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13:35	13:55	Electrostimulation	Julia Herbert
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14:20	14:25	Comfort Break	
14:25	14:35	Edit a paper to Neurourology & Urodynamics	Wendy Bower
14:35	14:55	Children's pelvic floor	Alexandra Vermandel
14:55	15:15	Children's pelvic floor	Jojanneke van Summeren
15:15	15:25	Forum discussion	All
15:25	15:45	Dyssynergia of the pelvic floor	Danielle van Reijn
15:45	15:50	Questions	All
15:50	16:00	Report of the ICS Physiotherapy Committee	Doreen McClurg
16:00	16:30	Coffee Break	
16:30	16:50	Vaginal Flatulence	Hedwig Neels
16:50	16:55	Questions	All
16:55	17:15	Women's experiences: The effects of vulvodynia on a couple's relationship and sex life	Minna Törnävä
17:15	17:20	Questions	All
17:20	17:30	How to submit a workshop	Paula Iguada- Martinez
17:30	18:30	Drinks Reception	

The Physiotherapy Forum is an opportunity for physiotherapists, or anyone interested in physiotherapy, to network, enjoy presentations from emerging and established researchers and clinical leaders and most of all, have fun. The Forum programme includes a variety of topics.

### **The use of electrical stimulation in Pelvic Health**

#### **Julia H Herbert**

This presentation will review the different applications of electrical stimulation that may be used with a range of dysfunctions in Pelvic Health; in addition, it will also review the evidence behind the different applications of stimulation modalities to include:

- Surface electrical stimulation using external electrodes
- Transcutaneous electrical nerve stimulation (TENS)
- Percutaneous tibial nerve stimulation (PTNS)
- Trans vaginal / anal neuromuscular electrical stimulation (NMES)
- Magnetic stimulation therapy

With a focus on the safe application of stimulation modalities, the current evidence and expert opinion regarding contraindications and precautions to the use of electrical stimulation in Pelvic Health will be reviewed. It will examine how these may differ dependent upon the modality chosen, for example, metal in the field of stimulation may be contraindicated with some externally applied stimulation modalities but not with transvaginal or trans anal stimulation. In view of the paucity of evidence in some areas, opinions from the clinicians in the room will be discussed.

### **Development of the most effective parameters for pelvic floor muscle contraction.**

**Dorien Bennink, department of urology, Leiden University Medical Center, Leiden, The Netherlands**

#### Background:

The mechanism of electrostimulation (ES) to treat pelvic floor dysfunction is complex and not fully understood. With electro stimulation, we are exciting peripheral nerves, both afferent and efferent nerves. We generate a signal: an action potentials which travel both towards the periphery and towards the central nervous system. Electrostimulation may elicit responses to these signals in the tissues innervated by the nerve, like a muscle contraction. The central nervous system appears to adapt and to reinterpret these signals. It's seems like a kind of modulation.

Electrostimulation to improve pelvic floor muscle contraction, FES : functional electrical stimulation, as it is often called. The term 'functional' could be interpreted as allowing: "produce a functional movement that is otherwise not possible". Up till now, in literature, it seems to be used to improve pelvic floor muscle function, linked to urine- and fecal incontinence in the assumption of muscle weakness, on the other hand there is no evidence that electrical stimulation itself improves muscle strength. The experiences and the benefit of ES for the patients themselves, has not been requested.

In research wide variety of parameters were used, not always clear described, so difficult to reproduce.

#### Discussion:

In this session, ES to improve pelvic floor function will be discussed.

- What kind of pelvic floor muscle function do we want to improve?
- And can we related this to pelvic floor complaints?
- Which parameters and which protocols for which pelvic floor dysfunction may be used ?
- What could be the benefit for the patient?

