating finger is placed parallel to the urethra, with the tip of the finger at the bladder neck, and its palmar surface pressed against the posterior/dorsal surface of the symphysis pubis. If the muscle is intact then there will be just enough room to fit the palpating finger between the urethra medially and the insertion of the puborectalis muscle laterally. If there is no muscle palpable on the posterior surface of the os pubis and the inferior pubic ramus immediately lateral to a finger placed parallel to the urethra, and if this finger can be moved over the inferior pubic ramus without encountering any contractile tissue for another 2–3 cm, then this implies an avulsion injury on this side. The extent of avulsion varies greatly, and there is also a spectrum of incomplete injuries: generalized thinning of the muscle, partial avulsion of the most inferior aspects (with the most cranial aspects of the puborectalis still adhering to the inferior pubic ramus) and partial avulsion of more cranial aspects, palpable as a hole, slit or gap in the insertion of the superior aspects of the puborectalis, or in the inferior aspects of the iliococcygeus muscle.

Q: WHAT CLIENT POPULATION/SYMPTOMS DO YOU ASSESS FOR TEARS IN?

A: Post-partum women, especially those who report 2+ hours of pushing, grade 2+ tear, episiotomy or those who report surgical intervention (forceps, vacuum).

Q: WHAT IS THE PREVALENCE OF LEVATOR ANI TEARS?

A: It is hard to be precise with this number due to the lack of post-partum follow up worldwide involving thorough pelvic floor examination. However, Dietz reports from 10-40% of women suffer from this, especially those with forceps delivery. From experience I can say majority of women I have done internal palpation examinations on who have reported use of forceps in their delivery have some form of pelvic floor trauma to the Levator Ani/puborectalis.

Q: WHAT ARE THE RISK FACTORS FOR LEVATOR ANI TEARS?

A: Prolonged second stage labor, high grade tearing (>2), forceps delivery, vacuum delivery.

Q: WHAT IS THE/YOUR TREATMENT PROTOCOL FOR LA TEARS?

A: LA treatment involves downtraining and re-up-training of the pelvic floor, scar tissue manipulation (if present), pelvic floor release (if needed), re-education of pelvic floor activation, breath education (diaphragm), offloading, myofascial release, deep core control, functional core re-training (lumbopelvic hip stability), management of prolapse (if present- ie. PFM rehab, pessary). The treatment will align with the patient goals and meaningful task. As we know mothers are often on their feet a lot during the day, carrying babe, breast feeding etc., and therefore need to optimize posture, function and control through their changing positions.

Q: WHAT IS THE PROGNOSIS FOR THOSE WITH LA TEARS?

A: I'm not sure if I can rightfully answer this question as the research does not have any concrete evidence or support for a definite 'prognosis'. In my experience, my patients who have complied with appropriate rehabilitation guided by their goals, have done relatively well. If they have prolapse symptoms or evidence of prolapse a pessary has also provided them with support to assist in re-training the pelvic floor and allowed them to pursue activities they may have not been able to do otherwise. PFM symmetry has been achieved with PFM rehabilitation. Further, functional deep corset control has resolved significantly for my patients to achieve their tasks successfully. I have had one patient who has continued to struggle with on/off low back pain and pelvic control issues due to her substantial LA tear. However with physiotherapy she has been able to successfully achieve two more pregnancies (with elective CS deliveries).

Q: WHAT ARE THE SIGNS AND SYMPTOMS THAT WOULD INDICATE POTENTIAL TEAR IF A CLINICIAN IS UNABLE TO ASSESS?

A: I'm not certain under what circumstances a clinician would be unable to assess, unless the patient could not tolerate an internal palpation examination; in this case reported symptoms could include the following: prolapse (visible at opening), symptoms of prolapse (pressure, heaviness, pain), pelvic pain, pelvic torsion, poor pelvic control, hip issues, incontinence, pain with intercourse. As you can see these symptoms are common across most post-partum women therefore an internal pelvic floor examination is important to confirm or negate a LA dysfunction/tear.

TAMARAH NERRETER

BAH MScPT CAFCI GCOMPT
Special Interest Women's Health Orthopedics, Sport Pelvis, Pediatric Continence Issues, Men & Womens Health, Pre/Post Natal, Pre/Post Surgical, Pelvic Floor Dysfucntion, Anorectal Dysfucntion, and Pelvic Pain

Diane Lee and Assicoates
BoDynamics Physiotherapy

Tamarah graduated with her Master of Physiotherapy in 2007 from Curtin University in Perth, Australia. Since then, she has been working in private practice in Vancouver, BC. While in Australia, Tamarah pursued her interest in women's health through various avenues: pioneering a post partum exercise pamphlet; honing her interest in sport and related physiotherapy treatment; and completing her Master's thesis on the practice of 'core' stability programs in the rehabilitation of osteitis pubis/groin injuries.

Tamarah's keen interest in women's health issues, led her to further professional development and certifications specific to women's health, perinatal care, rectus diastasis, pelvic health rehabilitation, pediatric continence, prolapse, urinary incontinence, and pelvic pain. Tamarah continues to treat diverse sports related injuries to a wide range of clientele as well.

Tamarah's approach to treatment is facilitated from her extensive post grad course work. She believes in a holistic whole body approach, empowering the individual through education, treatment and exercise.

Tamarah has completed professional training in The Integrated Systems Model (Lee D 2011- The Pelvic Girdle 4th edition), a whole body assessment and treatment approach practiced extensively at Diane Lee & Associates. She currently assists and co teaches on Diane Lee's ISM Series, Abdominal Wall Course and Women's Health Course.

Tamarah is currently doing her post grad at UBC, Graduate Certificate in Orthopedic and Manual Therapy (GCOMPT), completion 2019. Furthermore, Tamarah is certified in and has worked privately teaching Pilates (mat and reformer).

Non-Surgical Management of Pelvic Organ Prolapse

By Katie Kelly, PT and Newsletter Subcommittee Member

Pelvic organ prolapse (POP) can strike fear and dread in women. Aside from the common symptoms associated with POP (perineal heaviness, urinary/fecal incontinence, constipation, prolapsed tissue irritation), many are concerned that they will require surgery. While surgery is a good and necessary option for some women, others are happy to explore non-surgical options for symptom relief. In addition to the considerable amount of evidence in support of pelvic floor muscle exercises for effective conservative management of POP,[1,2,3] there are often other options, tips and tricks suggested by physiotherapists to help manage symptoms. This article investigates some of these other options.

PESSARIES:

These devices, typically made of silicone, are inserted into the vagina and placed under the cervix to support descending vaginal walls and manage prolapse symptoms. They are defined as supportive, or space-filling, and come in a variety of shapes and sizes. In recent history, they have been fitted and monitored by medical professionals, though pelvic floor physiotherapists in some provinces are able to fit and follow these patients. Some women return to a provider's office on a monthly/seasonal basis to have the device removed, cleaned and re-inserted, while other women can insert and remove their pessaries independently. Literature suggests that pessaries are a good option for a significant portion of women with stage 2 POP or higher, who are considering undergoing surgery.[4,5] Some emerging evidence suggest that pessaries might offer preventative benefits and/or symptom/staging improvement, even after the device is removed, although more research is needed.[6,7]

More recently, pessary devices have become directly available to the public. For example, the Uresta Bladder Support system is a kit containing 3 different sizes of pessaries (2 other sizes can be delivered if needed). Purchasers are to use trial and error to fit the vaginal device which is aimed at compressing the urethra in an effort to reduce leaks. Another is the Poise Impressa - a single-use, disposable bladder support device with a medical grade silicone core and non-absorbent polypropylene cover.[8] It too offers intravaginal urethral compression. Although the evidence is somewhat biased, these devices seem to deliver immediate improvement in urinary stress incontinence, though do not offer relief of other prolapse symptoms.[9,10,11,12] It's suggested that 20% to 40% of women with pelvic organ prolapse also experience fecal incontinence,[13,14,15] and until recently, pessary use offered little relief or varying degrees of success for this symptom. However, the Eclipse system (yet to be approved in Canada) is demonstrating effective management of fecal incontinence.[16] The pessary has a pump system, that allows for air to be inflated into the posterior half of the pessary, giving support to the rectum and anal sphincters. The air can then be deflated to allow for bowel movements.

EXTERNAL SUPPORT:

While no research was found by this author, clinical experience has demonstrated that some women find POP symptom relief from external perineal support devices. These include underwear-style braces like the V-brace,[17] or the baby Belly Band compression groin bands.[18] Clinically, some patients even report improved symptoms with compression shorts.

LIMITING STRAIN:

Pressure from a Valsalva maneuver and strain against the pelvic floor organs have been a long-standing risk factor for prolapse. Valsalva is defined as a forced exhalation against a closed glottis, mouth and nose while a strain is typically performed with a relaxed pelvic floor such as in during defecation.[19] One source for this includes vaginal deliveries, with research suggesting increasing risk of POP with each subsequent vaginal delivery and further risk with >4 vaginal deliveries.[20] However, method and type of delivery is beyond the scope of physiotherapy and this article.

Another source of pelvic organ pressure is from constipation, a contributing factor for POP.[20,21] Constipation management is part of a comprehensive POP treatment plan. Dietary changes including proper fiber intake, identifying and limiting triggering foods, proper fluid intake, and (with consult from medical or pharmacy team members) appropriate use of stool softeners or laxatives can help with stool consistency. Abdominal/colon massage techniques, general cardiovascular exercise, and implementing a bowel schedule can aid with colonic transit time. Many physiotherapists advocate for improved toileting postures, with knees elevated above hips and feet firmly supported, to ease relaxation of the pelvic floor muscles, improve the direction of force in the rectum and optimize evacuation of stool. For those with symptomatic rectocele, manual digitation or the use of a supporting device such as the Femeze can help to realign the rectum, to allow for effective stool evacuation.[22]

Limiting unnecessary Valsalva and strain can be an important part of physiotherapy treatment, as repeated pressure through the pelvic organs can worsen descent of prolapse.[23] For those using the Valsalva technique to manage chronic ear pressure problems, seeking proper medical management of this condition is encouraged. Additionally, Valsalva maneuvers are sometimes used as an abdominal-thoracic splinting technique

in heavy lifting. We also commonly encounter women who perform a Valsalva maneuver inadvertently, when attempting a pelvic floor muscle contraction.[24] Helping patients to determine when increasing intra-abdominal pressure may or may not be appropriate, and how to reduce unnecessary pressure is considered a valuable tool for patients.

Conservative treatment techniques often focus on performing the knack technique – a pelvic floor muscle contraction during a time of increased intra-abdominal pressure, such as with a cough, sneeze or heavy lift in an effort to reduce visceral descent.[25] Some clinicians propose managing intra-abdominal pressure by timing an increased intra-abdominal force (heavy lift, landing a jump) with an active exhale and kegel.

POSTURE:

Literature suggests that posture can play a role on pelvic floor pressure, as well as pelvic floor muscle recruitment. Pelvic floor muscle EMG activity is greatest during activities like maximum voluntary contraction, coughing, load-catching tasks and Valsalva maneuver when participants are in a more neutral position, compared to hyper- or hypo-lordotic postures.[26] Similar trends were observed in sitting postures, with less pelvic floor muscle recruitment in slumped (hyper-lordodic) sitting, versus upright, unsupported sitting.[27]
There is also evidence to suggest that thoracic kyphosis might be a contributing factor for uterine prolapse. In a sample of age-matched women, those with symptomatic uterine prolapse had a greater degree of thoracic curve, and greater thoracic kyphosis was associated with a greater degree of uterine prolapse.[28]

Some therapists use inverted postures, or a supported bridge position as a method to reduce the force of gravity on POP to help with symptoms. Assuming these postures intermittently prior to POP symptoms worsening, or at the end of the day, can be a relief for patients.

HYPOPRESSIVE EXERCISES:

These are a series of exercises aimed at strengthening the core and pelvic floor muscles with special attention to the breath and postures. They begin with a slow, diaphragmatic inspiration, then complete expiration, followed by diaphragmatic aspiration – a movement that brings the abdominal wall to the lumbar spine supposedly decreasing intra-abdominal pressure and improving pelvic floor muscle activation.[29] To date it remains controversial in the literature, though clinically, many attest to its benefit.[30,31,32,33]

PSYCHOSOCIAL:

An often-overlooked component of POP rehabilitation includes the psychosocial effect on the patient. Women who seek surgery for advanced stages of POP have lower body image, including feeling more self-conscious, less physically attractive, less feminine, and less sexually attractive as well as having lower quality of life on questionnaire compare to controls.[34] Clinically, we hear that prolapse symptoms can keep women from activities that they enjoy and participating in life in the way they desire. One study suggests that those seeking surgery for POP have significantly greater scores on depression scales, and that these scores improve following surgical repair.[35]
In patients with pelvic floor dysfunction, including POP, those with greater depression and anxiety scores had less benefit from pelvic floor muscle training and physiotherapy.[36] Their study suggests that patients with more anxiety and depression are less likely to be compliant with follow-up physiotherapy treatments, and they advocate that patients be screened for mental well-being as part of pelvic floor physiotherapy.

GENERAL HEALTH:

There is evidence that advise for general health can have an effect on pelvic organ prolapse. For instance, a BMI associated with obesity (>30 kg/m2) is associated with greater risk of POP, and even greater in those with a BMI associated with morbid obesity.[37, 38] Given that prolapse itself can limit the ability to exercise, guidance about exercising with prolapse and weight loss in general might serve useful for recovery. Chronic bronchitis is another risk-factor for POP, making discussing smoking cessation also worthwhile for rehabilitation.[38] Recommending medical treatment for chronic allergy symptoms in an effort to reduce cough, sneeze, clearing eustachian tubes, and blowing nose could help to reduce pressure against the viscera. Similar considerations should be given to gastro-intestinal symptoms like constipation, diarrhea, and bloating that might be risks factors for prolapse.

CONCLUSION:

POP is a condition that requires a multi-factorial rehabilitation approach. Physiotherapists are uniquely prepared to develop a comprehensive non-surgical treatment plan for those who suffer with prolapse. While we continue to use evidence informed practises, clinical pearls continue to help our patients effectively cope and rehabilitate pelvic organ prolapse.

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Pelvic Organ Prolapse Treatment: An Uplifting Approach and Online Program

By Leslie Spohr, PT and Newsletter Subcommittee Member

Pelvic Organ Prolapse (POP) effects more than 50% of women who have given birth vaginally.[1,2] For many, the condition can be quite isolating and have a negative impact on their quality of life. We contacted Haley Shevener, a personal trainer managing life with POP, and Annemarie Everett, a Women's Health Physiotherapist, to discuss their views on treatment for those with POP.

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Q: HOW DO YOU DEFINE AND ASSESS POP?

A: Pelvic organ prolapse (POP) refers to the descent of the pelvic organs towards the vaginal introitus (opening). This can be a very slight downward shift, or a more significant one. The degree of POP is typically noted with a 0-4 scale with 0 being no POP, and 4 being the maximum descent (vaginal walls or uterus outside the introitus). Any organ in the pelvis can shift: the bladder, bowel, uterus, and the type of POP is named after the region that prolapsed. With the exception of the uterus, we're not seeing the organ itself, but the walls of the vagina against which they're pushing. Some have just one area that has descended, while others have several.

POP is typically assessed by pelvic floor physical therapists (or physiotherapists) and urogynecologists, and sometimes gynecologists. There are different scoring systems used to quantify the extent of prolapse (expressed in a numerical grade) using the hymen as a reference point.

Q: ARE THERE SPECIFIC CHARACTERISTICS/RISK FACTORS OF THE POPULATION PRONE TO DEVELOPING POP?

A: POP is a condition that is multifactorial in origin. Vaginal delivery increases POP risk by 60-80%, particularly instrumental vaginal delivery (use of forceps increases risk by 20-40%) (Miedel et al., 2009). Increasing age, BMI >25, having asthma or a chronic respiratory condition, constipation, heavy occupational work, connective tissue disorders, and a family history of POP are also factors noted to increase the risk for developing POP (Dietz, 2015; Miedel et al., 2009, Braekken et al., 2009).

POP is common in a postpartum population. With the increased awareness given to pelvic physical therapy, more people are getting assessed in the early postpartum period (even in the absence of symptoms) and, as a result, more young women are ending up with prolapse diagnoses. POP has a reputation of being a concern reserved for those post-menopause but we hope to bring attention to how many women are experiencing symptoms of POP decades before menopause.

Q: WHAT HAVE YOU FOUND TO BE THE MISSING PIECE IN TREATMENT FOR THOSE WITH POP? DO YOU HAVE ANY RECOMMENDATIONS OR PRACTICAL TIPS FOR PRACTITIONERS?

A: The largest missing link we see is that providers often attempt to treat (only) the prolapse instead of the person with prolapse. One-size-fits-all recommendations are handed out with very little individual analysis and discussion. These recommendations are often not based on strong evidence, or are not up to date with our current understanding of movement and POP. Many - especially young mothers - are being told not to lift anything heavier than 5 or 10 pounds and to cease all exercise beyond swimming and those performed in a supine positions. We are not recommending that people disregard conservative recommendations, particularly in the early stages of healing, but we do believe that these recommendations need to be progressive and take into consideration the activities that each individual finds meaningful and fulfilling.

No two pelvic floors are the same and everyone experiencing POP has different goals and abilities. Research has supported that different people manage intra-abdominal pressure during activity differently, and that there is not an established threshold at which an activity is inherently problematic from a pressure standpoint. We feel strongly that people with POP need the education and encouragement to take ownership of their decisions and be given permission to integrate their personal goals and values with the recommendations from their providers.

Q: WHAT ARE SOME COMMON CHALLENGES FACED BY THOSE WITH POP AND/OR PRACTITIONERS TREATING THOSE WITH POP?

A: One of the biggest challenges to those managing POP is the lack of accessible resources, and the stigma that is often attached to the condition. Most diagnosed with POP had no idea it was even possible for prolapse of the pelvic structures to occur, had no idea where to seek treatment (or that treatment even existed!), and were terrified and humiliated to discuss their concerns with their friends, families, or even healthcare providers. Additionally, many people's concerns are written off as "par for the course" by their practitioners; this leads to people living with potentially modifiable symptoms because they simply don't know where to go or who to see.

Practitioners face challenges, as well, such as the astounding lack of research to guide treatment planning. For example, pessaries are one of the oldest medical devices to be discussed in medical literature, dating back to ancient Greece and Egypt. Despite their use for hundreds of thousands of years, we still do not have adequate studies looking at long-term pessary use, potential therapeutic benefits, prophylactic use, etc. Studies on exercise, sex, future birth decisions, etc. and POP are lacking, if they exist at all. With such little evidence with which to guide clinical reasoning, it's no wonder the recommendations for POP treatment are so varied.

Q: ARE THERE OTHER HEALTH PRACTITIONERS (IN ADDITION TO PHYSIOS AND OB/GYNS) THAT YOU FEEL ARE BENEFICIAL IN THE TREATMENT OF POP?

A: Practitioners and people with POP are both impacted by the myriad aspects of one's life affected by POP. For the benefit of both patients and practitioners, a multidimensional approach to POP treatment is important for best results.

A qualified exercise professional can be an excellent resource for the person with POP. In collaboration with a physio, trainers/coaches/exercise physiologists can assist the person with POP in navigating athleticism with POP.

POP often has a significant psychological impact on those managing the condition. A mental health professional (ideally with expertise in birth trauma and/or pelvic floor dysfunction) can be an invaluable resource to someone struggling to cope with the emotional aspects of POP management. Many also benefit from seeking relationship counseling, as one's partner is also often affected by the diagnosis of POP.

Many with POP struggle with navigating sex post-POP diagnosis. A sex counselor or therapist can be an incredible support person for the person looking to explore one's relationship with sex and sexuality with confidence.

Even if one isn't considering surgery, an urogynecologist is an excellent resource for the person with POP, particularly if one is interested in using a pessary.

Q: WHAT ARE THE GOALS OF TREATMENT FOR POP?

A: Everyone has different goals for treatment of their POP. Some seek symptom resolution or management, and they tend to do well with the help of physical therapy and lifestyle modification/education. Those for whom this conservative treatment doesn't meet their goal of resolving the structural defect, for example, are more likely to choose surgical management.

Q: WHAT ARE THE EXPECTED OUTCOMES?

A: Outcomes vary depending on each individual's presentation, circumstances, and treatments.

Research supports physical therapy as a first-line treatment for POP. A 2016 Cochrane review of the available studies on physical therapy for POP found that pelvic floor muscle training significantly decreased symptoms and improved POP-Q stage when compared to control groups (Dumoulin et al., 2016).

Surgical outcomes are varied and depend on the individual, the surgeon, and the techniques and materials used. There is no consistent data on success rates of POP surgery, so we recommend that surgical candidates discuss this with their individual providers.

Instead of attempting to predict outcomes, we seek to encourage people with POP to focus on the actionable steps that one can take to improve the quality of one's life one day at a time.

Q: ARE YOU AWARE OF ANY KNOWN PREVENTATIVE MEASURES FOR POP?

A: Unfortunately, research on POP prevention is lacking. Reducing one's risk factors for POP would likely mitigate the risk, but even those with no (known) risk factors for POP can end up with the condition.

We feel strongly that education on POP needs to occur before pregnancy, as pregnancy increases one's risk for POP and is a time where most are initially learning of the importance of their pelvic floor. Discussing birth methods and the risks associated with each is of paramount importance in the antenatal period. Too many people end up saying they "wish (they) had known" about the risks of forceps, longer second stages of labor, the benefits of pelvic floor physical therapy postpartum, or how to more appropriately navigate postpartum exercise and activity.

In the absence of known preventative measures, we encourage people to understand their own circumstances and take ownership of the factors that are within their control.

CONTINUED

Q: CAN YOU TELL US A BIT ABOUT POP-UP/POP-UP(LIFT)

A: POP Up: An Uplifting Guide (and POP Up(LIFT), the accompanying 12-week exercise program) is the program we created to fill the needs we saw in our personal and professional interactions with POP. As a mother and perinatal exercise specialist managing POP, and a pelvic floor physical therapist, we knew that people with POP deserved better than what was previously available to those looking for professional, evidence-guided information that understood the complex needs of those managing POP.

