THE MANAGEMENT OF PELVIC FLOOR MUSCLE DYSFUNCTION IN DIFFERENT COUNTRIES: A SURVEY OF MEMBERS OF THE INTERNATIONAL ORGANIZATION OF PHYSICAL THERAPISTS IN WOMEN'S HEALTH (IOPTWH) 2008

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In 2008 I undertook an email survey of IOPTWH chief delegates to gain a view of pelvic floor muscle rehabilitation around the world. 17 member groups were contacted and all replied. This document summarises their responses.

For simplicity, I shall use the terms 'physiotherapy' and 'physiotherapist' throughout, though those replying to the survey may have used other terms e.g. physical therapy. Similarly, some countries use the term 'women's health', while others specify 'pelvic' or 'pelvic floor' physiotherapist. I have chosen to abbreviate this to WH/PF.

A word of caution - this survey provides information on practice internationally but excludes many countries, so should not be seen as a definitive picture of the situation worldwide. Also, practice can vary greatly within a given country. The data received can be taken as current practice as reported by a women's health/pelvic floor physiotherapist or group of clinicians but the reader should not assume that this necessarily reflects the practice of all others within that country.

Respondents

My thanks to IOPTWH contacts in Australia, Brazil, Canada, Denmark, Germany, Hong Kong, Ireland, Israel, Netherlands, New Zealand, Norway, Portugal, Slovenia, South Africa, Sweden, United Kingdom and United States of America for providing information.

Questions

Chief delegates were asked the following questions:-

1. How are patients with urinary incontinence / pelvic floor muscle dysfunction managed in your country? (For example, who would they see first, and what is a typical course of treatment)
2. Which healthcare professionals are involved? Please give a little bit of information about their role. In particular, is there a role for nurses and midwives?
3. What is the role of the physiotherapist / physical therapist?
4. What specific training do physiotherapists / physical therapists undertake? Does this lead to an academic award? Are they then recognised as a specialist?
5. Is the role of the physiotherapist / physical therapist based on any research? If so, please give one or more significant references.

Answers
The replies varied considerably in terms of the length and depth of information provided. With the benefit of hindsight I can see that the questions were not ideal; some lacked clarity, and there was a degree of overlap, especially between questions 1-3. I have, therefore, chosen to summarize the information I received without reference to a specific question. Within the report I have not named individual countries, a point I return to in my conclusion.

First contact
People experiencing urinary incontinence or other pelvic floor dysfunctions consult a range of professionals as their first point of contact. In most cases this is a doctor; in many (approximately 50% of countries) their general practitioner / family doctor. In some cases first contact appears to be with a specialist e.g. gynaecologist, urologist, or they may see another professional such as a practice or district nurse. Up to 50% of the respondents said that patients can refer themselves directly to a physiotherapist, though this might not apply in all parts of the country. Some respondents commented that there are still many women who do not seek help at all.

First line treatment & referral to other services
This varies, depending on factors such as the patient (e.g. their age, symptoms), national practice, and local services available. In some cases, they are given advice on pelvic floor muscle exercises, usually by a nurse or doctor without any examination or ongoing supervision.

Patients who initially see their general practitioner / family doctor will frequently be referred on to another professional. In at least 13 of the 17 countries questioned this will be a WH/PF physiotherapist. Alternatively, it is likely to be a specialist doctor e.g. gynaecologist, urologist, colorectal surgeon or, on occasions, a continence nurse. Some countries report the development of multi-professional continence clinics.

All the respondents reported that specialists refer patients for physiotherapy. This appears to be the case for all (or the majority of) patients in some countries, often where failed conservative management is a pre-requisite of surgery. It is less prevalent in others. Referral to physiotherapy may or may not be preceded by investigations such as urodynamic studies.

A small number (4) of those surveyed suggested that surgery may be offered as the first choice of treatment, but in the majority of countries this is only considered if conservative methods fail. Likewise medication is prescribed for those with symptoms of an overactive bladder either as a first line treatment, or after other measures have been unsuccessful.

Women's health / pelvic floor physiotherapy

The role of WH/PF physiotherapists varies considerably from country to country as might be expected. While all the respondents report that physiotherapists in their country treat women with common symptoms such as stress and urge urinary incontinence or pelvic organ prolapse in adult women, the practice of others includes a wide range of client groups, conditions and other roles as indicated in table 2.

Table 2: The varied role of WH/PF physiotherapists

<u>Client groups</u> women older people (definitions vary e.g. men and women either 60+ or 70+) children pre- and post-operative (e.g. gynaecological surgery) pre-natal (groups, individual) post-natal (includes management following 3rd & 4th degree tear, voiding dysfunction) men
<u>Conditions</u> urogenital dysfunction pelvic pain vulvodynia sexual dysfunction / dyspareunia anorectal dysfunction prostate pain coccyx pain
<u>Other roles</u> urodynamics education (intra- and inter-professional, public) research 'case manager' e.g. for patient with urinary incontinence triage – the person who, individually or with others, decides which professional a patient will see

How an individual is assessed and treated also varies. However there are many similarities reported. For example, in the case of a woman with urinary incontinence, the survey results suggest that a WH/PF physiotherapist might undertake most or some of the following.