#### References:

How to report electrotherapy parameters and procedures for pelvic floor dysfunction

Angélica Mércia Pascon, Barbosa Nivaldo, Antonio Parizotto, Cristiane Rodrigues Pedroni, Mariana Arias Avila, Richard Eloi Liebano, Patricia Driusso

Pelvic floor electrostimulation in women with urinary incontinence and/or overactive bladder syndrome: A systematic review \_J. Jerez-Roiga,\*, D.L.B. Souza, A. Espelt, M. Costa-Marina, A.M. Belda-MolinaaServicio

Electrical stimulation with non-implanted devices for stress urinary incontinence in women  
Fiona Stewart, Bary Berghmans, Kari Bø, Cathryn MA Glazener

Biofeedback and/or sphincter exercises for the treatment of faecal incontinence in adults  
Christine Norton, June D Cody

Electrical stimulation with non-implanted electrodes for urinary incontinence in men  
Bary Berghmans, Erik Hendriks, Arnold Bernards, Rob de Bie, Muhammad Imran Omar

## **Physiotherapy for children with functional constipation: a pragmatic randomized controlled trial in primary care**

**Jojanneke van Summeren**

### Background

Children with functional constipation (FC) may experience long-term symptoms despite treatment. The pathophysiology underlying FC is poorly understood, but it is thought that many children have dyssynergic defecation. Health care expenditures for children with FC are high. Physiotherapy has shown promising results in hospitals, however, benefits of physiotherapy were considered optimal for children with FC of short duration. Therefore, we aimed to determine the (cost) effectiveness of physiotherapy plus conventional treatment (CT) compared to CT alone for the treatment of FC in children aged 4–17 years in primary care in the Netherlands.

### Methods

This was an 8-month pragmatic randomized controlled trial (RCT) in primary care of children with FC aged 4–17 years. CT comprised toilet training, nutritional advice, and laxative prescribing, whereas physiotherapy focused on resolving dyssynergic defecation. The primary outcome was treatment success over 8 months, defined as the absence of FC (Rome III criteria) without laxative use. Secondary outcomes included the absence of FC irrespective of continuation of laxative use, the global perceived treatment effect and societal costs. Researchers were blinded to group allocation during assignment and data analyses, but participants were not. Results of longitudinal analyses in the intention-to-treat population are reported as adjusted relative risks (aRR) and 95% confidence intervals (95%CI). An economic evaluation was performed alongside the pragmatic RCT. Incremental cost ratios (ICERs) were displayed as incremental costs to treat one extra patient successful with physiotherapy, confidence intervals were calculated with 5000 bootstrap replications.

### Results

Children were allocated to CT plus physiotherapy or CT alone (67 per group). The treatment success percentage was not statistically improved by adding physiotherapy to CT (aRR 0.80, 95%CI 0.44–1.30). At 4 months, fewer children receiving physiotherapy had treatment success (17%) than children receiving CT alone (28%), but this had equalized by 8 months (42% and 41%, respectively). The percentage of children without FC, irrespective of continued laxative use, was not statistically different between groups (aRR 1.12, 95%CI 0.82–1.34). After 4 and 8 months, the percentage of children without FC was respectively 68% and 83% in the physiotherapy group, and 64% and 61% in the CT group. Notably, parents reported significantly more global symptom improvement after physiotherapy than after CT (aRR 1.40; 95%CI 1.00–1.73).

The ICER to treat one extra patient successful with physiotherapy was €24060 (95%CI;€-16275 to 31390). The cost-effectiveness acceptability curve indicated that regardless the amount one is willing-

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to-pay (WTP), the probability that physiotherapy is cost-effective compared to CT is 0.5. For the outcome absence of FC irrespective of continuation of laxative use, the ICER was €1221 (95%CI €-12905-10956). By a WTP of €4000 the probability that physiotherapy is cost-effective is 0.85.

### Conclusions

We find no evidence to recommend physiotherapy for all children with FC in primary care. More research is needed to evaluate whether physiotherapy in primary care is (cost) effective for children with symptoms of longer duration and whether it can reduce costs on the long-term.