POP Up is an online course that includes over 20 hours (and growing) of content on every topic you could think of involving POP. We discuss symptoms, the pressure system, pelvic floor physical therapy, surgery, pessaries, daily movement habits, exercise, body image, sex, navigating difficult conversations, and so much more. Our 12-week exercise program gives someone 36 training sessions aimed at building a foundation of strength and confidence. So, much of the program is education we all should have received at one point or another, but is delivered so that those with POP have a resource that specifically addresses them. We aim to live up to our name as an uplifting resource, and empower people in managing and thriving with POP.

Q: WHAT DO YOU SEE AS THE ROLE OF POP-UP IN SOMEONE'S RECOVERY (I.E. WHAT IT'S IT'S INTENDED PURPOSE/VISION)?

A: We see POP UP as a support network, reference tool, and source of practical guidance. We wanted to get people away from frantically Googling at 3am and instead provide an in-depth education on their body and POP so that navigating this condition ceases to be so confusing and scary. Most of our current users have in-person support through their PFPT and use POP UP as a way to dive deeper than can often be reached in the clinic.

Additionally, it is a community. We have an adjoining Facebook group private for users and a map that allows users to pin their location, search for nearby users and, hopefully, connect with people nearby for in-person support. We believe that management of POP is so much better with friends!

POP-Up is opening its program for you to preview for a limited time!

Go to: pop-s-school.thinkific.com
Sign up for an account
When you get to the paying screen, enter the code "preview"

This code will allow you to see the content of the courses until March 15, so use it!

HALEY SHEVENER, CSCS

is a perinatal exercise specialist and strength and conditioning coach specializing in working with a pre/postnatal population in San Francisco, CA, and online. Following the birth of her son, a diagnosis of pelvic organ prolapse challenged her personal and professional identity. This impactful experience ended up becoming the catalyst that would lead her to create resources for people with POP, including the course she co-created, POP Up: An Uplifting Guide. Haley seeks to support people with POP in their movement practice, and beyond, with a body-positive, collaborative, evidence-guided, and empathetic approach that recognizes the myriad ways in which one's life can be affected by POP.

ANNEMARIE EVERETT, PT, DPT, WCS

is a physical therapist and women's health clinical specialist in San Francisco, CA. She has spent her career working with primarily pre and postnatal women, and was frustrated by the lack of modern, inclusive, uplifting resources for both patients and providers to navigate a POP diagnosis. She was excited to co-create POP Up to fill this need for accessible, evidence-based and comprehensive information for those with pelvic floor concerns. Instead of creating fear and restriction, Annemarie's goal is to inspire confidence and resilience in her patients to take charge of their rehabilitation with the highest quality tools and guidance.

Physiotherapy & Breastfeeding Support

by Mercedes Eustergerling, PT

There has been a role for physiotherapists in breast health for a long time. You may know someone who works in oncology, lymphedema, or surgery who sees women for breast-related issues. Similarly, physiotherapists are commonly found on paediatric health teams and see neonates, infants, and toddlers for their functional needs. However, when it comes to breastfeeding support, physiotherapists tend not to be involved.

ROLE OF PHYSIOTHERAPY – MATERNAL HEALTH

The physiotherapy scope of practice will vary from one location to another. At our core, however, we seek to improve function in our patients. For the lactating woman, this involves:

- Inflammation management
- Wound healing
- Persistent pain management
- Ergonomics
- Adaptations for physical limitations
- Comorbidities such as chronic pain, neurological conditions, arthritis, or musculoskeletal injury

Assessing and treating a breastfeeding problem is no different than a knee problem: it requires some knowledge of local anatomy and physiology, best practices and clinical guidelines, and patient-centered problem-solving.

Take the example of breast inflammation. In Australia, some physiotherapists use compression, manual therapy, and/or modalities to reduce the signs and symptoms associated with inflammation in the lactating breast. The World Health Organization and the Academy of Breastfeeding Medicine recommend these conservative measures as the first step in mastitis treatment. If physiotherapists – who are already trained in inflammation management – can learn the basics of breast anatomy and physiology, then we can contribute to evidence-based care for lactating women.

ROLE OF PHYSIOTHERAPY – INFANT HEALTH

During breastfeeding, the mother and the infant are called a dyad. Each dyad is unique in its maternal/infant composition, interactions, and needs. A lactating breast cannot be assessed or treated independently of the breastfeeding infant (with a few rare exceptions).

As with the maternal side, we can understand how physiotherapy can help an infant to breastfeed by looking at comparable functions and populations. In the adult therapy setting, we help people with the task of eating. A physiotherapist may work with a patient on the range of motion, strength, or coordination required to bring a spoon to the mouth. In a neurological practice, we use our knowledge of primitive reflexes to guide our patients toward a functional goal. The same is true for the breastfeeding infant: we can use neuromusculoskeletal physiotherapy to facilitate an optimal feeding position and mouth/neck/jaw coordination.

A physiotherapist in breastfeeding support might help infants with the following:

- Positioning
- Torticollis
- High or low muscle tone
- Muscle coordination

Women's health physiotherapy has expanded a great deal in the past few decades. We no longer see the pelvis as a mysterious part of the body, and we can proudly state that our profession has contributed to the knowledge base. Women nowadays expect to have access to pelvic physiotherapy when they need it. And with the research pointing to our skills as the first choice for breast care, women will be expecting us to help them in that area, too. Women's health doesn't stop at the armpits.

Physiotherapists who want to learn more about breastfeeding support can take courses and workshops throughout the country. They can also take advantage of the resources listed below

Resources

Vida Health & Wellness Blog – https://www.vidahealth.ca/blog

Academy of Breastfeeding Medicine - https://www.bfmed.org

Journal of Human Lactation - https://journals.sagepub.com/loi/jhl

Breastfeeding Medicine Podcast

Stanford Medicine Breastfeeding - https://med.stanford.edu/newborns/professional-education/breastfeeding.html

Canadian Lactation Consultant Association - http://www.clca-accl.ca

BIO

Mercedes Eustergerling is a physiotherapist and lactation consultant in Calgary, Alberta, where she enjoys helping women with chronic and complex healthcare needs. At Vida Health & Wellness, Mercedes provides pelvic physiotherapy and breastfeeding support in a small clinical setting. She also teaches breastfeeding health courses across the country and informational workshops for local parents. Mercedes is currently working on a research study on mastitis.

www.vidahealth.ca

UPCOMING COURSES

Mercedes is offering eight courses this year on Physiotherapy & Breastfeeding Support in partnership with Uro santé and Pelvic Health Solutions.

The Story of the Physio Detective

by Katerina Miller, PT, Newsletter Editor

A couple of days before the 2018 CPA congress started in Montreal, some attended Antony Lo's "The Female Athlete" course. This presented the perfect opportunity to request an interview, and Antony was gracious enough to agree to do it. So, after long days in class/gym, not yet being fully recovered from his jet-lag, and the very soothing background music of the hotel lobby, we had a very energetic interview!

Q: HOW DID YOU GET IN TO THE FIELD OF PHYSIO?

A: I got into the field of physio because I didn't study at high school. I wanted to be a doctor, because I was told my whole life that I could be a doctor if I studied, but I didn't study hard enough. I had a friend who was smart enough to be a doctor, but she wanted to be a physio. So I thought "if she doesn't want to be a doctor, and is going to be a physio, then…" I looked at a list of things to do, and physio is basically the next thing after doctor. Now it turns out that I'm a better physio than I would be a doctor.

Q: WHAT MADE YOU DECIDE TO WORK WITH WOMEN?

A: I was covering the antenatal/postnatal ward and I got paged to go to the antenatal clinic because there was a woman who was on the table, who couldn't get off the table (out of bed) because she was in a lot of pain. Not knowing what to do, I went there… I didn't even know how to begin assessing her. I did some gentle rocking of her pelvis in a rotation PPIVM (passive physiological intervertebral movement), and asked her how she felt - she got up and ran out the door because she was late picking up her kids, and the nurse was pushing me out the door because she had a waiting room full of people. I was left standing in the hallway, wondering what just happened, and there began my journey of wanting to learn more, and I have been working in the field ever since!

Q: WHAT DO YOU FIND TO BE WOMEN'S MOST COMMON CONCERN WHEN WEIGHT TRAINING OR CROSSFIT TRAINING?

A: In general it tends to be pain, as I tend to help people with pain. Additionally, I help people with prolapse, incontinence and diastasis, antenatal and postnatal. But, by far, the most prevalent population that I see is pain, but it doesn't mean that it is the biggest issue that they have to deal with.

Q: WHAT IS YOUR PET PEEVE REGARDING A GENERAL BELIEF OR MESSAGING IN THE ATHLETIC OR PHYSIOTHERAPY COMMUNITY?

A: I'll give you one of each:

One of my pet peeves about the athletic community, the coaching community, and the fitness professionals industry is not giving due recognition to women's health and the implications that it has on women, and how deeply it affects them, and how simply changing a few things can make a massive difference for a woman. It could mean the difference between coming to the gym or not.

My pet peeves about physiotherapists: Musculoskeletal/ortho/sports physios – is that they think that women's health physios just do Kegels. Women's health physios – is that they under-load their clients.

Q: DO YOU HAVE A FAVOURITE EXERCISE (OR THREE) THAT YOU LIKE TO PRESCRIBE?

A: A Dead lift (which is a hip hinge), a squat, and a step-up. You get all three planes of motion with those.

For example, the step up: For some people, getting up two inches is difficult – excellent, that's going to be appropriate. If at two inches you're not really feeling it, that's not what I want.

Q: ON THE OTHER HAND – IS THERE AN EXERCISE YOU REALLY DON'T LIKE SEEING WOMEN DO?

A: Yes. I would have to say that Clams is my number 1 hated exercise. I really can't see a good use for clams. I know that it is useful to lie on your side and open your legs for examination purposes, or self pleasure purposes, but most people do it because they try to get a better strengthening to the glut med, and I think that there are better ways to do that.

Number 2 would have to be (equally ranked) I think bent knee fall outs and leg slides. Obviously it's appropriate for some patients, but those patients are usually in the hospital. If your patient walked in, and you laid them down and told them that this is the exercise that's going to make them better, and then they get up and walk away – that just doesn't make sense to me.

Q: WHAT OUTCOME MEASURES DO YOU USE TO TRACK YOUR CLIENT'S PROGRESSION, IF THEY ARE ASYMPTOMATIC, BUT LESS THAN A YEAR POST-PARTUM?

"Please remember that I am answering this question as an external therapist, and I refer to WHPT for internal checks"

A: If they've got no symptoms, there is no need for any special care. In this situation, the outcome measure would be progression towards their goal; the patient's specific functional scale – no symptoms with a certain percentage achievement of a goal or task that we defined beforehand.

Q: WHAT IS YOUR THEORY ON DIASTASIS RECOVERY?

A: That it's complicated, it is multi-factorial, a lot has to do with genetics, people can underload it, people can overload it, and that the approach really is individual. And then I have to challenge that bias and ask – is it truly individual? Because what happens if we don't do anything about it? They get better anyway.

Q: DO YOU MONITOR WIDTH, DEPTH, OR DOMING? HOW DO YOU ASSESS IT?

A: I do measure width at rest and width on a curl up. I measure tension in supine. I do like to have a look in upright, but rarely have enough time in my session for that. And I do look at doming as well, but I'm not concerned when I see it. We see if we can do things where it doesn't do that, but – is that dangerous?...

And also - can we actually do anything to affect this? That would be my biggest questions, and I think the answer is yes, by doing something different. By establishing what their normal patterns are and changing them.

Q: DO YOU BELIEVE THE DIASTASIS IS PROTECTIVE TO THE PELVIC FLOOR?

A: I think, as a narrative to explain what I see, I think it makes sense that it might be able to offload the pelvic floor a little bit by blowing pressure out through the diastasis. I think I'd need to see more research before I concluded that it was protective of the pelvic floor, but I'm certainly willing to ask the question "is it protective of the pelvic floor?" I like to think that maybe it is, because right when you are at your most vulnerable, right when you have just given birth to a baby, right when your pelvic floor is stretched out 4-6 times its normal length, and you get up and you walk to the toilet – how can the stability model hold when your abdominal muscles are at their weakest point?

Q: ANY OPINIONS ON ABDOMINAL DOMING IN CHILDREN OR TEEN ATHLETES?

A: Yes. Don't worry about it. Teach them to have many different ways to do things. My son has one, and it doesn't impair his ability. I don't try and correct it.

Q: DO YOU USE LUMBAR SUPPORT BRACES ON PATIENTS OR ATHLETES WHO ARE LIFTING HEAVY LOADS?

A: I don't generally recommend a weight lifting belt, but I'll tolerate them.

Q: WHO WOULD YOU CONSIDER A CANDIDATE FOR THESE?

A: The athletes who are on the cusp. The athletes who if they lift 5 or 10 lbs more, it's gonna make the difference between going to the Olympics or some sort of event, and not qualify for it. So the stakes are really high, as it is, after all, a legal performance enhancer.

Q: WHAT WOULD YOU SAY TO PRACTITIONERS WHO BELIEVE CROSSFIT IS TOO HARD ON THE PELVIC FLOOR?

A: Go try CrossFit.

Q: IF A PATIENT IS SYMPTOMATIC DURING CROSSFIT, WHAT DO YOU RECOMMEND? ARE THERE CERTAIN MODIFICATIONS THAT YOU SUGGEST OFTEN?

A: It's difficult, but doing anything, everything, to make it asymptomatic is what I would do. Paying attention to loads, speed, range of motion, power – these are all important concepts that we as therapists need to understand.

ANTONY LO

Antony is an APA Musculoskeletal Physiotherapist who lives and works in Sydney, Australia. He also teaches locally and internationally at the junction of where Musculoskeletal, Women's Health, and Sports Physiotherapy meet. His key message in his seminars are "Do Something Different". He hosts a podcast called The Women's Health Podcast and has online and in-person education available at My PT Education. His special area of interest is helping women with pelvic floor dysfunction to progress into higher load and intensity exercise.

http://physiodetective.com/

Visit Antony Lo's and Marika Hart's Podcast:
https://womenshealthpodcast.info/

the physio detective

2019 WHD AWARDS and BURSARY PROGRAM

The 2019 WHD award applications are now available. If you wish to apply for one of the awards please click on one of the links below to begin your application.

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The Physiotherapy Assessment of Breastfeeding Related Conditions: Infant Factors - April 7-8, 2019

Pregnancy, Pelvic Girdle Pain & The Pelvic Floor - April 27-28, 2019

6th Pelvic Health Symposium - May 3, 2019

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Improving Pelvic Floor Function Through Spinal Manual Therapy - May 31, 2019

Gastrointestinal Disorders & the Pelvic Floor - June 1-2, 2019

Pediatric Incontinence & Pelvic Floor Dysfunction - June 8-9, 2019

Innovative Exercises for the Sensitive Nervous System - June 8-9, 2019

Mobilization of Visceral Fascia: Urinary System - July 12-14, 2019

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Menopause: An Integrative Approach For Physiotherapists - September 14-15, 2019

Innovative Exercises for the Sensitive Nervous System - September 27-28, 2019

Nutrition and Lifestyle Medicine for Fertility, Pregnancy, and Postpartum Recovery - October 5-6, 2019

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Breast Cancer Rehabilitation - December 7-8, 2019

Mobilization of Visceral Fascia Part 2: The Reproductive System - December 13-15, 2019

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Dermoneuromodulation - October 3-6, 2019 / Calgary, AB

Physiotherapy Assessment of Breastfeeding Related Conditions: Infant Factors - October 31-November 1, 2019 / Calgary, AB

Physiotherapy Assessment of Breastfeeding Related Conditions: Maternal Factors - November 2-3, 2019 / Calgary, AB

Mobilization of Visceral Fascia Part 2: The Reproductive System - November 15-17, 2019 - Calgary, AB

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

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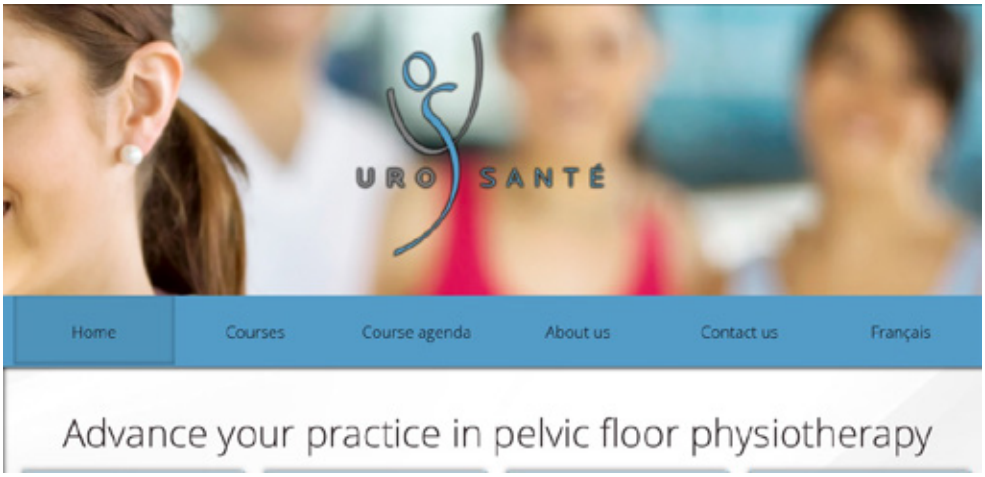

*Courses offered to Physiotherapists only

The Physical Therapy Approach for Dyspareunia, Montreal, QC, February 15-17 2019

The Physical Therapy Approach for Dyspareunia
& Male Urinary Incontinence, Winnipeg, MB, March15-18 2019

And 2 EXCITING NEW COURSES!

NEW!Yoga and the Pelvic Floor (with Diana Perez), Montreal, QC, March 30 2019

NEW!The Physiotherapy Assessment of Breastfeeding Related Conditions: Maternal & Infant Factors (with Mercedes Eustergerling),
Montreal, QC, May 3-6 2019

No previous experience in breast health or pediatrics is required.
Labs include breast palpation and manual techniques. (This course is open to **ALL physios**)

The Physical Therapy Approach for Dyspareunia, Calgary, AB, May 10-12 2019

Entry Level: Physical Therapy Approach to Female Urinary Incontinence
Halifax, NS, June 21-24 2019

For course details, registration and the full 2019 schedule go to:

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Claudia Brown and Marie-Josée Lord

Current Directions In
Women's HEALTH
Winter 2019
A Division of the Canadian Physiotherapy Association

NEWSLETTER ADVERTISING RATES 2019 - 2020

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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DEADLINES FOR ADVERTISING SUBMISSIONS

PUBLICATION DATE

Spring 2019:	April 15th, 2019	Between May 1 and 15, 2019
Summer 2019:	July 15th, 2019	Between August 1 and 15, 2019
Fall 2019:	October 15th, 2019	Between November 1 and 15, 2019
Winter 2020:	January 15th, 2020	Between February 1 and 15, 2020

For information please contact: Katerina Miller at whdnewsletter@gmail.com

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Women's Health

A DIVISION OF THE CANADIAN PHYSIOTHERAPY ASSOCIATION

IN THIS ISSUE

WORD FROM THE CHAIR

As the snow melts here in Saskatoon and some green shoots are emerging from the soil, so too are there new beginnings with our Division. The Women's Health Division executive has been working hard over the winter to bring our members fresh beginnings, including a new look and new learning opportunities!

We are excited to present the new logo and newsletter design in this edition. Our executive have been working hard with our graphic designer, Alex Perlin, to present a design that was both representative of the female body and pelvic health, but inclusive of the diverse populations that are included under our umbrella, including male and pediatric pelvic health. I want to acknowledge our Research Chair, Nicole Beamish, who has worked particularly hard on this rebranding, acting as the liaison between the graphic designer and our executive, and to Katerina Miller, Newsletter Editor, for the patience to bring this all to fruition!

By the time this edition of the newsletter comes out, the WHD-sponsored webinar, Clinical Pilates with a Pelvic Health Perspective, hosted by our very own Jessica Bergevin, WHD PR Co-Chair, will have already passed. I am excited to take part in this webinar and learn how clinical pilates might be integrated into my practice. Thank you Jessica, for taking to time to share your knowledge with the membership!

Our student representative, Hayley O'Hara has also been organizing some webinars of her own to facilitate learning for our student membership. She hosted Breastfeeding and Physiotherapy with Mercedes Eustergerling, Sex and Disability with Natalie Rose and is planning another webinar for the end of June on the topic of pelvic health for non-pelvic health physiotherapists. If you are interested in joining - stay tuned for more details. The webinars are targeted towards students, but anyone can join in!

Applications for the annual WHD awards closed March 31st and this year we had 31 applications to choose from! Once the applications have been vetted by the awards committee, we will contact the winners. Thank you to all those who applied for our awards and best of luck to you all!

The WHD is a member of the International Organization of Physical Therapists in Women's Health (IOPTWH) and as a member organization, is required to attend a general business meeting every four years. As chair of the WHD, I am extremely grateful to have had the opportunity to attend this meeting in Geneva, Switzerland during the World Confederation of Physical Therapy Congress in May. I was also blessed to have a travelling companion - Samantha Doralp, WHD Education Chair! We attended many presentations related to our division, including male pelvic health and women's health in the international context. Sam and I enjoyed networking with other IOPTWH members, which has given us many ideas of where to take the WHD. Although I am no social media expert, I tried to keep the membership updated through Twitter and Facebook.

As always, please feel free to contact me at whdchair@gmail.com if you have any ideas, questions or concerns. It makes me happy to be able to connect with our members on a personal basis.

EDITOR'S NOTE

With the spring coming, bringing us new growth and bloom, we are excited to bring you this newsletter in this new and refreshed look to the newsletter!

Aside from it being fresh-looking, it is also full of excellent information about the different aspects of pelvic pain. Pelvic pain is not an easy issue to address, and can be very difficult to treat. If only we could have all the answers to all the questions about pelvic pain... Well... This would be an endless issue. Instead, we are happy to present you with information from practitioners from the east coast of Canada, to the west, and of course - international research! This issue covers some MSK pain, bladder pain, vestibulodenia, testicular pain, and ways to treat those – including Graded Motor Imagery for pelvic pain.

Finally, our amazing research committee was able to address a question we had from one of our readers, regarding the use of LASER for pelvic floor physiotherapy. Intrigued? Good.

We hope you enjoy this Newsletter!