Assessment

- comprehensive subjective history
- bladder ± bowel chart
- quality of life questionnaire
- objective examination (N.B. vaginal examination is not undertaken in every country)

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Personalised treatment programme

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Treatment

- explanation and education
- advice e.g. behavioural modifications
- pelvic floor muscle training
- other appropriate exercises
- manual therapies
- biofeedback e.g. manometry; surface electromyography; real-time ultrasound; vaginal cones
- neuromuscular stimulation

Most respondents implied that women are seen individually, but in at least 4 countries WH/PF physiotherapists also see women in groups, for either advice or exercise.

Although few gave any indication of how often, or for how long, patients are treated, three examples given were:

i) an average of 5 visits over 5 months (range being 2-10 visits)
ii) typical course of treatment lasts 3-6 months
iii) up to 2 sets of 6 treatments (under insurance policy). Treatment starts twice a week, gradually decreasing

If physiotherapy is not successful then patients may be referred to a specialist for further investigations and interventions if she has not seen one already. In at least one country some WH/PF physiotherapists can refer patients directly for urodynamics and to a specialist themselves.

Other healthcare professionals

The survey indicated that, in addition to physiotherapists, there is a broad range of health professionals involved with the management of urinary incontinence and pelvic floor muscle dysfunction in IOPTWH countries. These are listed in Table 1, but the following should be noted:

- the job titles and roles vary from country to country

- in some countries they do not exist, or have no role in continence or pelvic floor dysfunction management
- the professional and roles within brackets were reported in some countries, but not many.

Table 1: Health professional and their role (Note - professionals and roles in brackets not commonly reported)

Professional	Role
Continence nurse/advisor	Assessment; advice; pads and other continence products; medication; catheters – indwelling and intermittent; stoma; pelvic floor muscle exercises; (biofeedback; neuromuscular stimulation; urodynamics; prescription of medication; pessary fitting)
Midwife / health visitor (seeing women pre- or post-natally)	Advice; pelvic floor muscle exercises
General practitioner / family doctor	Assessment; advice; prescription of medication; referral for investigation or to other professional
Specialist doctor e.g. gynaecologist, urologist, paediatrician	Assessment; investigations; advice; pelvic floor muscle exercises; prescription of medication; surgery; referral to other professional; (biofeedback; neuromuscular stimulation; 'team leader')
Urotherapist - a physiotherapist, nurse or midwife trained to treat urinary and other bladder dysfunctions	Assessment and range of treatments
Non WH/PF physiotherapist e.g. musculoskeletal, sports	Advice; exercise
(Psychologist)	Addresses psychological aspect of patient care
(Medical technician)	Urodynamics and other investigations

Training

Only 6 respondents mentioned that undergraduate physiotherapy students in their country receive any teaching or clinical experience in women's health or the pelvic floor, and most added that this was not sufficient to make them competent to practice in the specialty without further postgraduate education.

In at least 3 countries any qualified physiotherapist can legally treat pelvic floor dysfunction. In another the national women's health association requires physiotherapists to complete the group's training, or something similar outside

the country, before they treat incontinence. However, they admit that they may have no legal power to enforce this. All the respondents mentioned that most if not all WH/PF physiotherapists will have undertaken further training e.g. vaginal examination before practicing in the specialty. In some countries health regulatory bodies will insist that physiotherapists have advanced skills before they are licensed to practice.

At postgraduate level there is a wide variation in the level and extent of education on offer. In the majority of countries, most postgraduate courses are provided by either the national physiotherapy association, or the women's health group. In some cases, successful completion of such training is necessary for full membership of the national women's health / pelvic floor group. More formal postgraduate education to certificate and diploma level is reported in at least 50% of countries, and several offer study towards the award of Master of Science.

Specialists

6 respondents stated that there are WH/PF physiotherapists in their countries who are either employed as clinical specialists, or who can refer to themselves officially as specialists; in one case this is on completion of a Masters level programme. A further 5 said that although there is no official recognition for the term, it is used. Only one respondent said that WH/PF physiotherapists within her country are not allowed to call themselves specialists. Others use terms such as 'clinical expert' or 'physiotherapist with a special interest'. In at least one country there are WH/PF physiotherapists with the job title consultant or extended scope practitioner.

Evidence-based practice

The final question on the survey asked if the role of WH/PF physiotherapists in each country is based on any research evidence. There were 3 negative answers (no, not known, and not to my knowledge) but the remaining 14 reported varying degrees of evidence-based practice, both in the physiotherapeutic interventions used, and in the postgraduate education available. Respondents mentioned sources such as the International Continence Society, International Consultation on Incontinence, and Cochrane Reviews as well as guidance from national bodies and governments, and well known researchers and authors on the guidance for professionals and leaflets for the public. Finally, the need for further research was highlighted to further support our role and interventions.

Conclusion

Within the limitations of this study (as discussed earlier in the document) I believe that the results of this survey do offer an insight into the role of women's health and pelvic floor physiotherapists in member countries of the International Organization of Physical Therapists in Women's Health. They demonstrate both similarities and variations in physiotherapy practice, management of patients with incontinence and pelvic floor dysfunction, the role of other health professionals

involved (including the interaction between the professions), and the education of physiotherapists in the specialty.

Should a further survey be undertaken, I would recommend shorter, clearer questions, the answers to which would be clarified if necessary. Alternatively, I believe that semi-structured interviews - ideally in their own language - would produce more accurate and detailed data. I applaud the command of English shown by those who replied, but feel that use of their native tongue would have made the process easier for them, and encouraged more comprehensive answers from some. Subsequently, and with permission from those concerned, the data could be reported country by country, resulting in a more detailed and informative report. It would also be interesting to investigate practice in non IOPTWH member countries.