### Project group members

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## **Dyssynergia of the pelvic floor**

### **Danielle van Reijn**

Patients with a non-relaxing pelvic floor may present with a broad range of symptoms. These may include problems with urination, defecation and sexual function, which require relaxation and coordination diaphragm urogenital, m. levator ani and anal sphincters. Dyssynergia of the pelvic floor is often combined with gastro-enterological problems and is characterised by paradoxal anal contraction, inadequate anal relaxation and/or inadequate push effort. This is caused by lack of coordination of abdominal, rectal and anal muscles. Diagnosis of dyssynergia is made by detailed history, careful rectal examination and physiologic testing.

Pelvic floor physiotherapy(PPT) is mainstay treatment for patients with dyssynergia. PFT includes strategies to optimize lumbopelvic function, improve bladder, bowel and sexual function. Biofeedback is a successful neuromuscular approach to improve pelvic floor relaxation. Short-and long-term controlled trials have shown that biofeedback is effective in the treatment of patients with dyssynergia.

This lecture will provide an overview of the pathophysiology, diagnostics and multidisciplinary treatment in patients with dyssynergia.

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**Prof, Dr. Alexandra Vermandel**

**Coordinator of the Pelvic Clinic at the University Hospital Antwerp (UZA)**

**Docent Faculty of Medicine and Health Sciences, Antwerp, Belgium.**

### **Toilet training**

Toilet training (TT) is one of the challenging aspects of early childhood. It involves a complex integration of neurological, muscular, and behavioral mechanisms. During the last 60 years there is a trend toward an older age of initiating TT. The postponed age of TT entails negative consequences for the child, parents, health, environment and society.

Normal toileting is not simply a matter of learning to respond to bladder and bowel pressures by relaxing the sphincter, but rather a complex operant and social learning process. Over the past 100 years, recommended TT methods have oscillated between rigid and permissive programs.

Parents could benefit from clear guidelines outlining how to assist their children in the completion of TT.

The prevalence of toileting problems is significant in the pediatric population and may be important in the general population as well. Late ending of TT was associated with a later age of initiating TT, stool toileting refusal, increased constipation, and hiding to avoid potty visits during TT, urge incontinence, persistent daytime wetting, delayed acquisition of daytime bladder control.

### **Vaginal Flatus: Is it related to pelvic floor functional anatomy? And does it bother women?**

**H. Neels (PT, PhD)**

#### Background

A recent review of the literature revealed that evidence about “vaginal flatulence” is sparse. Vaginal flatus is the involuntary expulsion of trapped air from the vagina. But up until now, the prevalence, provoking factors and prevention or treatment options remain understudied. Although questions about “vaginal farting” or “queefing” appear frequently on social media and discussion forums. It can cause embarrassment and might impair a women’s quality of life. The underlying pathophysiology and mechanism of vaginal wind is not well understood. Given that the levator ani muscle is responsible for maintenance of the vaginal high pressure zone, it is plausible that the functional anatomy of the pelvic floor has a role in the pathogenesis of vaginal flatus.

## Aims

During this lecture, the methodology and intermediate results of two large studies will be discussed. The aims of these studies were:

- to evaluate the correlations between vaginal flatus and functional anatomy of the pelvic floor as assessed on clinical and transperineal ultrasound examinations.
- to describe the prevalence and frequency of vaginal flatulence and its bother in women between 18 and 50 years old.

## References

Neels H, Mortiers X, De Graaf S, Tjalma WAA, De Wachter S, Vermandel A. Vaginal Wind: A literature Review. Eur J Obstet Gynecol Reprod Biol 2017, 214, 97-103.

H. Neels received an IUGA Observership Award to participate in research at The Pelvic Floor Unit at Sydney Medical School Nepean, in 3D/4D translabial ultrasound, hosted by prof. H. P. Dietz.