Katerina Miller, PT, WHD Newsletter Editor

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THE PELVIC PAIN REVOLUTION: THE TIME IS NOW

by Carolyn Vandyken, BHSc. PT, Cred MDT, CCMA

A "funny" thing happened at the Inflammatory Breast Pain course that I attended this past weekend. A 35-year-old woman with nipple pain and breast pain also presented with persistent pelvic girdle pain. She was 4 weeks post-partum and had spent much of the preceding weeks exhaustingly going from practitioner to practitioner for help. With a diagnosis of "symphysis pubis dysfunction" given to her by her pelvic floor physiotherapist in her third trimester, she was given very little meaningful help which reinforced her lack of confidence in her body and her ability to regain her function. She felt "broken", hobbling around with severe pelvic girdle pain, severe nipple pain, vasospasm of the nipples and anxiety/fear/depression stemming from a previous miscarriage that happened just prior to her current pregnancy and delivery. What happened in physiotherapy was labelling of broken parts (dysfunction) and ill-suited exercise to overcome these problems. What did not happen in physiotherapy was a biopsychosocial approach that would attempt to address all of the underlying factors leading to her persistent pain problem. This patient had clear signs of central sensitization which is correlated with persistent pelvic girdle pain, vasospasm in her nipples, and anxiety/fear and depression. (1,2,3). She attended pelvic physiotherapy preventatively throughout her pregnancy with a proactive mindset; however, the lack of a whole-person approach did not serve her well and in no way prevented the complications that she was hoping to avoid.

Lewis and O'Sullivan (2018) have called for physiotherapists to reframe their practice. (4) They state that the "majority of persistent non-traumatic musculoskeletal pain disorders do not have a pathoanatomical diagnosis that adequately explains the individual's pain experience and disability". The Canadian Physiotherapy Association in a press release on April 3rd, 2019 commended the federal government for creating a task force to address the needs of those living with chronic pain across Canada. CPA stated that "the task force demonstrates the government's understanding that more can be done for chronic pain sufferers and that the current methods of treating chronic pain need to catch up with the latest research and best practices."

Why does it take the creation of a national task force to get our attention? What are best practices and why do we struggle to make the changes that are so needed to address the persistent pain crisis that grips our world? Are we part of the problem, or part of the solution as physiotherapists?

Lewis and O'Sullivan state, "we contend this requires those of us working in the musculoskeletal field to acknowledge the limitations of current surgical and non-surgical interventions for persistent and disabling non-traumatic presentations. We need to upskill and reframe our practice, language and expectations to consider aligning our current practice with that supporting most chronic healthcare conditions." (4)

> "Central sensitization in persistent pain still remains deeply underappreciated in clinical practice resulting in marked overuse of tissue-based treatments for persistent pain (opioids, injections, surgery, mobilizations, and manual therapy) when the target should be the central nervous system."

Research is calling us to reframe musculoskeletal pain. Persistent pelvic pain is simply MSK pain with the added complexity of diet, microbiome, neuroimmune and endocrine systems layered on top. If therapists treating shoulders and ankles are being urged to reframe their practice, then how much more should we as pelvic health therapists be required to stop the suffering by taking a biopsychosocial approach.

How do we shift our framework? It starts with truly adopting a biopsychosocial perspective with every patient with persistent pain. "Yet as so many people point out, the biopsychosocial framework doesn't seem to have seeped down very far, particularly when we look at undergraduate training about pain. It's like an abstract concept until we meet face-to-face with how poorly our original training sets us up for the "complexity and messiness" of persistent pain". (5)

A suggested framework was published by Vandyken/Hilton (2017) to incorporate a biopsychosocial approach into practice. (6). The following table summarizes this framework. (6)

PHASE 1	**ASSESSMENT**	• Determine peripheral and central mediators of pain • Complete measures: PCS, TSK, CSI, DASS (Repeated at multiple intervals for re-assessment) • Complete appropriate musculoskeletal evaluation • Identify strengths upon which to build treatment
PHASE 2	**DESENSITIZATION**	• Start with pain biology education • Address peripheral mediators with non-nociceptive manual therapy (dermoneuromodulation) and/or non-threatening movement • Restore and normalize sensori-motor awareness • Maximize activities that down-regulate the central nervous system • Breathing exercises • Guided Relaxation/Meditation • Qi gong/Tai chi • Yoga • Joy/laughter/CBT and other positive reinforcement
PHASE 3	**GRADED IMAGERY**	• Use with highly sensitized individuals who experience a pain response just by thinking of the triggering movement/functional activity • Progressions include: • Right/left discrimination • Visualization of others doing the movement • Visualization of yourself doing the movement • Mirror work as appropriate
PHASE 4	**GRADED EXPOSURE**	• Establish value-based, patient-centered goals • Step-wise progression to return to functional activity • Establish a Flare-up plan and utilize it • Use neurodynamic movements as needed in order to optimize tolerance to movement
PHASE 5	**SUPPORTED INDEPENDENCE**	• Establish self-efficacy • Support progress with check-ups and progression as needed

Central sensitization in persistent pain still remains deeply underappreciated in clinical practice resulting in marked overuse of tissue-based treatments for persistent pain (opioids, injections, surgery, mobilizations, and manual therapy) when the target should be the central nervous system (CNS). Rather than approaching pelvic floor muscle tension as a pathological state in the muscles, it should be considered a CNS-driven, upregulated pathophysiological process that co-exists with many other disease processes.

When we assess a patient with a state of generalized pelvic floor muscle tension, recognizing that this is a protective state responding to potential threat requires that we change our framework. (7) Generalized tensiondriven by central pain mechanismsrequires that we assess the phenotypic characteristics of sensitization within each patient. This starts with utilizing validated questionnaires such as the Pain Catastrophization Scale (PCS), Tampa Scale of Kinesiophobia (TSK), Depression, Anxiety and Stress Scale (DASS-21), Positive Affect, Negative Affect Scale (PANAS) and Fremantle Back Questionnaire (FreBAQ) to identify the phenotypes of each individual sensitized state.

There is a cache of validated treatment modalities for the sensitized nervous system such as pain education, yoga, mindfulness meditation and qi gong/tai chi, all based on strong self-efficacy, another important target in persistent pain.(6) Mindfulness meditation, for example is not the panacea for everyone with a sensitive nervous system; however, certain phenotypic characteristics such as rumination and magnification may be clinical indicators of those individuals who might respond best to mindfulness meditation. Pain catastrophization is another cognitive construct that can contribute to sensitization of the nervous system. These patients would benefit from reconceptualizing the alarm system by getting a healthy dose of pain education. (8) Phenotyping the characteristics of patients with central sensitization assists us in directing appropriate treatment strategies.

By failing to assess characteristics of our patient's sensitized nervous systems, we remain focused on treating the nociceptive drivers, creating pathology and dysfunction around the pelvic floor muscles, thoracic rings, and the SI joint. It is time to reframe how we treat persistent pelvic pain.We need to upskill and reframe our practice, language and expectations to consider aligning our current practice with that supporting most chronic healthcare conditions." (4)

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TALKING BLADDER PAIN SYNDROME WITH JILLY BOND, PT

by Katie Kelly, PT Newsletter Subcommittee Member

Jilly Bond is a pelvic health Physiotherapist in Cardiff, Wales, UK. She is a regular speaker at international conferences and runs professional development courses for physios all over the UK, and is developing online courses. Jilly has worked within the NHS and private sector for the last ten years within the full scope of male and female pelvic health, and has a specialist interest in visceral pelvic pain. She regularly hosts chats with physios from all over the world on her vlog, where you can also find free resources for patients. ***JillyBond.com***

Whenever I personally have a question about chronic pelvic pain, especially when it comes to the bladder, I turn to my resource across the pond, Jilly Bond. Jilly has been sharing her wisdom about the role of physiotherapy in bladder pain conditions for many years now. With a strong understanding of neuromuscular physiology and the biopsychosocial approach, and a keen clinical mind, she always offers great insight on the complexities of pain. I was privileged enough to nab an interview with this busy woman.

WHAT IS BLADDER PAIN SYNDROME?

It's easier to start with what it is not. For years it was thought that a chronic infection of the interstitium of the bladder was to blame for persistent visceral pain, and so the condition was called Interstitial Cystitis. However, with more recent developments in understanding interactions in the neuroimmune system and the role of non-bladder syndromes the condition was rebranded under the umbrella term "Bladder Pain Syndrome" in 2008. You'll see it called by the mesh term IC/BPS in the literature as we're in the process of terminology change. It's also not Painful Bladder Syndrome, that was posited for a while but the international community has agreed to use the term "BPS". Think BioPsychoSocial.

BPS is a diagnosis of exclusion, much like fibromyalgia. It remains poorly understood and patients wait on average 7 years through numerous invasive investigations for a conclusive diagnosis. I find most physios think their caseload includes a very small proportion of BPS patients.However, my experience is that the umbrella term covers most of my patients with pelvic pain who also have some visceral sensory or somatic dysfunction symptoms.

BLADDER PAIN SYNDROME IS DEFINED AS:

- Pain in the pelvic region lasting more than 6 months (usually superpubic, but it can be anywhere in the pelvis)
- Increasing pain with bladder filling and deferment
- Relief of pain with bladder emptying

With or without confirmed infection (i.e. this isn't important) (Engeler et al. 2014; Fall et al. 2010;Van de Merwe et al, 2008) I'll add that BPS presents with regular symptom flares that can remain for weeks or months at a time, and there may be cystoscopic findings of glomerulations or Hunner's ulcers. Both these urothelial wall issues are found in asymptomatic population and so are not a positive indicator of BPS. Reading the definition, it should become clear that these are the patients referred to your clinic with urgency that on questioning have pain, or present with vulvodynia and prolapse symptoms that improve with voiding, or they report dyspareunia and urgency.

Up to 70% of patients are wrongly diagnosed and it's our responsibility to use our understanding of visceral pain states to improve patient outcomes, regardless of what their physician has referred them with.

WHAT ACTUALLY HAPPENS?

Aetiological evidence is still lacking but it is agreed that there is an initial insult to the pelvic region, for example infection, trauma or abuse, that then warrants a complex neuroimmune response that becomes chronic. We don't know why. Research has shown that some people may have an underlying heightened autoimmune response, genetic sources are being investigated and previous life experiences play a role, especially those with heightened emotional or psychosocial background.

This results in sensitised afferent nerves at the level of the bladder, persistent urothelial and urethral inflammation and breakdown causing upregulation of the submucosal c-fibres (urine hurts when it contacts the submucosa level). Altered stretch responses and detrusor activity occur in 30% of BPS patients – the few who respond a little to antimuscarinics. At the same time the brain manages the persistent pain by upregulating the sensory and motor areas responsible for how full the bladder feels (heightened filling and pressure felt at reduced volumes to help you get rid of the threat), how tense the pelvic floor muscles are and how much attention you pay to your bladder consciously. As pain persists, the limbic system takes over its' management, and now their emotions and pain become interlinked. Hence, people often present to physiotherapy as chronically disabled by pain, hopeless and miserable.

We also know that persistent pelvic floor tension leads to venous pooling within the pelvic floor muscles, and that autonomic dysregulations can develop altering nerve firing and vessel responses within the muscle, leading to myofascial pelvic pain (pain on palpation, dyspareunia, generalised pelvic aching of unspecific location). A reduction in the vagal nerve tone is also noted in those with BPS, which heightens the sympathetic response to any perceived threat. There's also a role for "visceral overflow" where poor central visceral proprioception causes visceral "cross talk" which can result in threat responses to potentially normal pelvic organ functions.

In summary – something happens that causes a complex threat response resulting in changes at both the level of the bladder and centrally, and this becomes chronic. Thankfully, we are bioplastic and many of these changes can be reversed! I always aim for complete resolution of symptoms but realistically give patients methods for managing symptom flares that may arise as they face threats of all different types throughout life.

HOW CAN WE, AS PELVIC HEALTH PHYSIOTHERAPISTS, TREAT BPS?

Given that we know BPS is a condition altering both peripheral and central processes, any treatment purely aimed at the bladder is likely to be ineffective. This is now heavily evidenced. Treatment needs to be aimed at addressing the central changes alongside desensitising peripheral structures, and it needs to be individualised and holistic. It's important to work with the whole medical team, and I find I work with my counsellors, dieticians and psychosexual services the closest. Pain education is absolutely key to empowering patients in their recovery and ensuring that they understand it's a collaboration. I find it's helpful to get patients to draw a spider diagram exploring their "bears", or other potential stressors/threats such as poor relationships, financial worries and health beliefs. We neutralise the simple ones we can together in clinic, such as negative expectations or poor health and anatomy understanding, and the remaining issues form a great starting conversation for the counsellor. Patients also find it helpful to use the chart as a way of thinking about causes of their flares. If they can't think of a dietary or mechanical stressor, they're quick to point out another "bear" from their chart.

HOW DO YOU START WITH A COMPLEX BPS PATIENT?

The first thing I tend to do with patients is assess the degree to which their system perceives threat (Bears!) in their pelvis/bladder. I do this by applying Neuro Orthopaedic Institute (NOI) Group principles to the bladder and pelvic region. I measure their speed of left/right recognition and response to vanilla and complex pelvic and pelvic organ imagery, recording their autonomic responses; if they sweat, have erythema, feel nauseous, are tearful, etc. Any observed dysfunctions mean I start with graded motor imagery (GMI).

GRADED MOTOR IMAGERY FOR PELVIC PAIN?

Yes! The evidence is building that we can modulate symptoms faster by using concurrent neurocentric approaches. I get really excited about GMI as we're at the forefront of what we understand with its application to pelvic pain. At vital moments like this, it's creatively playing with evidenced concepts clinically that pushes us forwards. Mindfulness is fantastic for improving parasympathetic activity and calming the threat state, and at the moment I'm looking at integrating sensory information with visualisation during mindfulness, using smells and sounds to get the brain working in a different way. I love hearing from physios all over the globe exploring this clinically.

DO YOU USE GMI WITH EVERY PATIENT?

Yes and no. When perceived threat at pelvic imagery improves, or they have little autonomic response to testing, it's useful to add well evidenced treatments in an individualised approach. This may include graded exercise exposure building to interval training, musculoskeletal treatments to improve ease of breathing and thoracic movement,dietary interventions, stretches and pelvic self-care such as defaecation dynamics training.

WHAT ABOUT PELVIC FLOOR RELEASE WORK?

Pelvic floor muscle (PFM) myofascial release is hugely beneficial in this population. The important idea with internal PFM work is not to look to achieve a relaxed muscle, but to improve their venous drainage with contract-relax movement and to create repeated desensitisation with sub-threatening touch. There is evidence that stretching too firmly for the patient creates further muscular and neural dysfunction, so stay below their tolerance. Firm pressure is absolutely fine as long as they tolerate it well without your treatment becoming threatening. With a positive therapeutic relationship this treatment hits both central and peripheral mechanisms.

My research looked at women receiving standard physiotherapy input weekly, versus those also using a therapeutic wand twice weekly between sessions. In six weeks we observed more than a 50% reduction in pain in the wand group versus 40% in the standard group – not because of the wand but the increase in repeated PFM desensitisation and heightened locus of control of self-treatment. I mostly get women to use their thumbs to do contract-relax myofascial release between sessions, but men often prefer to use a wand.

ANY FINAL THOUGHTS YOU'D LIKE TO ADD?

Persistence is key. The evidence shows that when working with the pelvic floor you can achieve changes to bladder frequency, urgency and pain by altering maladapted centralised bladder processes in around 6 weeks. This doesn't necessarily mean they have to see you for that time weekly, they can be continuing with their own myofascial release, but it helps to have regular therapeutic input. Physios tend to be wonderful communicators, this is one condition where the more emotional support you can provide your patients, the faster you'll see their symptoms improve. It's all in the brain!

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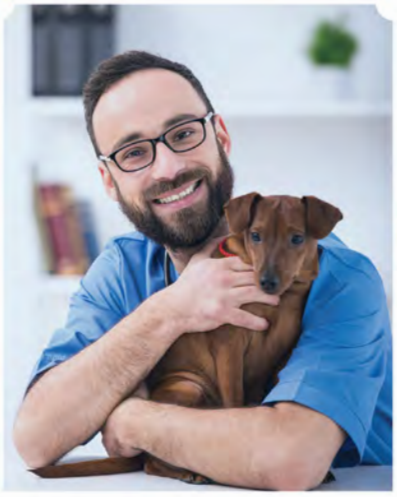

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PROVOKED VESTIBULODYNIA AND VULVODYNIA AN INTERVIEW WITH MARCY DAYAN

by Leslie Spohr, PT, Newsletter Subcommittee

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Marcy Dayan has over 20 years clinical experience in the management and treatment of pelvic floor dysfunction and is a Clinical Specialist, Women's Health (includes male and paediatric incontinence and genital pain). She has expertise in the management and treatment of urinary and fecal incontinence, genital and rectal pain, pelvic organ prolapse and perinatal musculoskeletal dysfunction. Active in clinical practice, research and teaching, Marcy works in private practice as well as at the Prostate Cancer Supportive Care Program, locums at the Multidisciplinary Vulvodynia Program at the Diamond Health Care Centre. She is a clinical instructor in the Master of Physiotherapy program at the University of British Columbia, lectures in the UBC Department of Midwifery and Pharmaceutical Sciences and teaches UBC urology and obstetrics/gynaecology residents. Marcy also teaches physiotherapy continuing education courses on incontinence, vaginal pain/dyspareunia, prostate cancer and diastasis rectus abdominis through Pelvic Rehab Courses.
She has presented on incontinence and genital pain at both medical and physiotherapy conferences.

Vulvodynia, which reportedly effects just under 30% of women, is a condition many health care professionals do not feel competent treating[1]. As a result, this complex condition can send those seeking help to a variety of specialists, attending multiple visits and undergoing a range of interventions–often with little improvement of symptoms a range of interventions–often with little improvement of symptoms[1]. Pelvic Floor Physiotherapy has been shown to be an effective, first-line approach to treatment of this condition[2].

In 2008, the Multidisciplinary Vulvodynia Program (MVP) was created in Vancouver, BC. We connected with Marcy Dayan, a clinical specialist in Women's Health who was the MVP physiotherapist for the first 9 years of the program and is a clinical faculty member and lecturer on urogenital pathophysiology in the Master of Physiotherapy program at the University of British Columbia, for her insight into this multifaceted condition. Below are answers to a written interview with Marcy.

WHAT IS VULVODYNIA? PROVOKED VESTIBULODYNIA (PVD)?

The International Society for the Study of Vulvovaginal Disorders (ISSVD), the International Society for the Study of Women's Sexual Health (ISSWSH), and the International Pelvic Pain Society (IPPS) have agreed on terminology and classification for persistent vulvar pain. The most current consensus document is dated 2015. This document classifies vulvar pain as either vulvar pain caused by a specific disorder (ie lichens sclerosis, hormonal deficiencies as in genitourinary syndrome of menopause, iatrogenic due to radiation, etc), or vulvodynia, which is defined as "vulvar pain of at least 3 months duration, without clear identifiable cause, which may have potential associated factors."

Vulvodynia can be further described according to various descriptors:

- Localized (e.g. vestibulodynia, clitorodynia) or Generalized or Mixed (Localized and Generalized)
- Provoked (e.g. insertional, contact) or Spontaneous or Mixed (Provoked and Spontaneous)
- Onset (primary or secondary)
- Temporal pattern (intermittent, persistent, constant, immediate, delayed)

Women may have both a specific disorder (e.g. lichen sclerosus) and vulvodynia.[3]

Provoked vestibulodynia (PVD) falls within the second type of vulvar pain disorders (vulvar pain of at least 3 months duration, without clear identifiable cause). These pain disorders are considered to have both peripheral and central sensitization. Studies have demonstrated both peripheral and central nervous system changes in vulvodynia/PVD. Increased density of nociceptor nerve endings in the introitus has been identified in PVD (Westromet al 1998, Bohm-Starke et al 1998, Tympanidis et al 2003, Halperin et al 2005, LeClair et al 2011, Goetschet al 2010). Central nervous system changes consistent with pain sensitization have also been identified in the literature on fMRI (Hampson et al 2013), and on both fMRI and microstructural changes in the brain (Gupta et al 2018).

In vestibulodynia, pain is experienced on what should be non-painful contact within the vulvar vestibule (allodynia). Often women do not use the word pain, rather using descriptors such as burning, raw or stabbing. Clinically, allodynia is most often seen at the posterior and posterolateral introitus. In women with comorbid painful bladder syndrome, allodynia is also often found on contact at the anterior and anterolateral introitus.

With generalized vulvodynia, there is allodynia on contact within the vulva, rather than localized to the vestibule or clitoris specifically. Women can present with localized, generalized or mixed (both localized and generalized) vulvodynia.

Women often present for treatment due to dyspareunia (pain with intercourse). The literature differentiates between superficial dyspareunia (pain on penetration at the vaginal opening) and deep dyspareunia (deeper vaginal pain with thrusting). However, clinical experience has shown that many women are not aware of the actual area of pain. With specific treatment interventions, the majority of women actually begin to identify that pain provocation occurs on very specific areas of introital contact rather than deeper, intravaginal contact. This is very important as it enables women to better learn how to manage these specific areas to significantly decrease or eliminate pain on vaginal entry. It also directly addresses the smudging (Butler 2003) that is occurring in central pain sensitization.

> "Clients would commonly tell me they were advised to 'have a glass of wine', 'more foreplay', or simply (devastatingly!) that 'nothing is wrong dear'."

HOW PREVALENT IS PVD IN THE GENERAL POPULATION? IN YOUR CLIENTELE?

The actual prevalence of vulvodynia and its various presentations (i.e. PVD) are unknown. Lifetime estimates range from 10-28% in reproductive aged women (Reed et al 2008, Arnold et al 2007, Reed at al 2004, Harlow et al 2003, Harlow et al 2014). Women with PVD are 7 times more likely to have difficulty and pain with first tampon use (Harlow et al 2003). Depending on my caseload at any given moment, the percentage of people I see with vulvodynia/PVD varies between 25-75%.

HOW DO YOU ASSESS FOR PVD?