## **How Vulvodynia Determined Women's Sexuality and Their Sex Life**

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Vulvar pain without any clear aetiology is usually called vulvodynia. The International Society for the Study of Vulvar Diseases (ISSVD) defines vulvodynia as chronic pain or discomfort involving the vulva lasting more than three months and for which no obvious aetiology can be found. Nowadays, vulvodynia can be classified according to the anatomical site of the woman's pain. The pain may be localised to a specific area (localised vulvodynia) or throughout the vulva (generalised vulvodynia). Vulvodynia can also be categorised based on whether a woman's pain is provoked, unprovoked or both. (1.) Localised, provoked vulvodynia is the most common form of the condition, with a prevalence of 16%, and patients are usually young nulliparous women. These women experience vulvar pain through direct touch, such as sexual intercourse, tampon insertion or physical examination. Most women with vulvodynia complain of pain during sexual activities (dyspareunia) or of inability to have intercourse due to pain. (2.) Women with vulvodynia have reported a reduced quality of life caused by such conditions as anxiety and depression, and feelings of shame and guilt regarding the pain in their genital area.

## Aims of study

The aim of this study was to describe women's experiences of the effects of vulvodynia on their relationships with their romantic partners. The purpose of this presentation is to describe the effects of vulvodynia on women's sexuality and sex life. This study also aimed to produce evidence-based information that can be used in health care encounters with women with vulvodynia and their partners to implement appropriate care.

## Study design, materials and methods

The data was collected from a closed discussion forum on the Internet through an anonymous network questionnaire. Women were asked to answer the question "What experiences you have had effects of vulvodynia on your pair relationship?" Thirty-three women with vulvodynia responded. The data was

analysed using qualitative inductive content analysis. The meaning units corresponding to the research question were reduced to parts corresponding to the original meaning. There were 608 meaning units to the research question.

## Results

Women with vulvodynia experience this syndrome not only physically, but also psychosexually. Vulvar pain affects the way women experience their womanhood and selfhood. Women with vulvodynia describe themselves as inauthentic women and deem themselves incomplete partners due to their challenges in performing, or inability to perform, penetrative vaginal intercourse. Sexual life might be limited by vulvodynia. The pain shapes the sexual activity as a schematic expression that manifests itself as an act of plan. The fear of sexual pain is experienced by both women and their partners. Vulvodynia teaches both sides of the couples to listen to the pain and limit sexual activity. In some cases, sexual life is described as enjoyable, but it may require sexual activity without sexual intercourse. Women even feel privileged when they are able to enjoy foreplay and sexual emotion without the anticipated intercourse.

Moreover, vulvodynia is reflected in couples' relationships. Vulvodynia affects living in the pair relationship and determines the sex life. Not only does sexual pain shape couples' sex life; it may also affect a relationship's stability and shape. Vulvodynia may strain the pair relationship, but its effect may also be neutral. It can even be empowering, depending on the women and their partners' pain behaviour models. However, some women choose to live without a partner because of this syndrome.

Women also feel that relationship and sexual problems are ignored during their encounters with health care professionals. Information and support from health care professionals are significant in the welfare of pair relationships.

## Interpretation of results

Early intervention regarding the symptoms of vulvodynia increases the sexual and reproductive health of a woman and her partner. Counselling by health care personnel with regard to the gentle self-care of the vulva area and pelvic floor physiotherapy is first-line treatment in minimising vulvar pain (4). Because vulvodynia often affects a couple's relationship, especially their sex life, information and support from health care professionals are critical aspects of treatment. It is important to incorporate the psychosexual aspect into the physiotherapy situation because it may help women with vulvodynia and their partners to cope with intimacy problems. A calm, natural discussion between a woman and a health care professional about this intimate problem will foster a sense of trust among female patients. Women with vulvodynia will be open to discussing these psychosexual aspects during care situations if they are given permission and space to bring up their sexual health concerns. The research results can be used in holistic care planning. Moreover, the partner should be taken into account in the multidisciplinary treatment of a woman with vulvodynia.

## Concluding message

Vulvodynia causes women many physical and psychosexual functional disorders which are reflected in the pair relationship. Hence, additional attention must be paid to information and support for women with this condition and their partners.

## Key words

vulvodynia, women's health, interpersonal relations, sexuality, qualitative content analysis

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