I am not able to explain my complete assessment within this interview, however, as in everything we do as physiotherapists, I do both a subjective and an objective assessment. I ask about current vaginal pain, aggravating and alleviating factors, onset, etc. The same as physiotherapists do in a typical assessment. Many women are unaware of aggravating and alleviating factors. Learning these is a very important component of treatment. Often the presenting concern is related to sexual vaginal contact or penetration. Even so, I always ask about a history of painful tampon use or pain with dry tampon removal and pain or physical discomfort on a speculum exam. Many people will describe new onset of dyspareunia, but on history will describe pain with nonsexual vaginal contact that predates the onset of dyspareunia. This information can be very helpful for treatment interventions.

A few key points regarding my objective assessment are to assess the labial architecture for signs of specific disorders, to assess pelvic floor proprioceptive awareness and motor control, and to digitally palpate the posterior and posterolateral introitus for pain location and description typical to that seen in provoked vestibulodynia. Using layered palpation principles and technique, the assessment for pain provocation is directed at the vaginal mucosa and not the pelvic floor muscle. Assessing for pain provocation by palpation takes skill and training on the part of the physiotherapist, as many clients cannot identify the tissue that is sensitized due to centralization and concomitant smudging. This specific assessment technique is then paired with specific cognitive behavioural and mindfulness techniques in what is, for many clients, one of their first home exercises in addressing sensitization.

I do not do the q-tip or cotton swab test for a few reasons. There is no standardized method for conducting the test (Pukall et al, 2002), it has been shown to underestimate pain (Dargie et al 2017), and most importantly, it does not provide me with anything additional or useful.

WHAT ARE SOME COMMON METHODS PRACTITIONERS USE/HAVE USED TO TREAT PVD?

When I started in this area of practice over 20 years ago, women would come to me saying their health provider has told them that nothing was wrong. Test results were negative and everything "looked normal". Clients would commonly tell me they were advised to "have a glass of wine", "more foreplay", or simply (devastatingly!) that "nothing is wrong dear…"

Fortunately this has been changing over time as research in both pain pathophysiology and vulvar pain itself has increased, and medical professional education has begun to include these concerns. Pain pathophysiology principles have begun to be incorporated into treatment interventions. As well, fewer women are being prescribed corticosteroids for dyspareunia in the absence of an identified disorder and systematic reviews seems to be demonstrating that antidepressants have insufficient evidence to support their recommendation in the treatment of vulvodynia (Leo and Dewani 2013). Current practice seems to be a mix of pain education, cognitive

behavioural therapy and mindfulness, sexual health awareness and pelvic floor physiotherapy. As pelvic floor physiotherapists, with adequate post entry-level training, we can use cognitive behavioural therapy and mindfulness techniques as well as sexual health education and information integrated within our treatment plan.

WHAT TREATMENT METHODS HAVE YOU FOUND TO BE CLINICALLY EFFECTIVE IN TREATING THOSE WITH PVD?

My treatment approach is multifaceted. However, my approach does not involve any passive treatment, nor does it attempt to treat the pelvic floor muscle itself. PVD/vulvodynia research has identified pathology in both the central and peripheral nervous systems. I feel that research looking at pelvic floor tone in PVD/vulvodynia patients has an inherent confounder within the research that is best described by the nociceptive withdrawal reflex. When we experience pain, we contract a specific group of muscles that reflexively withdraws this area from the painful response. This occurs before we have a realization of pain (think finger on a hot element). Once a specific contact is known to be painful or have a threat of damage, this reflex occurs even before the actual contact occurs (think of cooking on a stove top knowing that one element is broken and permanently hot. You know it will burn you on contact. You will automatically protect from touching it). This occurs throughout our body and occurs whether there is a noxious stimulus or a sensitized response without the possibility of actual tissue damage. Also, the threshold for this reflex is lower where sensitization is present. (Curatolo 2015, Manresa 2009, Neziri 2010, Lim 2011)

My approach focuses on patient education (pain pathophysiology and not a "tissue issue" - David Butler's phrase), using evidence based principles for addressing sensitization, pelvic floor proprioceptive and motor control retraining exercises, and pacing and grading exercises that allow for patient self efficacy and empowerment in achieving their goal: pain free vaginal penetration/insertion/contact. I integrate CBT and mindfulness techniques directly into physiotherapy exercises, as well as include sexual health information and education right up to specific suggestions.

I am currently the principal investigator of a study looking at physiotherapy and PVD from a purely active assessment and treatment program involving pain pathophysiology awareness/education, pelvic floor proprioceptive and motor control training and pacing and grading towards introital contact and penetrative activity. There are no trigger point, myofascial or other passive tissue techniques by either the client or physiotherapist. If anyone is interested, I have lots of ideas for future research for my next life, or for you in this life! Please contact me if you are curious.

WHEN/WHY DO YOU CHOOSE TO USE BIOFEEDBACK WITH SOMEONE? WHAT SORT OF INFORMATION DOES IT PROVIDE YOU?

Biofeedback is a tool, not a treatment. Just like a stethoscope is a tool. A health professional can't treat a lung infection with a stethoscope. However, EMG biofeedback is not only a tool for the health professional, but also for the patient in a treatment program that targets self-efficacy and motor learning according to current principles of treating pain sensitization. It is interesting that most clients initially look at the graph and then very quickly find it much more helpful and meaningful to do the proprioceptive and motor control exercises without looking, and then to check back on the graph to see if what they felt/experienced in their body interoceptively was matched by the graph. It is used as an objective confirmation for their own internal experience.

However, this cannot be done without the physiotherapist present observing and assessing. The first level of assessment is the physiotherapist, not the biofeedback. The physiotherapist must constantly be assessing and watching for motor control strategies that substitute such as leading with respiration, TrA, upper abs, gluts or adductors. Leading any part of the exercise with the incorrect muscle contraction, even if the pelvic floor is also simultaneously contracting, can lead to false positives on the EMG reading, and ineffective motor control strategies for normalizing the nociceptive withdrawal reflex. The physiotherapist must catch these and point them out to the patient. There are also other components of the EMG software than the simple graph of pelvic floor activity. Most EMG biofeedback units come with specific games. Different games tend to encourage and enhance specific skill sets in PF proprioceptive awareness and motor control. Specific games can be chosen depending on the need(s) of each individual patient. Electrode placement is also important. Intravaginal and intrarectal electrodes are invasive, cannot be used in many positions and provoke the protective nociceptive withdrawal reflex without the pacing required for graduated exposure so critical to treatment in central sensitization.

DO YOU FIND WORKING WITH OTHER PROFESSIONALS IMPORTANT FOR TREATING PVD? WHICH ARE MOST COMMONLY INTEGRATED IN THE TREATMENT?

Yes! Really helpful. And possible even if you work in private

practice. I find that working with and having other professionals to refer to is really important. I work most closely with physicians (gynecologists, pain specialists, family practice and some urologists) and counselling therapists (Registered Clinical Counsellors, psychologists, etc).

I work in British Columbia and patients can attend physiotherapy without a physician referral. If someone attends physiotherapy without having seen a physician for their vaginal pain, I always ensure that they make an appointment with a physician to rule out other conditions. Physiotherapists do not diagnose disease and I don't want to miss something. On the other hand, I often pick up things and need to refer back to the physician. In my experience, conditions that I have picked up are Lichen Sclerosus, Mullerian anomalies, and peri or post menopausal hypoestrogenization. I have also initiated many discussions with physicians on the best location for local estrogen to be applied.

I also have a list of private and publicly funded psychologists or counselling therapists that I can refer to or suggest that the person I am treating can contact. It is really important to know what is appropriate for education and information within physio scope of practice and when it is time to refer to a counsellor in terms of sex education, sexual health, sexual response, CBT and mindfulness techniques, relationship concerns, anxiety, etc... If the person is already working with a therapist, I ask them if their therapist understands PVD/vulvodynia and pain conditions. If they say no or are unsure, I offer to speak to their therapist to explain current research on the pathophysiology of this condition, the impact on relationships/sexual response/etc, or anything else that the patient feels would be helpful for me to explain. Both the therapist and I require written consent for this conversation. I have also developed a list of sliding scale therapists that I can offer to my patients if finances are a concern.

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Graded Motor Imagery an Interview with Katie Kelly

by Katerina Miller, PT, Newsletter Editor

With the help Leslie Spohr (Newsletter sub-committee member), I had the privilege and honour to ask our own subcommittee member, Katie Kelly, a few questions about a topic that is near and dear to her heart. Katie has been working hard, researching the use and benefits of Graded Motor Imagery in pelvic pain, and was kind enough to share some of her knowledge with us. We hope you enjoy reading her answers as much as we did!

Katie Kelly, Pelvic Floor Physiotherapist, opened her own physiotherapy practise in Moncton, NB, in 2017. Following graduation, she completed her first post-graduate pelvic health course in 2011 and has been treating pelvic floor patients since this time. Katie is often a guest lecturer for the School of Physiotherapy at Dalhousie University, with a focused knowledge on pregnancy, pelvic health and exercise with regards to weight loss. 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. Katie received both her BSc and MSc in Physiotherapy from Dalhousie University, is a member of the New Brunswick College of Physiotherapists, the Canadian Physiotherapy Association's Women's Health Division, the Canadian Sex Researcher Forum and the Canadian Obesity Network. Her latest goal is to help expand the knowledge of her peers. Please watch for her debut courses appearing online in 2019. ***katiekellypt.ca***

GRADED MOTOR IMAGERY (GMI) IS COMMONLY USED IN TREATING AND MANAGING CHRONIC PAIN IN THE MUSCULOSKELETAL WORLD. COULD YOU EXPLAIN THE COMMONALITIES AND DIFFERENCES WHEN USED FOR PELVIC PAIN?

One of the arguments that I was met with, when I first started thinking about using GMI with vulvodynia and penetration pain patients, was whether the pelvic floor muscles had a significant enough motor component to allow for motor imagery. As a physio, I knew that of course they do! Upon contraction they go from a basin shape, to a dome shape – drawing the coccyx ventrally and cranially, and lifting upwards[1]. But to other health professionals and lay people, this was not an obvious range of motion. And because of this, it can be challenging for patients to envision the movement. This is certainly different than typical GMI use in the orthopedic world. If I ask someone to imagine making a fist, that is a movement pattern that is very familiar, and even if it were not, I could demonstrate myself. However, this is obviously different when it comes to the pelvic floor.

Another difference was a greater difficulty in finding images to use for GMI exposure. Pictures of knees and hands are easy enough to come by but pictures of the pelvic floor are harder to find and tend to derive from the pornography industry. When using pornography-based images, it slants towards a very specific body type – typically young, well-tanned, hairless, white women, and for that reason I am very hesitant to use those images. I've been slowly developing a database of images that we've been taking with consenting models, during various stages of pelvic floor treatment and obstetric exams. I hope to make it available to practitioners in 2020.

COULD YOU GIVE A GENERAL OUTLINE OF A GRADED IMAGERY TREATMENT SESSION?

According to the Neuro Orthopaedic Institute (NOI) group (who should be given all the credit with the techniques), GMI is broken down into 3 stages[2]. The first is left/right discrimination. In the standard MSK world, this might be differentiating between left and right hands, or for the spine, left versus right side flexion/rotation. This can be problematic in the vulvar world, given the vulva is a midline structure that does not have an obvious unilateral movement. As a solution, I have oriented the images on angles, and have asked participants to determine left versus right orientation. However, I can tell you that this method has not been tested in any research. Alternatively, I'll have people search through magazines and circle images favouring the right or left side of the pelvis. This isn't really ideal, since it's not the exact area of pain, but it's the best we have right now.

The second stage is explicit motor imagery, where a participant imagines themselves performing somewhat challenging positions or activities, without pain. The participant needs to imagine themselves from their own perspective, not imagining observing themselves performing the activity. This can be very challenging, as even the imagined movement itself will increase or cause pain. Patients also struggle to prevent muscle guarding while imagining themselves performing a movement they perceive to be painful. I typically start with imagined movements/activities that are simple and easily achieved, perhaps wearing underwear, and then work towards activities, like vaginal penetration, that might more regularly cause pain.

The third stage is mirror therapy. In standard orthopedic practise this means putting a non-painful limb in front of a mirror, giving the reflection the appearance of the opposite and painful limb.

The patient is then instructed to watch the reflection and to move the non-painful arm, gradually, into positions that would be more and more challenging for the symptomatic limb. As the person watches the reflection in the mirror, the brain perceives that the painful limb is doing the movement. Sometimes, the affected limb is performing the action behind the mirror, other times not. This component of GMI is obviously more challenging for the midline genital structures. I have yet to find a way to place one half of the vulva in the mirror and perform a unilateral movement. I am still playing with ways to include this phase for those with genital pain. Sometimes it's as simple as having patients examine their own genitals in a mirror, as many have never seen their own genitals before. Sometimes I ask them to perform their homework in a mirror, or to watch our physio session in a mirror. Other times I will do left-right discrimination around the vulva or vestibule with a Q-tip, while having them watch the reflection.

ARE THERE ANY OTHER HEALTH CARE PRACTITIONERS THAT ARE INVOLVED WITH THIS THERAPEUTIC PROCESS?

In regards to GMI training specifically, I will often refer to psychology or sexology. If I have a patient who cannot look at her genitalia in the mirror, or is having great difficulty engaging in graded imagery, and it is not an isolated physiology-based reason, then this is my cue to refer. The genitals certainly house a lot of stigma and emotion – for many women they hold trauma, embarrassment and taboo. I don't think many women are raised in households where they are encouraged to examine their genitals and it really can seem like a forbidden and foreign environment.

WHAT IS THE SUCCESS RATE WITH THIS METHOD?

I wish that I could give you information on this! To my knowledge there has yet to be a study examining the role of GMI with respect to the pelvis or genitals. Even with our team's research, we are far from being able to study the true effects of GMI. Each phase has to be broken down, and we need supporting research to pass ethics board approvals. Hopefully, slowly we will start to see some true numbers.

In orthopedics, a systematic review finds that a full GMI program likely has a moderate effect compared to the single components of GMI, and a large effect compared to standard physiotherapy[3]. This is interesting because it does offer some support that even components of the GMI protocol might be useful for treatment, but that all three phases seem to produce the best outcome. I caution applying this interpretation for the vulvar and pelvic floor population, though, since we just haven't done much research.

Clinically, I can tell you that I do see good results when used as part of a comprehensive treatment program. I do find distinct differences between pelvic floor conditions though. Vestibulodynia patients seem much easier to treat, compared to vulvodynia patients. Though I feel vulvodynia patients have a different presentation of their centralized symptoms, perhaps benefiting more from a GMI treatment protocols. This might just be my own biases, however.

EXCEPT FOR PAIN, WHAT ELSE DO YOU USE IMAGERY FOR IN TREATMENTS?

Clinically, I use this largely for pain. However, I sometimes weave imagery strategies in for patients who have urinary incontinence or prolapse when describing how best to contract the pelvic floor. I think that most practitioners do this, maybe without realizing. I use descriptors like "Imagine the pelvic floor squeezing around a marble and lifting it towards you belly", or "close the vaginal opening like you are closing curtains", or "squeeze your pelvic floor like you are drinking a thick smoothie through a narrow straw". Using metaphors, similies and visual descriptors can help portray our requests of muscle movement to our patients. I will also use this strategy with women who are quite distressed about a pelvic organ prolapse. I'll cue them to envision themselves squatting, or lifting without the sensation of prolapse descent.

> "The genitals certainly house a lot of stigma and emotion – for many women they hold trauma, embarrassment and taboo."

ARE THERE ANY RISK FACTORS INVOLVED WITH USING GRADED IMAGERY IN THE PELVIC PAIN POPULATION?

There are risk factors to manage with all treatments, I believe. GMI is intended to access the motor cortex in a manner similar, but significantly less than actual movement[4]. This is why athletes envision their sport before competing. And for this reason, patients can experience increased pain levels after treatment, even if they did no actual movement at all[5]. However, I feel as though there are fewer risks performing GMI therapy for chronic pain patients, compared to attempting a lot of manual therapy or exercise on a sensitized nervous system and potentially causing a flare-up. If imagined movements increase pain levels, I expect that they are not ready for a great deal of typical manual

therapy. These are likely patients that would benefit from a top-down treatment approach aimed at improving maladaptive centralized changes.

WHO MIGHT BE A GOOD CANDIDATE FOR MOTOR IMAGERY TRAINING?

I will often use these treatments on patients who don't consent to any hands-on treatment, or those who have severe allodynia, muscle guarding or anxiety and cannot tolerate a lot of manual therapy. If after my evaluation I suspect a high degree of central sensitization or motor-autonomic dysfunction then I will also attempt this technique. I've also attempted to use GMI on patients with bladder pain (after encouragement from Jilly Bond – check out her interview in this issue) though I find bladder pain more challenging as patients cannot actually view their bladder. However, maybe that makes imagery all the more important. I also use these methods on patients with coccydynia, or rectal pain, or ischial pain, or sacroiliac joint pain – really anyone who isn't responding as I would like, to my standard treatments.

Sometimes I find myself using GMI on unexpected patients. It has happened often, that a patient has completed all of her manual stretches and dilations and as we are preparing for returning to intercourse I will ask – "can you imagine having intercourse with your partner without pain?" and they will answer "No". I must then regress the questions – "Can you imagine allowing digital penetration without pain", or "Can you imagine external stimulation from your partner without pain", etc. I keep regressing backwards until I get a positive response. Then we have a discussion around this, and often I will integrate some motor imagery techniques into their homework.

WHAT KIND OF HOMEWORK WOULD A PATIENT BE EXPECTED TO DO?

A patient's homework depends on their stage of treatment. Sometimes they are searching through magazines, looking for pelvises. Sometimes I have them attend their focus to people who are wearing jeans – as wearing denim is often painful. Sometimes they have 3 activities that they need to imagine throughout the day. Maybe they have homework where they need to examine their vulva in a mirror. It is always patient specific, pertinent to their goals and should be just on the edge of challenging. I should say that having patients watch other people wear denim is one that I see with a very high success rate. I love having patients come back for follow-up wearing their own jeans, before I even request them to try!

YOU ARE CURRENTLY INVOLVED IN A STUDY EXAMINING THE EARLY STAGES OF GRADED IMAGERY FOR PELVIC PAIN CONDITIONS. CAN YOU TELL US MORE ABOUT IT?

I am very lucky to be able to work with the team at Mount Allison University's Sexual Health Lab and the head of the lab, Dr. Lisa Dawn Hamilton. Because there is so little research in this area, we are examining if viewing images of the genitals in various positions - including standing, sitting, PAP exam, tampon insertion, and penetrative intercourse, has an effect on viewing anxiety, anticipated anxiety and anticipated pain levels, in those with self reported genital pain conditions, compared those without. This would be the second stage of the GMI protocol – Explicit Motor Imagery. This has been a passion project with no funding, and so things are slow going (mostly because I am an inexperienced researcher), though our findings are as you would expect. We find that those with reported genital pain have higher levels of all three outcomes when rating scores while viewing penetration-based genital images. One of my goals for this year is to get our findings published.

HOW DO YOU SEE GRADED IMAGERY USED IN THE PELVIC HEALTH WORLD IN THE FUTURE?

I really hope that GMI techniques become integrated into practise just like in other areas of physiotherapy. I am not sure if GMI on its own will be sufficient to treat genital pain conditions, but I do think that it is a very valuable technique that offers a lot of use for the genital pain population in particular. Hopefully this article encourages others to be interested and take up some research of their own!

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Valentine's Day Challenge

By: Kiera McDuff Adapted by: Hayley O'Hara, April 15, 2019.

Physiotherapists and physiotherapy (PT) students across Canada participated in the 5th annual Valentine's Day Challenge this year. The challenge first started in 2015 as a way to support women in need in multiple cities on Valentine's Day, as well as to increase awareness about issues that impact women and women's health. The challenge consists of a collection drive for donations of toiletries, feminine hygiene products, and incontinence supplies to be donated to local women's centres as well as monetary donations.

Women who access shelters may be homeless or marginalized, while being faced with the challenge of surviving and raising children on minimal income. Many of these women may also be struggling with mental illness, substance abuse, and domestic abuse. Unfortunately, this population tends to have decreased access to health care, which makes accessing and affording basic necessities – such as medications, medical interventions, and psychological support–very challenging. This is especially applicable when many of these women are also caring for children or other family members.

Most women need to use feminine hygiene products, such as pads and tampons, on a monthly basis as part of staying healthy and clean during menstruation. The average cost of a box of tampons has been estimated to be between $7-10 (with pads being slightly less expensive) before tax. At face value, this may not seem like a lot. However, when one considers the multitude of financial, emotional, and physical stressorsthat many women at local shelters are facing, this cost is burdensome.

Despite the fact that feminine hygiene products are a necessity for most women, these items areless frequently donated to shelters and not given much attention. Feminine hygiene products are among some of the most needed items at shelters across Canada – other top items include incontinence supplies, toiletries, and undergarments. The goal of the Valentine's Day Challenge is to raise awareness about the reality of women living in shelters and the issues they face surrounding their lack of access to basic hygiene products and necessities.

The Valentine's Day Challenge has been an excellent way to increase engagement in the women's health physiotherapy community and celebrate Valentine's Day by including all women. This year we had an incredible 5 universities and 9 clinics across 6 provinces who participated in the challenge. Throughout the challenge, students, faculty, and clinicians were incredibly supportive and made a huge effort to raise awareness and collect donations at their respective facilities. The success of this year's drive can be attributed to the hard work and contributions of all of our volunteers and we thank you deeply.

And the Results are in...

I am delighted to recognize the incredible efforts of everyone who completed the Valentine's Day Challenge! This year we collected 1350 new, unused toiletries, feminine hygiene products and incontinence supplies and raised $545 for local women's shelters. The Women's Health Division will be matching this amount by $500. All of this hard work has gone a long way to support women across Canada this Valentine's Day. I look forward to hearing about the success of next year's challenge with the hope that even more students, universities and practitioners are able to get involved!

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Physiotherapy for Chronic Testicular Pain

by Linc Pisio, PT

There are many causes of testicle pain some are more serious than others. As we all know, testicles are very sensitive, and even minor incidents can cause significant pain. And when it's present, testicular pain can have a major impact on one's quality and enjoyment of life. Physiotherapy is often helpful in treating testicular pain when joints, nerves or muscles are involved.

Linc Pisio is an Orthopedic & Men's Pelvic Health Physiotherapist at Lakeview Physiotherapy and Acupuncture in Calgary, AB. He graduated with his BScPT from the University of Saskatchewan in 1999. Since then, he has practiced in private orthopedic and sports injury clinics in Saskatoon and Calgary. He has multiple acupuncture and needling certifications and has completed many myofascial release courses with John Barnes and others. He has also taken a series of Integrated Systems Model courses with L.J. Lee. Men's Pelvic Health has been the focus of his practice since 2016.

WHEN YOU NEED TO SEE A DOCTOR BEFORE ATTENDING PHYSIOTHERAPY

There are many medical conditions that can cause testicular pain: tumors, hernias, infections, kidney stones, etc. Some of these are very serious, making a visit to your doctor an important first step before a physical therapist gets involved. Sudden, severe testicle pain can be a testicular torsion – a twist in the spermatic cord that cuts off blood flow to the testicle. Seek emergency medical care for this...delayed treatment could result in permanent tissue damage. A trip to the Emergency Room is also wise if there is blood in your urine, nausea, fever or chills along with your testicle pain.

Swelling, lumps or persistent pain in your testicles or scrotal area are also a cause for concern. A visit to your doctor will allow him or her to examine you and perform appropriate tests to rule out serious problems and find the cause of your symptoms. This might include lab tests, imaging (your doctor might order an ultrasound test), or consultations with specialists.

Often, there are straightforward reasons for the symptoms, and the doctors know exactly what to do to help you. However, it is not uncommon for doctors to work through all the testing, rule out serious problems or medical issues (phew!), and you - the patient - is left without a solid explanation for your testicle pain. In fact, medical studies show that this is the case 20-25% of the time.

HOW PHYSIOTHERAPY CAN HELP

Sometimes testicle pain comes from muscle, joint or nerve issues that doctors' tests can't easily identify.

Let's begin by thinking about the nerves. There are several nerves that run to the testicles and scrotum. Some of these originate in the low back, and some leave the spine at the tailbone.

SOMETIMES THE JOINTS ARE THE PROBLEM

If the spinal joints aren't moving properly, the nerves can get irritated as they leave the spine, and cause pain in the testicles or elsewhere. Sometimes it is movement in the spine above or below where the nerves leave that is the problem. We carefully check the spine, and treat any stiff joints between the vertebrae to make sure they are moving properly.

Sacroiliac and hip problems are other frequent contributors to testicle pain that require treatment. The sacroiliac joints are the jointsbetween the tailbone and the pelvic bones.If it's not moving smoothly, there can be increased muscle tension in the pelvic floor (the hammock of muscles that stretches across the underside from tailbone to pubic bone). A pair of nerves that innervate the scrotum pass through these muscles and can become irritated by them. Hip issues can cause similar problems.

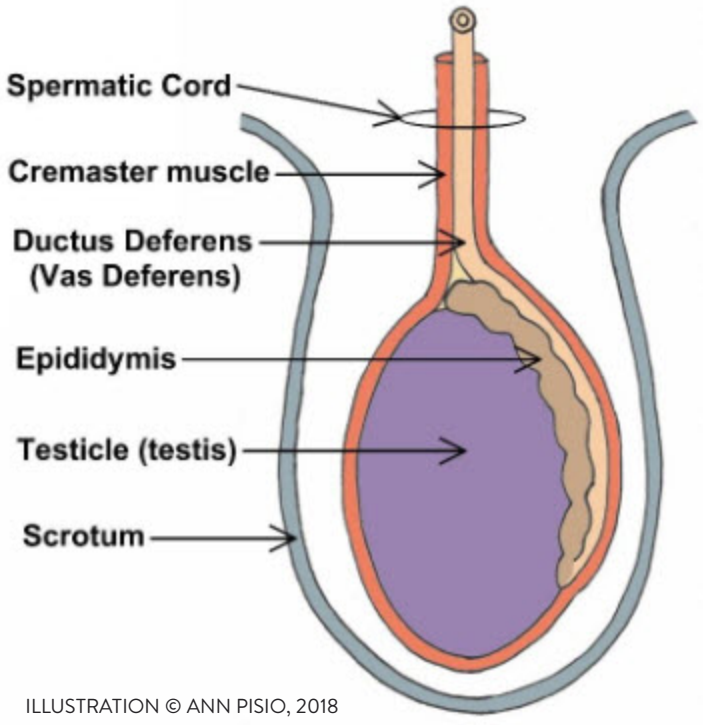

ILLUSTRATION © ANN PISIO, 2018

SOMETIMES THE NERVES ARE COMPRESSED

After leaving the spine, the nerves take different twisting and turning paths to get from the spine to the testicles. These nerves thread their way between and around various muscles, bones and ligaments. In fact, sometimes the nerves pass directly through the middle of a muscle. If there are tight muscles or other restrictions along the way, these can put pressure on the nerves, resulting in pain in the scrotum or testicles. Although the pain is felt at or within the scrotum, sometimes the squeeze is on the nerve several inches away, up in the back or abdomen, or between the scrotum and the tailbone.

When pressure on nerves is the culprit, muscles that may compress the nerve are stretched out to take the pressure off. Often, patients are taught how to stretch these muscles themselves, along with exercises to keep the back moving properly. Sometimes habits like sitting for too long at one time need to be adjusted to keep the nerves happy.

CALMING AND LOOSENING MUSCLES IS OFTEN THE KEY!

Muscles can contribute to testicular pain in several ways. As mentioned above, many muscles can put pressure on various nerves along their paths to the testicles or scrotum, causing pain. Additionally, tight or overused muscles can develop trigger points that can radiate or "refer" pain to the scrotum or its contents. Interestingly, the abdominal muscles can be a major culprit. This is why sometimes too many sit-ups are the real problem!

There is a muscle right inside the scrotum that can be part of the problem. The testicles are suspended in the scrotum by the spermatic cord. The cord has several layers, including a muscle layer called the cremaster. This is a muscle that raises or lowers the testicles to regulate their temperature (moving them closer to the body when stepping into a cold lake, for example). Like any other muscle, sometimes these muscles can go into spasm, causing major pain. This is called a "cremasteric cramp".

Muscle trigger point release techniques are used to treat irritable spots in muscles. Several of the muscles that cause testicular pain are easily accessible externally. Others are only accessible on the inside, via the rectum. When possible, patients are taught how to treat these areas themselves.

SCAR TISSUE MOBILIZATION

Sometimes scar tissue is a source of the pain. Studies have shown testicular pain after vasectomy to be a problem for many men.

There are several medical reasons for this that physiotherapy can't help. However, in some cases, the surgical incisions in the scrotum and spermatic cord can heal with painful scar tissue, and can be a source of ongoing pain. Physiotherapists use a variety of techniques to mobilize and stretch scar tissue that can help reduce pain and irritability. Often, patients are taught to do these mobilization techniques themselves.

THE EFFECTS OF STRESS

It's been said that the pelvis is a "gossipy" area. It responds to the internal chatter going on in our bodies. Many of the muscles in this area are tied into the fight-or-flight part of the nervous system. If a person is feeling worried or overwhelmed about anything (not just about the testicular pain!), the pelvic muscles can become overactive, and contribute to the problems discussed above. This is particularly true of repetitive or prolonged periods of stress. Stress creates tension, and muscles under sustained tension anywhere in the body can become irritable. The pelvic area seems particularly susceptible to this, and many men report increased symptoms during times of stress. To help with this, we often teach patients particular exercises and techniques to help calm the nervous system and relax overactive abdominal and pelvic floor muscles in particular.

If you think that stress could be a component of your pain, setting aside a little time during the day for a mindfulness/meditation practice can make a significant difference. There are many smart-phone apps out there that can get you started with this. "Headspace" is a free, commonly-recommended app, but there are many others. "Body-scan" style meditations are also often a great place to start.

WHAT NEXT?

If you are struggling with testicular pain, physiotherapy may help!

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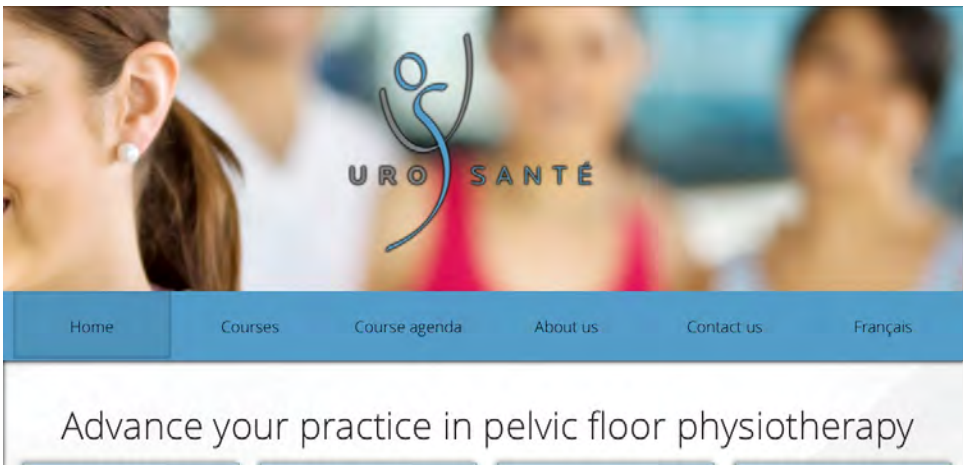

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Claudia Brown and Marie-Josée Lord

Laser treatments for pelvic floor conditions – what do we currently know?

Laser vaginal treatments have become 'trendy' over the past few years, with multiple companies promoting laser vaginal treatments for urogynecological disorders (Digesu & Swift 2017). As physiotherapists, it is important that we question these claims and draw our conclusions from the available science that may or may not support these claims. Currently, research does not support the idea that laser vaginal treatment can improve stress urinary incontinence or certain aspects of vaginal atrophy/sexual function (Digesu & Swift 2017). In fact, the FDA recommends that health care providers do not use energy-based devices to perform vaginal 'rejuvenation' or vaginal cosmetic procedures (FDA 2018). Laser treatments should not be considered effective for urogynecological disorders until we have evidence from robust clinical trials that adequately explore potential long-term complications and the safety and efficacy of laser treatments (Shobeiri et al., 2019).

Below are summaries and links to the current research and recommendations for laser vaginal treatments.

IUGA COMMITTEE OPINION: LASER-BASED VAGINAL DEVICES FOR TREATMENT OF STRESS URINARY INCONTINENCE, GENITOURINARY SYNDROME OF MENOPAUSE, AND VAGINAL LAXITY

S. Abbas Shobeiri, M.H. Kerkhof, Vatche A. Minassian, Tony Bazi
"This committee opinion reviews the laser-based vaginal devices for treatment of genitourinary syndrome of menopause, vaginal laxity, and stress urinary incontinence. The United States Food and Drug Administration has issued a warning for unsubstantiated advertising and use of energy-based devices. Well-designed case–control studies are required to further investigate the potential benefits, harm, and efficacy of laser therapy in the treatment of genitourinary syndrome of menopause, vaginal laxity, and stress urinary incontinence. The therapeutic advantages of nonsurgical laser-based devices in urogynecology can only be recommended after robust clinical trials have demonstrated their long-term complication profile, safety, and efficacy" (Shobeiri et al., 2019).

LASER TREATMENT IN UROGYNAECOLOGY AND THE MYTH OF THE SCIENTIFIC EVIDENCE

G. Alessandro Digesu & Steven Swift
In this editorial Digesu and Swift explain that "intravaginal laser therapy has become a very expensive and popular option among our peers for the treatment of urogynecological disorders, without any serious trials comparing active laser treatment with placebo or other standard of care therapies. It is performed on an outpatient or day surgery basis and is mainly funded by the patient, with a cost of $600–1,500 per visit, totalling $2,000–4,000 per completed course of treatment. Unfortunately, 3 years later, we have to reiterate the same conclusions published in our previous editorial, that the therapeutic advantages of intravaginal laser treatment in urogynecology can only be recommended after robust clinical trials have demonstrated its safety and efficacy. Before those trials become available, it should only be offered in the setting of a clinical trial" (Digesu & Swift 2017). You can access the full editorial online at:
https://link.springer.com/article/10.1007/s00192-017-3458-5

FDA WARNS AGAINST USE OF ENERGY-BASED DEVICES TO PERFORM VAGINAL 'REJUVENATION' OR VAGINAL COSMETIC PROCEDURES: FDA SAFETY COMMUNICATION

Recommendations for Health Care Providers:

- Be aware that the safety and effectiveness of energy-based devices to perform vaginal "rejuvenation" or cosmetic vaginal procedures has not been established.
- Understand that the FDA has not cleared or approved any energy-based medical device for vaginal "rejuvenation" or vaginal cosmetic procedures, or for the treatment of vaginal symptoms related to menopause, urinary incontinence, or sexual function (FDA 2018).

"Intravaginal laser therapy has become a very expensive and popular option among our peers for the treatment of urogynecological disorders, without any serious trials comparing active laser treatment with placebo or other standard of care therapies."

A SYSTEMATIC REVIEW ON VAGINAL LASER THERAPY FOR TREATING STRESS URINARY INCONTINENCE: DO WE HAVE ENOUGH EVIDENCE?

Vasilios Pergialiotis, Anastasia Prodromidou, Despina N. Perrea, & Stergios K. Doumouchtsis

Abstract:
Introduction and hypothesis: Current treatment strategies for stress urinary incontinence (SUI) raise concerns about safety and efficacy. The purpose of this systematic review was to

present available evidence related to vaginal laser therapy as a treatment option for SUI.

Methods: We searched the MEDLINE (1966-2017), Scopus (2004-2017), Clinicaltrials.gov (2008- 2017) and Cochrane Central Register of Controlled Trials (CENTRAL) (1999-2017) databases for relevant studies in this field. We aimed to include all observational studies (prospective and retrospective, randomized and nonrandomized) that reported outcomes on vaginal laser therapy as a treatment option for SUI.

Results: Thirteen studies were included that recruited 818 patients who underwent laser therapy for SUI. The methodological quality of most included studies was low, as they were either individual case control studies, case series or poor-quality cohorts (Oxford Level of Evidence 3b and 4). According to the existing evidence, laser therapy may be a useful, minimally invasive approach for treating SUI. However, the methodological limitations of included studies render them prone to significant bias, limiting their scientific integrity.

Conclusions: As the demand for minimally invasive approaches for treating SUI increases, it is expected that more patients will seek alternative treatments over current standards (midurethral slings). Given the limitations of the existing studies, it seems that conducting future trials is necessary to elucidate this field

Full text is available at:
https://www.researchgate.net/publication/322533546_A_Systematic_Review_on_Vaginal_Laser_Therapy_for_Treating_Stress_Urinary_Incontinence_Do_We_Have_Enough_Evidence

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Our Approach to Non-Traumatic, Chronic Musculoskeletal Pain: Are we Heading in the Right Direction?

By Nicole Beamish, PT, PhD

Musculoskeletal conditions are the **second highest contributor to global disease.**[1] Although the prevalence of musculoskeletal conditions varies by age and diagnosis, 20%–33% of people worldwide live with a painful musculoskeletal condition.[1]

It is clear that musculoskeletal pain is a growing problem and as physiotherapists, we should be equipped to help ease this burden. So, we must question why this problem exists and reflect on our practices and how we approach our patients with persistent musculoskeletal pain.

> "We need to look at how other chronic health conditions are managed, learn from these approaches, and alter how we approach these conditions. In a sense, they assert the idea that it is indeed time for us to leave the biomedical model and embrace a biopsychosocial perspective in our clinical practices."

In a recent **editorial in the British Journal of Sports Medicine**, Dr. Jeremy Lewis and Dr. Peter O'Sullivan suggest that our current approach to musculoskeletal pain is failing.[2] They suggest that this is a result of two misconceptions that occur when diagnosing and treating individuals with persistent musculoskeletal pain.2 Lewis and O'Sullivan2 explain that there are potentially two reasons for this:

1. Structural changes that are diagnosed through imaging are being attributed to the individual's pain and disability when these changes are often seen in pain-free individuals.

2. Clinicians are promoting treatments for conditions that do not appear to be supported by research evidence.[2]

These are interesting ideas to consider. If a patient perceives that their pain is caused by a specific structure and that only the therapist has the tools to 'fix' or manage their pain we create an environment where the individual can feel 'damaged' which can result in not only a fear of movement but, in a quest to seek treatment to 'fix' these structural issues.[3]

Lewis and O'Sullivan[2] suggest that we need to look at how other chronic health conditions are managed, learn from these approaches, and alter how we approach these conditions. In a sense, they assert the idea that it is indeed time for us to leave the biomedical model and embrace a **biopsychosocial perspective** in our clinical practices. In their editorial, they compare managing persistent musculoskeletal pain to the management of non-insulin dependent diabetes where the focus is not on the 'cure' but on the 'management' plan. The goal of the intervention is not only to control the condition but to limit the impact this condition has on the individual's health and well-being.[2]

Lewis and O'Sullivan[2] end their editorial by urging clinicians to take a step back and look at how they are approaching individuals with musculoskeletal disorders. They stress that as clinicians we need to evolve with the research evidence.[2] To do this, clinicians should critically look at the research that investigates both the surgical and non-surgical interventions for persistent musculoskeletal conditions.[2] We must also reflect on our current practices and strive to reframe the language we use to ensure we are providing care that aligns with the care provided to individuals with other chronic healthcare conditions.[2] Taking a broader approach to the assessment and treatment of our patients with chronic musculoskeletal disorders will, in turn, help our clients achieve their goals and their optimal state of health.

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Women's Health

A DIVISION OF THE CANADIAN PHYSIOTHERAPY ASSOCIATION

SUMMER 2019 NEWSLETTER

Women's Health

A DIVISION OF THE CANADIAN PHYSIOTHERAPY ASSOCIATION

IN THIS ISSUE

WORD FROM THE CHAIR

I was lucky to get together with most of the WHD executive in Charlottetown for Forum at the end of June to have a strategic plan review. It is so valuable to meet face-to-face, especially when we are spread from Nova Scotia to Saskatchewan. We have prioritized some projects for the fall including devising a position statement on internal physiotherapy pelvic examinations and interventions and planning a course for Congress 2020 (the 100th anniversary of CPA!) which will be in Ottawa at the end of May next year. We will also be sending out a survey for our members to get a better understanding of how we can serve you better. The results of this survey will guide our strategic plan for 2020-2023.

The end of June is also a time when we have turnover on our executive. While the majority of our group have agreed to stay on, we said goodbye to Jesse Robson, our past-chair, who has been on the executive since 2014. Our student representative Hayley O'Hara also ended her term, but we are hoping that she will stick around and help us out in other capacities. One of our long-standing sub-committee members, Brittany Vandyken is also moving on to other projects. We are blessed to have had these amazing, intelligent and energetic women help us out and wish them all the best in their future endeavours.

This fall, the International Pelvic Pain Society (IPPS) is holding its annual conference in Toronto (October 17-20th). The pre-conference session is Clinical Foundations: An Integrated Approach to the Evaluation and Treatment of Chronic Pelvic Pain and the post-conference session is Clinical Skills for Building Self-Efficacy in Pelvic Pain. Keynote speakers include Dr. Andrew Horne (University of Edinburgh - UK), co-author of Endometriosis: The Expert's Guide to Treat, Manage and Live Well with Your Symptoms, and Dr. Catherine Allaire, a clinical professor at the University of British Columbia who specializes in pelvic pain and endometriosis. Content includes several talks on the general mechanisms of pain and visceral pain syndromes, amongst other topics. Don't miss this great opportunity to find out what is happening on the world pelvic pain stage and be sure to come and visit us at our booth in the exhibit hall - we would love to meet you!

Wishing you a lovely rest of the summer and please feel free to drop me a note if you have any comments or suggestions! **whdchair@gmail.com**

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

EDITOR'S NOTE

Happy summer everybody!

After a very interesting and successful CPA Forum, as well as an opportunity to meet up and make plans, the WHD is proud to present to you our update. Please have a read through the "Strategic Plan – Summary and Update" and feel free to email us with questions and/or suggestions you may have.

As always, the summer issue is not focused on a specific theme, and can therefore provide you with all kinds of information. Aside from the strategic plan and WHD update, in this section you can find a summary of the most recent guidelines for return to running, a book review, an international update, and our awards section. Although we do not have an official research corner in this issue, we do have a very valuable input from our research chair, Nicole Beamish. **Please have a look here**. This link takes you to a free online edition of the British Journal of Sports Medicine. There, you can find original research articles, as well as blogs, podcasts, editorials and videos.
We hope you enjoy this Newsletter, as well as your summer!

Katerina Miller, PT
WHD Newsletter Editor

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BRITTANY VANDYKEN

The Women's Health Division would like to send an enormous thank you to Brittany Vandyken for her help on the PR Subcommittee. Brittany is very passionate about pelvic and women's health and has spent the last three years helping to source the content and articles that keep the WHD Twitter and Facebook accounts active and engaging. Brittany is now stepping back from this role with the WHD as she continues to work on expanding her clinic in Huntsville, Ontario.

Thank you so much for your passion and commitment to the WHD Brittany! We wish you the best in your future endeavours.

2018-2019 AWARD WINNERS

Over the past year the Women's Health Division has had the pleasure to award several deserving applicants with $750 worth of bursaries. Please allow us to introduce our most recent winners:

AWARD	RECIPIENT
Conference Bursary	Sheela Zelmer
New Graduate Award	Jane Jing Bai
Remote Areas	Ashley Froese
Student CPA Congress	Laurin Black
Advanced Training	Lisa Flanders
Leadership Award	Anne-Marie Fafard

We encourage you to continue applying for upcoming awards!

RETURN TO RUNNING: 2019 POSTPARTUM GUIDELINES

A SUMMARY FROM TOM GOOM'S RETURNING TO RUNNING POSTNATAL – GUIDELINE FOR MEDICAL, HEALTH AND FITNESS PROFESSIONALS MANAGING THIS POPULATION

by Leslie Spohr, PT

With intentions to address the current lack of standard framework regarding returning to running in the postpartum population, earlier this spring, Tom Goom, Gráinne Donnelly, Emma Brockwell and associated colleagues released comprehensive, evidence-based, clinically-influenced guidelines to assist clinicians working with this population. The following information is based on those guidelines, and is easily accessible to the public **at this link.**

The guidelines are intended to provide an overview of considerations, rather than specifics, and while the authors recognize that the guidelines may be applicable to other pelvic health populations, they are intended for the postnatal population. They plan to revise these guidelines in a year's time and to perhaps include the post-surgical population and others.

The authors evaluated the evidence for these guidelines using the Royal College of Obstetrician's and Gynaecologist's (RCOG) classification.

(Goom, Tom & Donnelly, Grainne & Brockwell, Emma. (2019). Returning to running postnatal - Guidelines for medical, health and fitness professionals managing this population.)

It is of most importance that a mother's body has been allotted the appropriate amount of time to heal and regain suitable strength before returning to a high impact sport like running after having a baby. It is also highly recommended that all women, regardless of delivery method, seek out a pelvic health assessment with a specialised physiotherapist for full evaluation of the pelvic floor and abdominal wall function.

The general consensus from the authors is that prior to 3 months postpartum, low impact exercise progressions should be implemented with a graded return to running occuring no earlier than 3-6 months--depending on the 'readiness' of the mother based on the screening tests.

For the first 3 months postpartum, the authors recommend a low impact exercise timeline such as the following:

0-2 WEEKS

- Pelvic Floor muscle exercises (once catheter removed) targeting strength and endurance functions
- Basic core exercises (e.g. pelvic tilt, bent knee drop off, side lying abduction)
- Walking (for cardiovascular exercise)

2-4 WEEKS

- Progress walking/pelvic floor muscle/core rehab
- Consider introduction of squats, lunges, bridges, in line with the functional requirements of day-to-day life as a new mother.

4-6 WEEKS

- Introduce low impact exercises (e.g. static cycling or cross trainer) taking into account individual postnatal recovery, mode of delivery and perineal trauma. Recovery should be such that the new mother is comfortable sitting on a saddle.

6-8 WEEKS

- Scar mobilization (for either C-Section or perineal scar)
- Power Walking
- Increased Duration/intensity of low impact exercises
- Deadlift techniques beginning at light weights no more than the weight of the baby in a car seat (15kg) with gradual load progression (e.g. barbell with no weight). This aims to strengthen and restore strategies for carrying out the normal everyday tasks require when caring for a newborn and/or older siblings
- Resistance work during core and lower limb rehab.

8-12 WEEKS

- Introduce swimming (if lochia has stopped and there are no issues with wound healing)
- Spinning (if comfortable sitting on spinning saddle)

If the mother is less than 3 months postpartum and wishing to return to running, the authors recommend continuing with the screen and educating the mother on recommended timeline and low impact exercises. If the mother is 3 months postpartum, or more, completing the screen is recommended and educating her about the potential to return to running provided the screening tests are passed, but emphasizing that the test may indicate the mother is not ready to return to running just yet.

RETURN TO RUNNING SCREEN

CRITERIA FOR RETURN

- Err on the side of caution due to the risk of pelvic floor dysfunction
- Combine time-based criteria with specific signs, symptoms, tests and recognized risk factors
    - Pre-existing hypermobility conditions (e.g. Ehlers-Danlos)
    - Breastfeeding
    - Pre-existing pelvic floor dysfunction or lumbopelvic dysfunction
    - Psychological issues which may predispose a postpartum mother to inappropriate intensity and/or duration as a coping strategy
    - Obesity
    - Cesarean Section or perineal scarring
    - Relative Energy Deficiency in Sport (RED-S)

TIME BASED CRITERIA

- Aim between 3-6 months postpartum, provided the individual has passed the following criteria

ASSESSMENT OF PELVIC HEALTH

- Return to running is NOT advised if the following subjective and objective issues are identified during screening

SUBJECTIVE

- Urinary and/or faecal incontinence prior to or during commencement of running
- Pressure/bulge/dragging in the vagina prior to or during commencement of running
- Ongoing or onset of vaginal bleeding, not related to menstrual cycle, during or after attempted low impact or high impact exercise (refer back to care provider)
- Reduced pelvic floor muscle endurance. Recommended baseline in standing:
- 10x fast reps
- 8-12 reps of 6-8 second maximum voluntary contraction
- 60 seconds submaximal 30-50% contraction
- Genital Hiatus (GH) + Perineal Body (PB) ≥7 cms on Valsalva for 6-8 seconds
- Regardless of Modified Oxford Manual Muscle Test (MOMMT) score, it is advisable that the evaluation of risk developing POP should be carried out via the GH+PB component of the POP-Q Assessment. If POP or significant apical loss is identified, a vaginal pessary should be considered to reduce the worsening of fascial support and facilitate the return to running.
- Women with <3 MOMMT scores with no identifiable compromise in their fascial support or other signs and symptoms, may be considered appropriate for graded return to running.
- Women with ≥3 MOMMT score that demonstrate significant apical loss or ballooning should have fascial support deficits addressed
- Evidence of incontinence during examination

OBJECTIVE ASSESSMENT OF LOAD AND IMPACT MANAGEMENT

To pass this assessment, the mother needs to achieve the following without pain, heaviness, dragging or incontinence

- Walking 30 minutes
- Single leg balance 10 seconds
- Single leg squat 10 repetitions each side
- Jog on the spot 1 minute
- Forward bounds 10 repetitions
- Hop in place 10 repetitions per leg
- Single leg 'Running Man': opposite arm and hip flexion/extension (bent knee) 10 repetitions per side

VIDEO ANALYSIS MAY BE OF ASSISTANCE

Tests may be repeated after management strategies (e.g. pessary or continence aid) have been made. If successful, these devices can be used to help in the return to running.
Special consideration of RED-S is important at this stage as there is an increased risk of stress fractures, pelvic floor dysfunction and fertility issues in postpartum women with RED-S.

STRENGTH TEST

Aim for 20 repetitions of each test

- Single leg calf raise
- Single leg bridge
- Single leg sit to stand
- Side lying abduction

It is also recommended that all key hip muscles (abductors, adductors, flexors, extensors and rotators) are assessed. Weakness is not considered a barrier to return to running, but rather help guide areas for strength work.

ADDITIONAL CONSIDERATIONS

WEIGHT

Increased weight increases load on pelvic floor. Women are considered at a higher risk of pelvic floor related symptoms if they have a BMI >30.

FITNESS

Encourage safe and appropriate early postnatal fitness work.
Rehabilitation plans will vary depending on the individual birth experience and symptoms.

BREATHING

Encourage a slow pace return to running that allows the individual to maintain a conversation. Breath analysis is recommended as part of the postpartum evaluation to ensure optimal strategies.

PSYCHOLOGICAL STATUS

Screening for Postpartum Depression and potential of running to be used as a coping mechanism.

DIASTASIS RECTUS ABDOMINIS (DRA)

Expert consensus is that running prior to regaining functional

control of the abdominal wall may be counterproductive and result in overloading or compensatory strategies in the pelvic floor.
A mother may return to running if the DRA is functional (i.e. there are strategies to control intra-abdominal pressure (IAP) and transfer load across the abdominal wall).

SCAR MOBILIZATION

Both C-Section and perineal scars can result in pain and re-striction. It is recommended to assess and implement advice and guidance regarding scar mobilization.

BREASTFEEDING

It is likely that a mother returning to running is still breastfeeding.
Breastfeeding has been thought to prolong the altered hormone environment resulting in some breastfeeding mothers experiencing increase joint laxity compared to baseline. This may increase a mothers' risk for developing injury or (pelvic floor) dysfunction. Hydration, timing of runs/feeds and level of exertion should be discussed with the mother

SUPPORTIVE CLOTHING

Proper fitting sports bra and footwear should be advised as sizing may not be the same as pre-pregnancy. Supportive clothing may offer benefits in reducing stress urinary incontinence, and could play a role with pelvic floor rehabilitation

SLEEP

Sleep deprivation (<7-9 hours/night) is associated with increased risk of injury, lower health, increase stress and may reduce muscle protein synthesis. Education regarding optimizing sleep, day-time naps and good sleep hygiene may be warranted.

RELATIVE ENERGY DEFICIENCY IN SPORT (RED-S)

Previously referred to as the Female Athlete Triad Syndrome.
Refers to the impairment of bodily functions due to the excess energy expenditure without adequate replacement as a result of excessive activity or other lifestyle factors. Potential for compromise of psychological well being, bone health, pelvic floor function and fertility.

If the mother is more than 3 months postpartum and unable to pass all of the above tests, a rehabilitation program to address deficits or referral to relevant specialists (Physio, GP, GYN, etc) is warranted. If she is able to pass all of the above tests, a graded return to running program, similar to the following, could be considered:

- Graded to return to running (e.g. NHS 'couch to 5km' plan)
- Start small, often 1-2minutes of running at an easy pace.
- Include walking breaks
- Goal-Specific
- Short term - target distance
- Long term- specific race
- For challenging goals consider working with a running coach
- Risk Factors to injury (i.e. if obese reduce distance to a 'couch to 3km' rather than 5 km)
- Build training volume (e.g. distance/time) before intensity
- Total distance/time should not be increased by more than 10%/week.
- During low training volumes, consider using 'relative increase' rather than the 'absolute' increase to avoid painfully slow progressions.
- Monitor signs and symptoms and modify program appropriately or refer to appropriate professional(s) help to address (postnatal) issues.
- Heaviness, dragging, incontinence, and moderate to severe pain may indicate excessive training distance or intensity
- Running with a stroller should focus on the health and well being of baby
    - Use a stroller designed for running (includes 5 point harness, fixed front wheels, hand-operated brakes, rear wheel suspension, pneumatic tires, 3 wheel and a wrist strap.)
    - Stroller companies often recommend that running with baby does not commence until baby is 6-9 months old to protect their neck and spine.
    - Due to altered mechanics of running with a stroller, special focus on flexibility of the spine, pelvis and hip and glute strength should be recommended.
    - Two handed method results in the most similar speed and stride length to non-stroller running.

SUMMARY OF EVIDENCE BASED RECOMMENDATIONS:

Evidence Based Recommendation #1: Postnatal women can benefit from the individualized assessment and guided pelvic floor rehabilitation for the prevention and management of pelvic organ prolapse, the management of urinary incontinence, and to improve sexual function. (Level 1+)

Evidence-Based Recommendation #2: Return to running is not advisable prior to 3 months postnatal or beyond if any symptoms of pelvic floor dysfunction are identified prior to, or after attempting, return to running. (Level 4)

Evidence-Based Recommendation #3: The assessment of pelvic health, load impact management, and strength testing described in this section is based on expert clinical consensus drawing from the best available evidence. No studies specific to the postnatal population have been carried out to evaluate readiness to return to exercise. (Level 4).

Evidence-Based Recommendation #4: The recommendations for considering additional factors in a woman's postnatal evaluation such as weight, breathing, psychological status, DRA, Breast health/feeding, RED-S and running with a buggy are made by considered expert consensus based on the best available evidence. There is a paucity of research investigating these factors specific to the postnatal population and running. (Level 4).

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RepaGyn® is kept behind the counter at pharmacies across Canada, and is available for you to recommend to patients.

"My pelvic floor health Physiotherapist recommended RepaGyn to me due to vaginal dryness from child birth, and due to breastfeeding my little one. I wasn't sure how I'd react or like this product, but I was pleasantly surprised and have been using it for a month now and it has helped restore moisture and helps the area to feel less irritated."

~ A

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.

✔ Relieves vaginal dryness

✔ Hyaluronic acid helps promote healing of the vaginal mucosa[1]

✔ Convenient and easy-to-use vaginal ovules

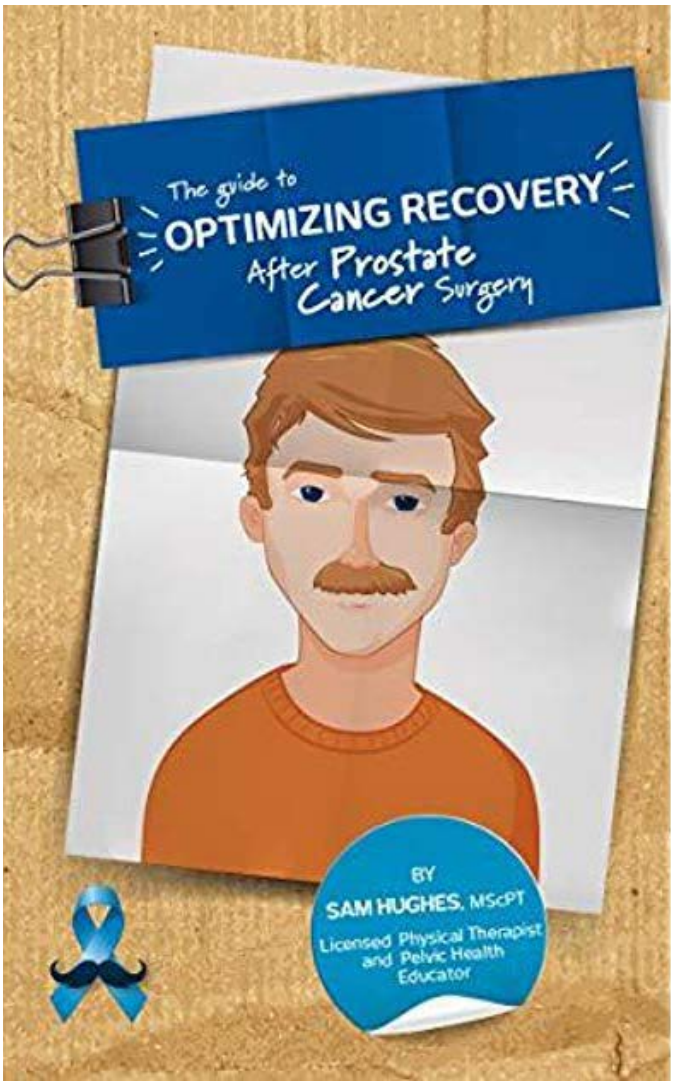
Note: RepaGyn is kept behind the counter. Similar to OTC, behind the counter (BTC) status allows patients to access certain medications at a pharmacy without seeing a doctor.

*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.

BioSyent
t: 1.888.439.0013
repagyn@biosyent.com
www.repagyn.ca

BOOK REVIEW: THE GUIDE TO OPTIMIZING RECOVERY AFTER PROSTATE CANCER SURGERY BY SAM HUGHES, MSCPT



Reviewed by Alison Pethrick, MPT, PGCertPhysio (PF Physio)

The Guide to Optimizing Recovery after Prostate Cancer Surgery by Sam Hughes, MScPT is a sensitive and helpful handbook that outlines what to expect while recovering from prostate cancer surgery. Prostate cancer is the second most common form of cancer in men worldwide and is very often treated by surgical removal of the prostate gland. Having a guidebook to assist and empower men and their families through recovery is a useful resource for a large population of men and their families going through what can be a very stressful time.

For a relatively short book (156 pages), The Guide to Optimizing Recovery After Prostate Cancer Surgery covers a wide span of information - including an outline of prostatectomy surgery, types and causes of incontinence, appropriate pelvic floor training, and how sexual health may change post-operatively. The information is well researched and clearly presented in approachable language without being over-simplified, and accurate illustrations are used to assist in the explanation of key or complex points. Each chapter is concluded with a 'Notes' section which is a full page spread, allowing and encouraging patients or family members to immediately reflect, write down questions to ask their health care provider, or to do a self-summary of the important information contained in the previous chapter. The author's experience and care working with this patient population is further demonstrated throughout the book with helpful and important tips being highlighted throughout the text, content educating regarding skin care and incontinence product recommendations and a section highlighting the importance of emotional support and stress management.

Additional features that are included are the 'Q & A: Urologist's Corner' and the detailed, user-friendly Appendices. The 'Urologist Corner' section receives input from two British Colombia based urologists and answers questions regarding surgical procedure, changes in penile length, and penile rehabilitation post-operatively. This section allows men to identify questions that they may want to discuss with their own urologist as well as ensure that they are aware of treatment options and timelines for recovery going forward. Following the 'Urologist's Corner', the appendices include practical advice regarding urinary urgency and constipation management as well as general breathing and stretching recommendations – all accompanied by clear illustrations demonstrating appropriate posture and technique. They also include a bladder diary template, encouraging men to track their urinary voids and incontinent episodes to assist in monitoring for change over a period of time.

Overall, this book is a fantastic resource for patients and their families looking for more information on the prostatectomy process and would be helpful both prior to surgery and post-operatively to inform their recovery. The guidebook clearly outlines what to expect from the procedure, as well as what to expect from recovery and provides realistic timelines, suggestions regarding management, and when to seek external help. While it does not replace an information session or one-on-one pelvic health assessment, it is an excellent support and adjunct to ensure that information is retained and understood. I plan to keep this book available in my own clinic, and will suggest it as a resource to my male patients undergoing prostate cancer surgery.

The Guide to Optimizing Recovery After Prostate Cancer Surgery is available on **the author's website** or at **Amazon.ca** for $24.22.

CONFERENCE BURSARY

Hello, everyone! My name is Laurin and I am currently a Physiotherapy student at the University of Toronto. In June of 2019 I had the opportunity to attend the Canadian Physiotherapy Association's Forum 2019 hosted in Charlottetown, PEI with the assistance of a bursary generously provided by the Women's Health Division. While at Forum, I was able to craft my own experience by selecting sessions on various topics with the underlying theme of Physiotherapy and the Aging Population. Some of my favourite sessions included discussing the use of medical cannabinoids versus opioids, muscle and power training for seniors, and how to promote exercise in elders in Indigenous communities. Through attending these sessions, I was able to make valuable connections with Physiotherapists and Physiotherapy students from across Canada, which provided great insight into what Physiotherapy looks like across the country. The knowledge, connections, and memories gained through this experience will stay with me throughout my career and beyond. Thank you, WHD for the amazing opportunity!

10 REASONS TO ATTEND WCPT CONGRESS

By Juliet Sarjeant and Samantha Doralp

The World Confederation for Physical Therapy (WCPT), founded in 1951, represents over 450,000 Physical Therapists around the globe from over 120 member organizations. Every two years, this global community gathers at congress. This year, two of our Women's Health Division executive members were given the opportunity to travel to Geneva in May to attend. As a key stage for our global PT voice, it is an opportunity that every PT should consider. With that, here are 10 reasons you should consider WCPT congress in 2021 in Dubai!

1

Get inspired! WCPT Congress is a place where you can hear talks from clinicians and researchers around the world which will inspire your practice.

2

Get involved in research. Are you interested in networking with researchers? WCPT Congress is an excellent opportunity for clinicians to meet with researchers in their field and explore opportunities to work together!

3

Expand your knowledge base. As a WH PT, are you curious about other areas of practice? Popping into a speaker session on advocacy, migrant health, leadership or education can expand your knowledge base and support what you do in WH!

4

Meet physiotherapists from around the world. Hearing about practices in different parts of the world, such as funding, resources, models of care, education and clinical experience is eye-opening and might change your perspective and appreciation for not only what you do, but how you do it.

5

Connect in real-time with colleagues who you have only met virtually. Having a face-to-face conversation is so much more valuable and enjoyable. It is a great way to share your ideas and build on what you have been communicating about digitally or over the phone.

6

Experience hands-on and workshop learning. WCPT Congress has pre- and post-congress courses ranging from infant assessment, aquatic therapy and the theory and practice of the shoulder. These break-out sessions allow you to further develop your skill set!

7

Explore and network with leading physiotherapy technology vendors. This is a great way to see leading edge technology in the world of physiotherapy from leaders in the field. Scope out wearable technologies and new rehab tools that you can incorporate into your clinic or discover exciting job and volunteer opportunities!

8

Go on a clinic visit. Visiting clinics in a new country and seeing different models of care may give you ideas on how you can improve your practice back in Canada.

9

Represent your country. This is a great opportunity to represent the amazing things that Canadians are doing in PT practice. Get out there and wave our flag proudly!

10

Last, but definitely not least, travel and see a new part of the world! Congress 2021 is in Dubai, UAE and 2023 is in Tokyo. Start saving your pennies to take advantage of these upcoming opportunities! If cost is an issue, WCPT uses the fees for abstract submission to support a bursary program to support travel costs for those interested in attending. Check out their website for more details!

We hope to see you there in 2021!

Branch Out –

Take Your Skills to the Next Level with Visceral Manipulation...

The Barral Institute is endorsed by the International Alliance of Healthcare Educators.

Learn hands-on from the original developers of the techniques. The visceral system influences musculo-skeletal articulations and tension patterns in the body causing functional and structural problems. An integrative approach to evaluation and treatment requires assessment of the structural relationships between the viscera, and their fascial or ligamentous attachments to the musculoskeletal system. It also requires an understanding of the dural and neural components that are often missed when treating traumas and dysfunctions.

Upcoming Classes:

Visceral Manipulation: Organ-Specific Fascial Mobilization; Abdomen 1 (VM1)

Vancouver, BC	October 24 - 27, 2019
Toronto, ON	November 30 - December 3, 2019
Ottawa, ON	Mar 12 - 15, 2020

For additional VM dates in North America, please visit Barralinstitute.com

"Visceral Manipulation enables one to gain awareness of relatively ignored structures."

- M. Nicholson, PT

Gail Wetzler
PT, DPT, EDO, BI-D

"As a Physical Therapist and Director of Curriculum of the Barral Institute, I invite you to experience the value of visceral mobilization as it relates to specific results for your patients."

Visceral Manipulation Can Benefit:

- Pelvic/Vaginal Pain
- Endometriosis
- Incontinence
- Fibroids & Cysts
- Dysmenorrhea
- Infertility Issues of Mechanical Origin
- Prenatal & Postpartum Musculoskeletal Pain

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SUMMARY AND REVIEW OF 2017-2020 STRATEGIC PLAN

VISION

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 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 health.

Another difference was a greater difficulty in finding images to use for GMI exposure. Pictures of knees and hands are easy enough to come by but pictures of the pelvic floor are harder to find and tend to derive from the pornography industry. When using pornography-based images, it slants towards a very specific body type – typically young, well-tanned, hairless, white women, and for that reason I am very hesitant to use those images. I've been slowly developing a database of images that we've been taking with consenting models, during various stages of pelvic floor treatment and obstetric exams. I hope to make it available to practitioners in 2020.

MISSION

Our mission is to provide leadership and direction to members of the CPA for the advancement of physiotherapy practice in women's health by fostering excellence in practice, education, and research for the benefit of Canadians. We aim to:

- Acquire and make available information and educational materials
- Encourage and develop the publication of research in the field
- Facilitate communication between and among members
- Promote ongoing professional development
- Enhance physiotherapy service delivery specific to women's health and/or pelvic health

CORE ACTIVITIES OF THE WOMEN'S HEALTH DIVISION AND PROGRESS:

1. Provide leadership and direction of the advancement of the WHD and the practice of physiotherapy in women's health/pelvic health (WH/PH) fostering excellence in practice, education, and research for the benefit of Canadians. This is being done via:

- Training strong leadership skills in our executive - ongoing expectation from each executive member to adhere to their responsibility
- Developing effective subcommittees - all committee chairs are responsible for the efficient functioning of their subcommittees via delegation of responsibilities and recruiting additional subcommittee members when needed.
- Investigating an interest in a division name change - this was voted by the members of the WHD 2017 and 2018 not to be done at this time.
- Working on increasing regional representation in our subcommittees - although no targeted recruitment is happening, our committee and subcommittee members are representing British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, New Brunswick, and Nova Scotia.
- Exploring the potential for a clinical specialty/certification/mentorship program - we have done an environmental scar and are working on gathering information about the proper process and will be working with National Office on this. Team leads to have a decision regarding whether to move ahead with this project by time of next strategic planning session (June 2020)

2. Acquire and make available resources and opportunities relevant to WHD members. This is being done via:

- Monthly e-blasts
- Social media
- Website - a new design was introduced, and the website is being updated regularly. Currently working on making the current and following newsletters searchable.
- Newsletter
- Awards
- Courses - such as Antony Lo's "The Female Athlete" in 2018. We are also bringing you a Functional Pilates course in 2020, so stay tuned!
- Webinars

3. Encourage and support knowledge translation in the field of WH/PH. This is being done via:

- $5000 PFC grant
- Encouraging and facilitating network between and amongst WH/PH clinicians and researchers - we are working on - Spotlight researchers, student & research projects, research programs across Canada via newsletter & social media
- Increasing awareness about WH/PH via knowledge translation - We are working the CPA's Knowledge Translation Division to create a space for knowledge exchange. We will be working hard to present a great Women's and Pelvic Health stream at Congress 2020
- We have partnered with Physiopedia to help improve global knowledge in Women's and Pelvic Health.
- Our new guidelines for the PFC award include an end of project KT activity with the WHD and we are looking forward to that next summer.

PELVIC HEALTH SOLUTIONS

www.pelvichealthsolutions.ca

Visit www.pelvichealthsolutions.ca for our regularly scheduled courses, including urinary incontinence and female & male pelvic pain (levels I, II & III) in Ontario

Menopause: An Integrative Approach For Physiotherapists - September 14-15, 2019

Innovative Exercises for the Sensitive Nervous System - September 28-29, 2019

Treating Male Pelvic Pain - October 26-27, 2019

Treating Pediatric Functional Gastrointestinal Disorders - Evaluation and Management - Nov. 1-3, 2019

CBT Skills for Distressing Physical Symptoms - November 9-10, 2019

The Use Of Pessaries For Pelvic Organ Prolapse (POP) In Pelvic Floor Rehabilitation - Nov. 16-17, 2019

Bowel and Bladder Treatment of the Client with Neurologic Dysfunction - November 23-24, 2019

Oncology & The Pelvic Floor - December 6, 2019

Breast Cancer Rehabilitation - December 7-8, 2019

Pregnancy, Pelvic Girdle Pain & The Pelvic Floor - December 13-14, 2019

Western Courses

Level I: The Physical Therapy Approach to Female and Male Urinary Incontinence -

September 27-29, 2019 / Beausejour, MB

Dermoneuromodulation - October 3-6, 2019 / Calgary, AB

Level I: The Physical Therapy Approach to Female and Male Urinary Incontinence -

October 4-6, 2019 / Abbotsford, BC

The Assessment & Treatment of Breastfeeding Related Conditions

October 31-November 3, 2019 / Calgary, AB

Online Courses Through Embodia

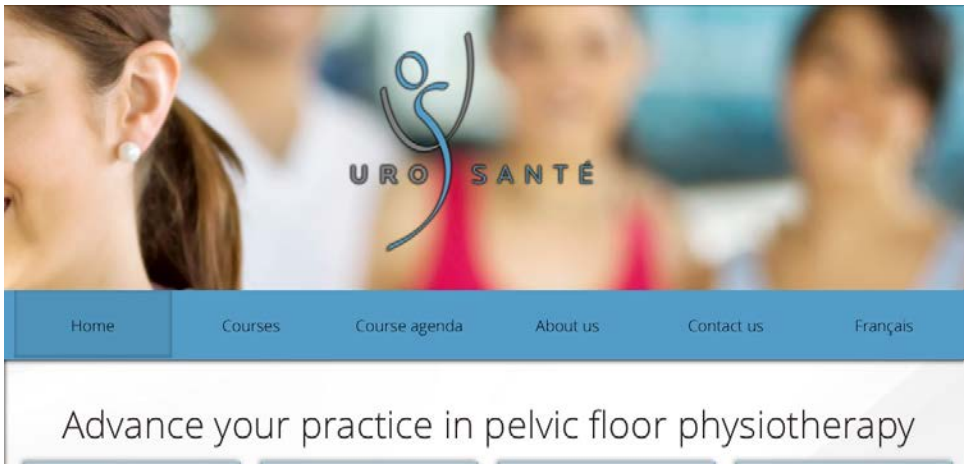
Can't make it to a course? Pelvic Health Solutions has online courses where you can learn at your own pace, on your own time and earn a professional development certificate.

Learn more at www.embodiaacademy.com

Find us on Facebook

Pelvic Floor Physiotherapy Courses

www.physiourosante.com



*Courses offered to Physiotherapists only

L'approche physiothérapeutique pour la dyspareunie,
Montréal, QC, Sept. 27-29 2019

NEW!The Physiotherapy Assessment of Breastfeeding Related Conditions:
Maternal & Infant Factors (with Mercedes Eustergerling),
Halifax, NS, Sept. 27-30 2019
No previous experience in breast health or pediatrics is required.
Labs include breast palpation and manual techniques. (This course is open to ***ALL physios****)*

The Physical Therapy Approach for Dyspareunia,
Halifax, NS, Oct. 25-27 2019

-COMBO-
L'approche physiothérapeutique pour les troubles ano-rectaux (2.5 jours)
ET
Nouveau! L'approche en physiothérapie pour la santé pelvienne chez l'homme (1.5 jours)
Québec, QC, 15 au 18Novembre 2019

Nouveau! L'approche en rééducation pelvi-périnéale pour les cancers uro-gynécologiques
Montréal, QC, 29 au 30 Novembre 2019 (1.5 jours)

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

Claudia Brown and Marie-Josée Lord

NEWSLETTER ADVERTISING RATES 2019-20

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 2019:	July 15th, 2019	Between August 1 and 15, 2019
Fall 2018:	October 15th, 2019	Between November 1 and 15, 2019
Winter 2019:	January 15th, 2020	Between February 1 and 15, 2020
Spring 2020:	April 15th, 2020	Between May 1 and 15, 2020

For more information please contact: Katerina Miller, **whdnewsletter@gmail.com**

ADVERTISING RATES 2019

Please note that the following prices are subject to GST/HST according to location of advertiser.

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 2019-20

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 2019 NEWSLETTER

Women's Health

A DIVISION OF THE CANADIAN PHYSIOTHERAPY ASSOCIATION

IN THIS ISSUE

WORD FROM THE CHAIR

I have just returned from Toronto where I was attending the International Pelvic Pain Society (IPPS) annual conference—the first time it has been held in Canada! It was a fantastic four days of learning with other pelvic health PTs, clinical psychologists, OB/GYNs and other health care providers from both Canada, the U.S. and abroad. The topics of discussion included care for women with endometriosis, adolescent dysmenorrhea, the effects of childhood trauma on chronic urogenital pain and caring for the transgender population, just to name a few. This was the first conference that I have been to where I wanted to attend every single session that was offered! (No chance to go for a nice stroll in the sunshine or shopping!) Next year, IPPS will be in Denver—I am thinking that Colorado in the fall would be wonderful! Anyone want to join me?

One of the topics of conversation during the conference was the use/sharing of educational materials and I am happy that this issue of our newsletter will expand on that subject and am looking forward to reading what the newsletter team has put together. Several physiotherapists at IPPS also congratulated me on the quality of our newsletter, for which I could take no credit. Kat and her team are an amazing group of women and I want to thank them for their great ideas, dedication and energy.

On another note, by the time this newsletter goes to print, Kat will have given birth to her first baby - we are all excited to meet the new member of our division!

Upcoming events:

- Congress 2020 - the 100th anniversary of CPA! The WHD is hosting a pre/post Congress course on Clinical Pilates and we are planning a fun evening for our members! Mark your calendars!
- Valentine's Day Challenge: This is the fifth year of the VDC - an event organized by our student representative to encourage PT students (and PTs!) to collect menstrual products for local women's shelters. Share some of your time to help women who are less fortunate than ourselves! Contact **whdstudentrep@gmail.com** for questions or to get involved.

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

EDITOR'S NOTE

Hello dear readers, and welcome to the Fall Issue of the WHD Newsletter. In honour of the school year that started not too long ago (although sometimes it seems like it's been ages), this issue is dedicated to EDUCATION. We did our best filling up this issue with tools that you will be able to use to help educate your patients and clients about different aspects of pelvic health. There is one more major handout we are still working on, but you will have to wait for the next issue to get it. Having said that, all the handouts presented to you in this newsletter will be available for you as resources on our website—**womenshealthcpa.com.**

Don't forget—it's that time of the year again—get ready for the Valentine's Day Challenge! On February 14, 2020, physiotherapy students and practicing women's health physiotherapists from across the country will be organizing a collection drive for new, unused toiletries, feminine hygiene products, and incontinence supplies for local women's centres. We are currently recruiting physiotherapy students and clinicians who would like to represent their school/workplace for the challenge. If you are interested, please contact Linnea Thacker at **whdstudentrep@gmail.com** for more information.

Do you have an important topic to talk about? Or a question you would like us to look into? Please do not hesitate to reach out and let us know! Please send your notes and questions to me at **whdnewsletter@gmail.com.**

Hope you enjoy your Fall Newsletter!
Katerina Miller, PT
WHD Newsletter Editor

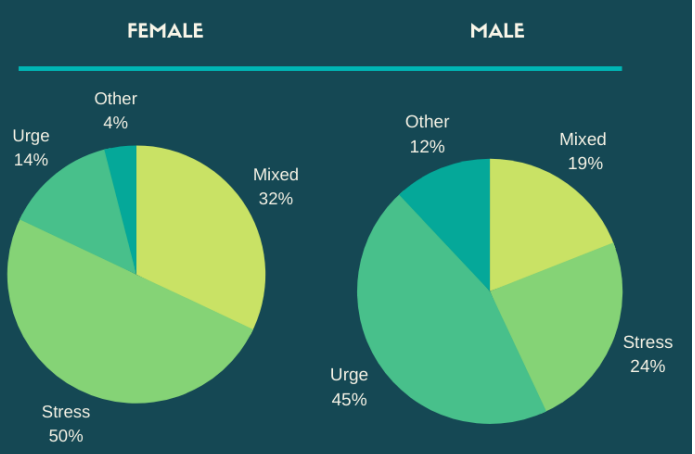
WOMEN'S HEALTH DIVISION EXECUTIVE MEMBERS

Chair	Juliet Sarjeant	whdchair@gmail.com
Secretary	Devonna Truong	whdsecretary@gmail.com
Social Media Chair	Alison Pethrick	whd.prchair@gmail.com
Communications Chair	Jessica Bergevin	whdwebsite@gmail.com
Education Chair	Samantha Doralp	whd.educ.chair@gmail.com
Research Chair	Nicole Beamish	whdresearch@gmail.com
Treasurer	Jessica Doig	treasurer.whd@gmail.com
Newsletter Editor	Katerina Miller	whdnewsletter@gmail.com
Student Rep	Linnea Thacker	whdstudentrep@gmail.com

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

DO YOU LEAK?

HOW COMMON IS IT TO LEAK URINE?



Source: CanadianContinence.ca

50% 33%

50% of women over the age of 65 leak urine

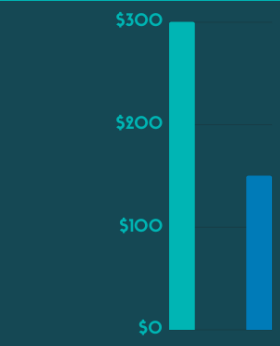
of people, who have learned from reading or verbal instruction only, do their kegels incorrectly

Incontinence

Is the number one reason for admittance into long term care facilities

Pelvic Floor Physiotherapy

Is the first step in treatment for urinary incontinence



AVERAGE MONTHLY COSTS

Incontinence Supplies

1 Physiotherpay session (1hour)

Time to Seek Help if:

You're leaking urine
Any amount, any time, any gender, any age

You know where every public toilet is when you leave the house

It feels like you "ALWAYS" have to go

"Having to pee" feels like an emergency

You push to pee or have difficulty initiating urination

You're under 60 and pee more than once at night, or over 60 and more than twice

You pee more than 6 times a day

You don't feel like you fully empty your bladder

You're avoiding activities, or interactions because of bladder concerns

You have pain with peeing

You're over 8 and wet the bed

Find a Physio:

https://www.womenshealthcpa.com/find-a-physio

HEALTHY BOWELS

ARE YOU HAVING NORMAL MOVEMENTS?

30%

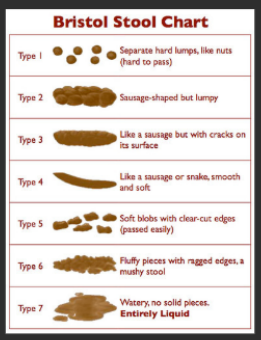
APPROXIMATELY 11 MILLION CANADIANS SUFFER FROM CHRONIC CONSTIPATION

defined as fewer than 3 bowel movements /week that are not soft and easy to pass (Gastroinsestinal Society, 2019)

10%

APPROXIMATELY 3.5 MILLION CANADIANS SUFFER FROM FECAL INCONTINENCE

(Canadian Continence.ca)



IDEAL STOOL CONSISTENCY IS TYPE 3 OR 4

ACHIVIEING A SQUAT POSITION CAN HLEP FULLY EMPTY THE BOWELS

Image Source : Squattypotty.com

WHAT CAN HELP

- Appropriate water intake (~1.5-2L/day)
- Appropriate fiber intake (25-30g/day)
- Moving (30+ mins of exercise/day)
- Pelvic Floor Muscle training
- Implementing proper bowel habits and posture

Time To Seek Help If:

You are pooping less often than you feel is normal

You leak fecal matter

You have ongoing hemmrhoids or fissures

You don't feel like you fully empty your bowels

It takes more than 10 minutes to have a bowel movement

You often strain to pass your bowels

There is pain with bowel movements

You often have to splint or assist to empty bowels completely

You are avoiding activities, or interactions because of bowel concerns

You only have bowel movements when using laxatives

Find a Physio:

https://www.womenshealthcpa.com/find-a-physio

Created by Leslie Spohr, PT

Monitoring Your Core and Pelvic Floor After Birth

Urinary Symptoms:
Leaking urine, increased urinary urgency (strong feeling like you have to urinate), urinating more often.

Bowel Symptoms:
Leaking feces or gas, constipation, or hemmeriods, or any bowel changes since delivery.

Pelvic Pain:
Pain in the pubic bone, hips, low back or pelvis, which typically worsens with activity.

Vaginal Bleeding:
Bleeding more than 5 pads per day after the 5th day of birth, for vaginal or c-section deliveries. If this occurs please check with your medical provider.

Abdominal Muscle Sepration:
A visible bulge or dome, or a trench or indent somewhere along the midline of the abdomen, that is apparent when the abdominals are in use - like when doing a sit-up.

Pelvic Organ Prolapse:
Vaginal pressure, heaviness, pain and achiness, or seeing internal tissue descend outside of vagina.

Penetration Pain:
Pain during or after sexual intercourse, PAP exam or menstrual product insertion.

Scar Pain:
Pain in a scar from injury at birth, episiotomy, or C-section. This pain can be all the time or with certain activities.

It's always a good idea to monitor for the above changes after a delivery. If you notice any of the above symptoms, please talk to your obstetrical care provider or women's health physiotherapist about recovery.

Physiotherapist
Name:_____
Date: _____

Created by Katie Kelly, PT

4 POSTPARTUM Ps

THAT PELVIC HEALTH (AKA PELVIC FLOOR) PHYSIOS CAN TREAT

1 PEEING (OR POOPING)

Regardless of delivery method (vaginal or caesarean), more than 40% of women will report leakage of urine - often with a cough/laugh/sneeze/lift. 20% will report leakage of fecal matter - often associated with a 3-4th degree perineal tear. Some women also report stronger urges to go to the bathroom and may find it difficult to hold it in.

2 PRESSURE (PROLAPSE)

Pelvic Organ Prolapse (POP) is the descent of one, or more, of the pelvic organs (bladder, uterus, rectum, etc) toward the vaginal opening. It is typically associated with feelings of heaviness, dragging, or bulging in the vagina or around the opening. It can look and feel differently from person to person and day to day. Approximately 50% of women have some degree of prolapse. Symptoms can be reduced, and even eliminated, with pelvic floor physio and may not require surgery.

3 PAIN

It is normal to experience pain in the first 4-6 weeks after giving birth. Pain should be relatively manageable and improve with time, as should any bleeding. Ongoing pain in the pelvic region (hips, back, vagina, anus, perineum, scars (C-section/perineal tears, etc.), pain elsewhere in the body or pain with intercourse, vaginal exams or use of menstrual products should always be discussed with your health care provider.

4 PEAKING

Diastasis Rectus Abdominus (DRA) is a separation or stretching of the tissue down the middle of the abdominals. It is often seen as a peaking or hollowing. It can lead to feelings of a weak core, low back pain, pelvic floor dysfunction, and difficulty regaining pre-pregnancy abdominal form and function.

** We help with prenatal conditions and birth preparation as well

WHAT IS PELVIC HEALTH PHYSIOTHERAPY?

Pelvic Health Physiotherapists (PHPTs) are physiotherapists who have acquired additional education and training to treat conditions of the pelvic floor. PHPTs assess posture, movement, breath mechanics, abdominal wall function, scar healing/mobility, pelvic floor muscle function and coordination, and more,

Typical assessments and treatments run approximately 1 hour. With your consent, there may be an internal vaginal or rectal exam performed to assess the pelvic floor muscle function. This is not an absolute requirement to treatment, and may be declined at any point.

Pelvic Floor Retraining is the first line of defence for symptoms of urinary leaking and pelvic organ prolapse

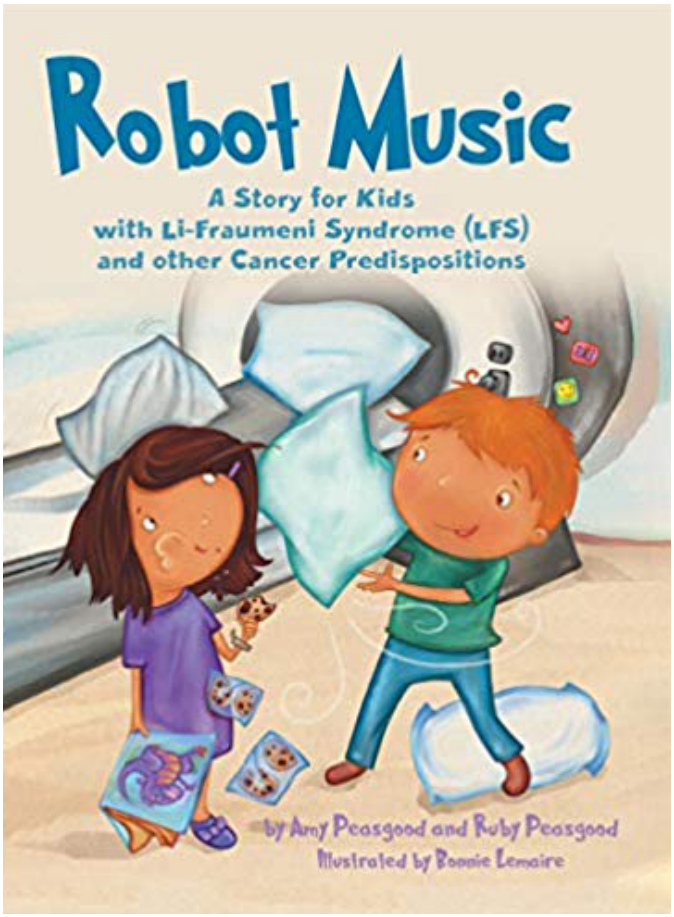
PELVIC FLOOR REHABILITATION IS MUCH MUCH MORE THAN "JUST DOING KEGELS".

FIND A PHYSIO:

https://www.womenshealthcpa.com/find-a-physio

Created by Leslie Spohr, PT

BOOK REVIEW: ROBOT MUSIC BY AMY PEASGOOD AND RUBY PEASGOOD



Reviewed by Devonna Truong, RPT

Cancer is a challenging conversation for many, so how do we begin to talk about it with young children? Pain, feelings of discomfort and illness are not our preferred topics of conversation with young children, but Amy and Ruby Peasgood create a safe space for young children to be curious, ask questions and gain more of an understanding about our world.

Robot Music is an illustrated book for children and their families that have both been diagnosed with and are affected by Li-Fraumeni Syndrome (LFS) and other genetic cancer predispositions. LFS is an inherited genetic predisposition to a wide range of cancers and this book offers insight into the basic concepts surrounding the diagnosis of LFS. This book allows young children to discover more about what a day at the hospital can look like and serves as a playful introduction to some of the harder conversations ahead for a child diagnosed with LFS through the exploration of good friends Rosie and James.

In Robot Music, Rosie and James go on a lively adventure together through the hospital where they share and learn about each other's experiences with cancer and LFS. It highlights real feelings associated with hospital visits, waiting rooms, needles and the big, dreaded, robot-music making MRI machine. They learn about each other's stories as they camp out in the MRI machine with a full stock of snacks and discover more about LFS as they go digging through the hospital treasure chests.

MRIs are often used as a method to screen children at risk for LFS because they are non-radioactive and non-invasive. As a result, a big part of living with LFS results in regular MRI scans for early detection and more successful treatment. Unfortunately, this means a lot of hospital visits, ultrasounds and blood work as well. The development of scan anxiety is often a common reality in living with LFS, which rings true for Rosie, who often feels the imaginary caterpillars wriggling in her stomach. Robot Music is an outlet of empathy and understanding for children as it is sensitive to the difficult feelings and anxieties that many experience.

The book's foreword is thoughtfully written by Dr. David Malkin, Oncologist at The Hospital for Sick Children in Toronto. It powerfully introduces the important themes covered throughout the book and relates the real word importance this book serves to address to adult readers. The book also includes a handy "word list" for the bigger, medical words for both young and older people to reference to enhance their understanding.

The authors, Amy and Ruby Peasgood, both live with LFS. Amy was inspired to create this book when three-year-old Ruby started asking questions about cancer and her frequent hospital visits. In 2014, Amy was diagnosed with Stage IV metastatic breast cancer and tested positive for LFS shortly after. She has also been successfully treated for thyroid, lung and skin cancer. Amy now navigates life with LFS and metastatic breast cancer in the company of her beloved family. Ruby is followed at Sick Kids under the Toronto Protocol.

Robot Music offers an enlightening, yet real story that initiates important and necessary conversations that can truly make a difference for a child and their journey through life with an inherited genetic predisposition to cancer and other inherited illnesses. Amy and Ruby are two strong, inspiring ladies who created this book in hopes to help other children and their families through their own insight and stories.

Robot Music can be **purchased on Amazon.** All profits are used directly to support LFS research and the LFS community!

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)

Bowel and Bladder Treatment of the Client with Neurologic Dysfunction - November 23-24, 2019

Oncology & The Pelvic Floor - December 6, 2019

Breast Cancer Rehabilitation - December 7-8, 2019

Pregnancy, Pelvic Girdle Pain & The Pelvic Floor - December 13-14, 2019

Labour & Delivery: Maternal Support through Comfort Measures and Pelvic Biomechanics - January 25-26, 2020

Mobilization of Visceral Fascia: GI System - January 31-February 2, 2020

An Integrative Approach to Chronic Pelvic Pain with Endometriosis Masterclass: Nutrition and Physical Therapy - February 22-23, 2020

Mobilization of Visceral Fascia: Urinary System - February 28-March 1, 2020

The Male Pelvic Health Masterclass - April 24, 2020

The Evil Triplets of Pelvic Pain (and their friends...) - April 25-26, 2020

Western Courses

Level 1: The Physical Therapy Approach to Female and Male Urinary Incontinence - February 21-23, 2020 / Calgary, AB

The Use Of Pessaries For Pelvic Organ Prolapse (POP) In Pelvic Floor Rehabilitation - April 4-5, 2020 / Calgary, AB

Gastrointestinal Disorders & The Pelvic Floor - May 1-2, 2020 / Calgary, AB

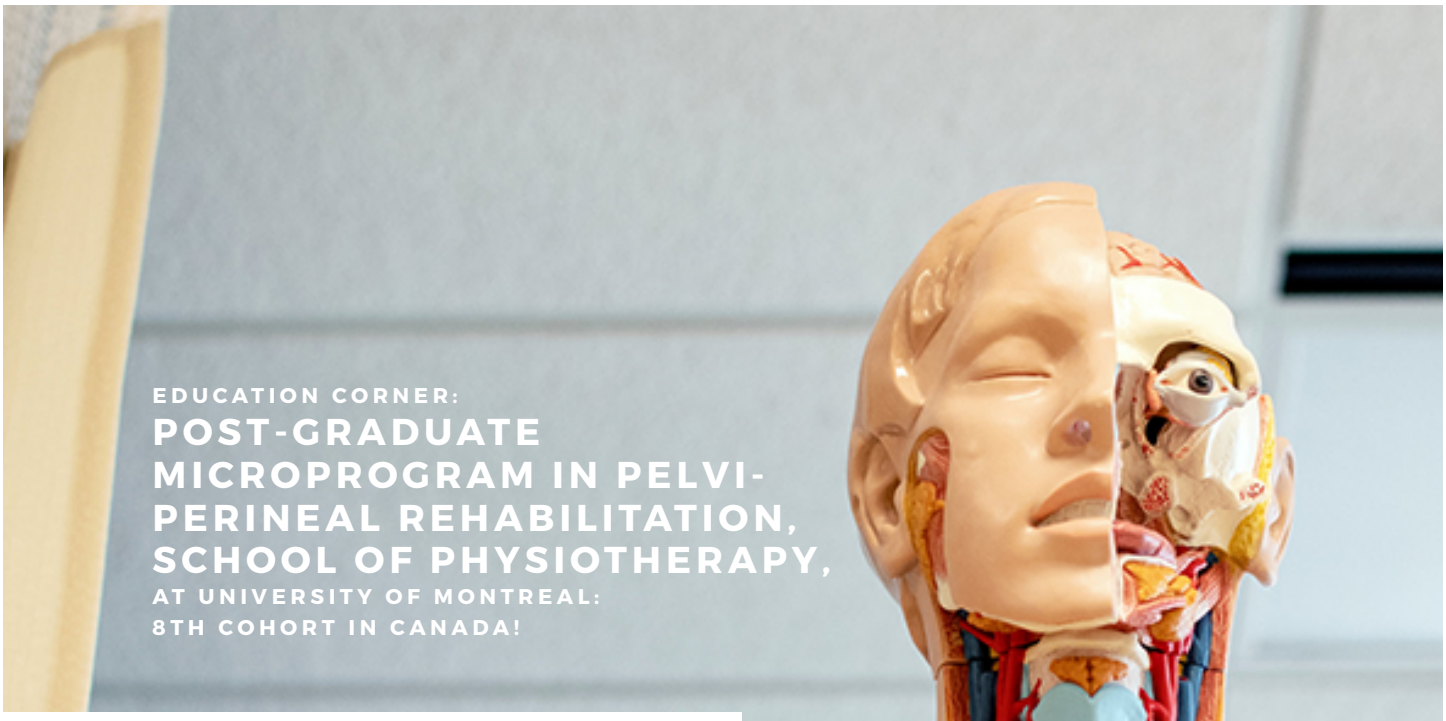
Improving Pelvic Floor Function Through Spinal Manual Therapy - May 3, 2020 / Calgary, AB

Online Courses Through Embodia

Can't make it to a course? Pelvic Health Solutions has online courses where you can learn at your own pace, on your own time and earn a professional development certificate.

Learn more at www.embodiaacademy.com

Find us on Facebook



EDUCATION CORNER:

POST-GRADUATE MICROPROGRAM IN PELVI-PERINEAL REHABILITATION, SCHOOL OF PHYSIOTHERAPY, AT UNIVERSITY OF MONTREAL: 8TH COHORT IN CANADA!

The School of Rehabilitation at the University of Montreal, would like to congratulate the 8th cohort of physiotherapists, who graduated from the Post-graduate Microprogram in Pelvi-Perineal rehabilitation, this May. 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 oncological, 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 expertise 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 readings, lectures, workshops, clinical reasoning sessions, practical sessions, clinical internships and multidisciplinary exchanges. It is offered every year and the deadline for admission is November 1 of every year. The number of admissions has been increased from 25 to 36, due to its popularity!

For more information, visit **readaptation.umontreal.ca/rpp**.

DONATING TO SISTERING WOMEN'S SHELTER

For this year's 5th annual Women's Health Division (WHD) Valentine's Day Challenge (VDC), the University of Toronto Department of Physical Therapy, along with associated departments in the Rehabilitation Sciences building, raised $1000.00 to support women in need. The students and faculty also donated over 250 women's toiletries and hygiene products. All of the proceeds were donated to Sistering, a local Toronto women's shelter.

Hayley O'Hara, WHD's former Student Representative and current New Graduate Representative, visited Sistering to drop off the proceeds in person. She graciously received a tour of the facility from the lovely staff at Sistering. The facility includes an arts and crafts room where the women can learn how to sew, knit, and create clothing and other objects. There was also a room where several of the women are hired to put together safe injection kits. These kits are given to those suffering from addiction and provides them with a safe means of injecting with the aim of reducing harm, preventing disease transmission, and assisting with the process of becoming clean.

The women who are hired to build the kits go through the process of applying for the job, which includes learning how to build a resume, and the job itself keeps them clean while providing them with an income that they can then use as a starting point for other career prospects. The facility also has a large kitchen staffed with excellent chefs that provide daily meals for the women. There are few barriers to entering Sistering's doors, they allow all women to stay and bring their belongings if they wish.

Each year, the Women's Health Division offers to match the donation of the school or clinic that raises the greatest amount of funds up to $500. As a result, the WHD provided a generous donation of $500 to top the previously donated $1000. Pictured here is Hayley (left) dropping off the cheque to Sistering. Hayley receives updates in the mail detailing how the money is being spent. For each $500 donation, 15 women are able to go on a day trip outside of the city. The cost covers the women's transportation, meals, and activities. This provides the women with a peaceful opportunity to be immersed in nature, create bonds with each other, and try new things that they otherwise would not be able to afford.

The Women's Health Division hopes to continue providing meaningful experiences like this for women in need by continuing the tradition of the annual Valentine's Day Challenge. We encourage all clinics and physiotherapy programs across Canada to participate in our upcoming VDC which will be running from this December up to February 14 2020. Look out for e-blasts and newsletters from the WHD for details on how to participate!

BECOME PART OF THE WHD COMMITTEE: TREASURER ROLE

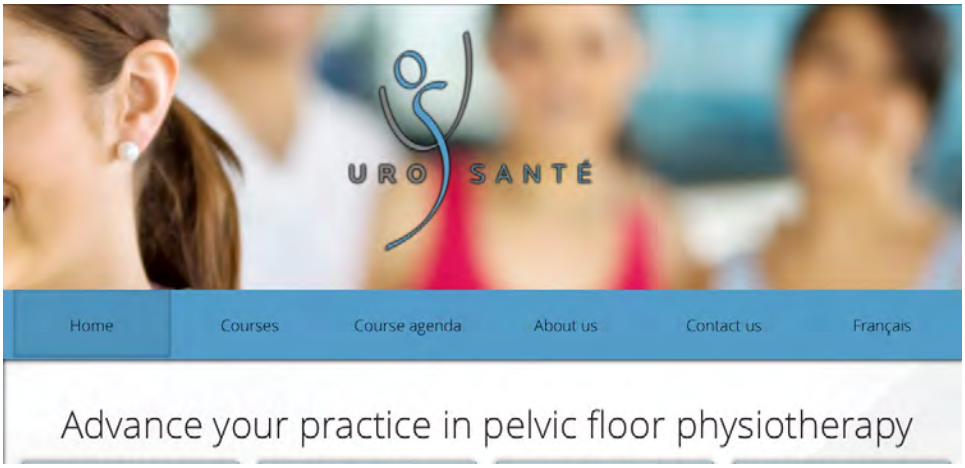
The Volunteer Treasurer is an invaluable member of the WHD Executive Committee, who is expected to attend monthly 1-hour meetings via Zoom with a report on Division finances, manage the day-to-day finances and liaise with the finance assistants at head office. The treasurer will also develop the annual budget with assistance from the Chair.

Time commitment: 1 hour per week + 1 hour Zoom meeting per month. This role comes up for renewal in Spring of 2020, with the option of staying. Experience as a treasurer is an asset, but not mandatory.

If interested in this role, please contact Devonna Truong at **whdsecretary@gmail.com**.

Pelvic Floor Physiotherapy Courses

www.physiourosante.com



*Courses offered to Physiotherapists only

-COMBO-
L'approche physiothérapeutique pour les troubles ano-rectaux (2.5 jours)
ET
Nouveau! L'approche en physiothérapie pour la santé pelvienne chez l'homme (1.5 jours)
Québec, QC, 15 au 18 Novembre 2019

Nouveau! L'approche en rééducation pelvi-périnéale pour les cancers uro-gynécologiques
Montréal, QC, 29 au 30 Novembre 2019 (1.5 jours)

The Physical Therapy Approach for Dyspareunia,
Montreal, QC, Jan. 10-12 2020

NEW! The Physiotherapy Assessment of Breastfeeding Related Conditions:
Maternal & Infant Factors (with Mercedes Eustergerling),
Vancouver, BC, Feb 7-10 2020 AND Québec, QC May 1-4 2020
No previous experience in breast health or pediatrics is required.
*Labs include breast palpation and manual techniques. (This course is open to **ALL physios**)*

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

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

Claudia Brown and Marie-Josée Lord

AWARDS AND BURSARIES

NEW GRADUATE AWARD
JANE JING BAI

Firstly, I would like to thank the CPA and Women's Health Division for selecting me as the recipient for the New Graduate Award 2019. As a new graduate, introducing a pelvic floor physiotherapy practice at three clinics, that originally did not offer this service prior to me joining the team, felt very daunting. I felt a great responsibility to ensure that my scope of practice was as vast & inclusive as possible. I knew early on that pelvic floor physiotherapy was going to be a good fit for me, under the mentorship of Claudia Brown at McGill. Since then, I've chosen to take seven (and counting) continuing education courses with Pelvic Health Solutions and have had incredible experiences with their educational formatting. They make sure that each practitioner feels confident to integrate their teachings into clinical practice the next day with lots of hands-on lab time, case-study discussions, and memorable (also hilarious) speakers. This grant has provided an opportunity for me to further invest in myself to improve on my skillset, knowledge, and build confidence as a Pelvic Floor Physiotherapist.

CONFERENCE BURSARY AWARD
SHEELA ZELMER

I had the opportunity to attend the International Pelvic Pain Society annual meeting in Chicago Illinois in 2018. It was an action packed 3 days of expert guest lecturers and workshops. I attended an outstanding roundtable discussion with a diverse multidisciplinary group. It was exciting to collaborate with other health professionals from various countries about pelvic pain. In addition to the educational content, there were many social events. It was a great opportunity to network with other professionals from Canada and the USA. Social media has made us all fast friends and I am looking forward to connecting with them again in person when IPPS comes to Toronto in October of this year. Although Chicago is not that far from my home town of Toronto, travel expenses including conference fees make attending quite costly. The WHD bursary has helped offset those costs, and I am so grateful.

REMOTE AREAS AWARD
ASHLEY FROESE

When I decided to pursue a career in the field of Women's Health & Pelvic Floor Physiotherapy, I had no idea how rewarding and life changing it would be. My interest first began when a local Gynecologist expressed the need for the service in our rural area as prior to women were having to travel 2 hours one way to attend a session. It really wasn't until after I experienced my own vaginal delivery, did I then understand how uneducated we are as women when it comes to our body's post partum healing and recovery. Prior to signing up and taking my first course, I did a lot of research and talked to other Pelvic Floor PT's about their experience and coursework. I was so very thankful to find another Pelvic Floor Physiotherapist with over 8 years of experience who was willing to provide me with guidance and mentorship. From my experience, I would strongly encourage new pelvic floor PT's to seek out a mentor who can guide, encourage, lead and collaborate with you on your new journey. In turn I also encourage experienced PT's to give back to the profession and mentor others who can learn from your clinical experience and more effectively apply their book knowledge to hands on practice. It didn't take long after completing my first three courses in pelvic floor function, dysfunction and treatment which covered urinary incontinence, pelvic organ prolapse, bowel dysfunction, and pelvic pain, that I realized that their were still gaps in my overall practice. Often when women presented to the clinic, they had a history of endometriosis, hysterectomy, other post-surgical condition, cancer, a skin condition, or other things contributing to symptoms. This lead me to pursue taking the Capstone course offered by Herman & Wallace Pelvic Rehabilitation Institute. This course covered abdomino-pelvic connective tissue connections, endocrine disorders, endometriosis, PCOS, fibroids, vulvar skin conditions, pelvic surgeries, gynecological oncology, pharmacology along with advanced treatment techniques. I benefited greatly from this course and can say that I've really grown in both my skill set and confidence when working with patients. I want to thank the Women's Health Division for their scholarship and award which helped to cover the cost of this most recent course, and more importantly for offering the opportunity to recognize, support and encourage rural Physiotherapists who are working to offer this valuable service to their patients. I look forward to continuing to grow and learn in this field, seeing pelvic floor and women's health continue to evolve across the country, and working together with other amazing Physiotherapists in our profession.

AWARDS AND BURSARIES

LEADERSHIP AWARD

ANNA-MARIE FAFARD

I am honored to have been nominated for the 2019 CPA Women's Health Division Leadership Award, even more so that it is named after a colleague I highly respect. Jodi Boucher is a strong woman, hard worker whom dedication to improve health care delivery has touched many. Thank you Jodi for who you are.

I received this award in relation to my attendance to the 2018 INCAM Research Symposium in Montreal where I presented a poster on a case-study and volunteered for the symposium. INCAM is a Canadian collaborative and interdisciplinary research community generating knowledge through research on complementary, alternative, and integrative medicine/health care to enhance the health of Canadians. My participation in the 2018 INCAM Research Symposium has allowed me to share some findings with other Canadian research minded practitioners and academics. It was a good place to learn further about research and how to better communicate our findings with others. Case-studies are a good place to start, for all, to open the dialogue about what we are doing in our practices. I encourage all WHD members to continue to learn and share their findings. The more educated we are, the more Canadian women will benefit.

FIND A PELVIC HEALTH PHYSIO!

Are you a Women's Health Division Member?
Would you like to be included on the map?
If you are a WHD member and would like to be included on the map, please email **whdwebsite@gmail.com** and request the registration link.

ADVANCED TRAINING AWARD

LISA FLANDERS

Always learning and ever curious, I am continually driven to find new techniques and tools to support my patients. Through happy coincidence, in December of last year, I learned of a course in treating transgender and gender diverse populations. I promptly messaged the course coordinator to find out more.

In June 2019, I travelled to New York City to participate in this course with the incredible Holly Hermann and her team, on treating patients who are Transgender and gender diverse. It was an incredible experience to say the least. My eyes were opened to an entirely different way physiotherapists can support their patients. From having lengthy discussions on language and creating supportive, welcoming and inclusive clinic settings, to panel discussions with community members, along with new learning and training surrounding the numerous surgical procedures a physiotherapist may encounter.

Combined with the incredible instructors, fellow course participants and numerous community members, I left the weekend with a whole new array of thoughts and ideas to support my patients. The icing on the cake was it aligned with New York Pride and the 50th anniversary of the Stonewall riots, which made the weekend extra special.

With support of the Women's Health Division and this award, I have been able to create a clinical environment to treat an entirely diverse patient population and help them feel safe and heard. At the same time, providing evidence based practice and the highest level of care. It is with gratitude I accept this award from the Women's Health Division of the Canadian Physiotherapy Association, these awards allow myself and my fellow colleagues be the best physiotherapists we can be and continue to elevate our profession the highest standard of compassion and care.

Branch Out –

Take Your Skills to the Next Level with Visceral Manipulation...

The Barral Institute is endorsed by the International Alliance of Healthcare Educators.

Learn hands-on from the original developers of the techniques. The visceral system influences musculoskeletal articulations and tension patterns in the body causing functional and structural problems. An integrative approach to evaluation and treatment requires assessment of the structural relationships between the viscera, and their fascial or ligamentous attachments to the musculoskeletal system. It also requires an understanding of the dural and neural components that are often missed when treating traumas and dysfunctions.

Upcoming Classes:

Visceral Manipulation: Organ-Specific Fascial Mobilization; Abdomen 1 (VM1)

Toronto, ON	Nov 30 - Dec 3, 2019
Vancouver, BC	Oct 1 - 4, 2020
Calgary, AB	Nov 19 - 22, 2020

For additional VM dates in North America, please visit Barralinstitute.com

"Visceral Manipulation enables one to gain awareness of relatively ignored structures."

- M. Nicholson, PT

START TRAINING
$100 PER MONTH

Gail Wetzler
PT, DPT, EDO, BI-D

"As a Physical Therapist and Director of Curriculum of the Barral Institute, I invite you to experience the value of visceral mobilization as it relates to specific results for your patients."

Visceral Manipulation Can Benefit:

- Pelvic/Vaginal Pain
- Endometriosis
- Incontinence
- Fibroids & Cysts
- Dysmenorrhea
- Infertility Issues of Mechanical Origin
- Prenatal & Postpartum Musculoskeletal Pain

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TAKE PART IN THE VALENTINE'S DAY CHALLENGE!

The Women's Health Division is happy to announce our 6th annual Valentine's Day Challenge! On February 14, 2020, physiotherapy students and practicing women's health physiotherapists from across the country will be organizing a collection drive for new, unused toiletries, feminine hygiene products, and incontinence supplies for local women's centres. We are currently recruiting physiotherapy students and clinicians who would like to represent their school/workplace for the challenge. If you are interested, please contact Linnea Thacker at **whdstudentrep@gmail.com** for more information.

Women's Health
A DIVISION OF THE CANADIAN PHYSIOTHERAPY ASSOCIATION

VISIT OUR WEBSITE FOR RESOURCES, CONNECTIONS, PAST NEWSLETTERS, AND MUCH MORE!

WOMENSHEALTHCPA.COM

The Women's Health Division of the CPA is happy to announce our...

6th Annual

Women's Health Division

Valentine's Day Challenge

On February 14, 2020, physiotherapy students and practicing women's health physiotherapists from across the country will be organizing a collection drive for new, unused toiletries, feminine hygiene products, and incontinence supplies for local women's centres. **We are currently recruiting physiotherapy students and clinicians who would like to represent their school/workplace for the challenge.** If you are interested, please contact Linnea Thacker at whdstudentrep@gmail.com for more information.

Women's Health
A DIVISION OF THE CANADIAN PHYSIOTHERAPY ASSOCIATION

Canadian Physiotherapy Association

NEWSLETTER ADVERTISING RATES 2019-20

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:
Winter 2020:	January 15th, 2020	Between February 1 and 15, 2020
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

For more information please contact: Jessica Doig, **treasurer.whd@gmail.com**

ADVERTISING RATES 2019

Please note that the following prices are subject to GST/HST according to location of advertiser.

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 2019-20

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.

Canadian Physiotherapy Association
CONGRESS 2020
100

JOIN US IN OTTAWA, ONTARIO, FOR CPA'S 100TH ANNIVERSARY!

CONGRESS 2020 WILL BE HELD MAY 28-30, 2020