Greetings to all our members and friends of IOPTWH to this full October newsletter. Many new plans are underway for our women’s health community.

Plans are complete now for the first joint IOPTWH and IPTOP (International Association of Physical Therapists working with Older People) conference, which will be held in Boston April 26-28, 2013. Please see the complete flyer later in this newsletter. Additionally an email was sent out to all delegates and friends, as the registration is now open since September.

Topics include osteoporosis, update on urogynecologic surgeries, and nutrition for the aging population, pelvic organ prolapse, case studies, sexual function and aging, breast cancer and many more topics of interest to our membership. This presents a unique time to network with our international colleagues in both subgroups. There will be vendors of interest and time to view the displays and gather literature. We are honored to have Dr. Marilyn Moffat, President of WCPT, to give our opening remarks and present a lecture on Active Aging.

The registration fee will include all continental breakfasts, lunches and dinner Saturday night where we have a keynote speaker. Local hotel information will be included in the flyer for you to book your hotel.

Exciting news also is that our web pages have been configured so you can view them from your mobile device. By just
Greetings from the first combined subgroup WCPT International Physical Therapy Conference
Date: April 26-26 2013.
International Organization of Physical Therapists in Women’s Health (IOPTWH)
International Association of Physical Therapists working with Older People (IPTOP)
Where: The Conference Center at Harvard Medical School
77 Avenue Louis Pasteur
Please forward the link below to your member groups for the conference information and registration pages.
http://conference.ioptwh.org/

Editor’s Letter

THE ROLE OF PHYSICAL THERAPY IN SEXUAL HEALTH

The theme of this newsletter - The Role of Physical Therapy in Sexual Health - was inspired by Talli Rosenbaum, who is an internationally recognized expert on the role of combined physical therapy and sex therapy in the treatment of sexual pain disorders. She highlighted in her interview, presented in this newsletter, that physical therapists involved in treating pelvic floor dysfunctions are in optimal position to obtain certification to effectively speak about sexual health to their patients. In this issue, we shed some light on this area that is mostly ignored by the physical therapists for a number of reasons. I would like to thank all those therapists who generously contributed to this newsletter, who opened a window to a “sea” of potentials and opportunities that will ultimately help women in all aspects of their lives.

Best wishes,
Hana

* http://www.artcyclopedia.com/feature-2005-03-Dali-Figure.html

Salvador Dalí
Woman at the Window*
1925

President’s Message (Continued)

putting in ioptwh.com into your mobile phone browser the newly configured pages pop up and you are able to navigate easily around the IOPTWH website. Many thanks to Stephen Smith and his team at Caduceus-Webs for this enhanced addition to our website. Along those same lines, we are looking for someone to volunteer to be our website coordinator of our website and work with the board with new enhancements and additions so that we can continue to be responsive to our membership.

Enjoy the newsletter and them contributions of many through out the pages. I look forward to hearing your comments, suggestions or any questions you may have. Please feel free to contact me directly.
See you in Boston!!
Best
Rebecca
Secretary’s Report

Gill Brook
IOPTWH secretary
gill.brook@lineone.net

As always, there has been a steady stream of correspondence concerning the Organization since I last reported, and the executive committee continues to work towards its goals as agreed at our last general business and executive committee meetings and subsequent Skype conference calls.

Friends of IOPTWH

As mentioned in the last newsletter, I have been able to put women’s health physiotherapists in India in email contact with each other, adding another clinician within recent months. In addition, I recently met a UK physiotherapist who works in Singapore and was able to put her in contact with another women’s health clinician working there. I hope to meet up with them at the WCPT Congress there in 2015.

Women’s health PTs in non IOPTWH member countries

I am regularly contacted by members, either by email or via the discussion forum, for details of PTs in non member countries; most recently Mexico, Argentina, Egypt, South Korea and Switzerland. Occasionally we have a Friend there, so I can pass on their details. If not, the WCPT website (www.wcpt.org) lists contact details for all the national physiotherapy associations within its member countries.

Website sponsors and advertisers

As reported in the last newsletter, the executive committee is seeking sponsors and advertisers for the website, to minimise the cost to our membership. Can you suggest any companies we might approach? We have submitted some names to the website managers, but others would be appreciated and can be emailed to me at gill.brook@lineone.net.

Website co-ordinator - volunteers please!
The executive committee is still looking to appoint a website co-ordinator from within our membership to take the lead in monitoring, managing and developing the Organization’s website. No experience is needed and you will be well-supported by the executive officers and staff at CaduceusWebs. We anticipate that the average commitment would be about one hour per week and the role would be suitable for two people if you would like to job share. Please email me (details above) if you would like to discuss this further, or if you can suggest someone who I can contact directly.

Title debate

As previously reported, following a debate at last year’s General Business Meeting, the executive committee has initiated a discussion within the membership concerning the name of the Organization. Thank you to those chief delegates who replied on behalf of their national groups before the deadline of 31st July 2012. The executive officers will now consider your comments and decide on the way forward.

Gill Brook
IOPTWH secretary
Treasurer’s Report

Ros Thomas
IOPTWH Treasurer 2011
ros.thomas@virgin.net

As usual I am grateful to those countries, which have paid their dues on time and thank them for prompt payment.

This year fewer than half had paid by the end of March and now, at the beginning of September I am still waiting for dues from 3 countries. It would be very helpful if all countries could ensure prompt payment in 2013. My ‘reminder’ letter only goes to the chief delegates so it is their responsibility to see that their treasurer is informed.

The Executive Committee continues to seek sponsorship/advertising for the website in an effort to reduce the running costs.

Balance of accounts

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Update on Review of IOPTWH Scope of Practice Position Statement

Dr. Meena Sran PT, PhD
Vice-president, IOPTWH

At our General Business Meeting (GBM) in Amsterdam last year we agreed to review our Scope of Practice Position Statement. The current document with possible changes (based on discussions with delegates at the GBM) was sent out to all chief delegates earlier this year. Comments and concerns were to be voiced to myself by the end of May 2012. A few countries have responded with items that they feel have been overlooked or should be added.

The next step is for the IOPTWH executive to review a draft document with the suggested changes included. Then the document will go out again to all chief delegates for review. We can then decide, based on the potential impact of the changes on physical therapy practice, whether we should wait until the next General Business Meeting to formally vote on the revised document or whether a vote before then would be advantageous.

If you have any comments or questions about this process please do not hesitate to contact me at meenasran@hotmail.com
PHYSICAL THERAPIST AS A SEX THERAPIST: CHALLENGES AND OPPORTUNITIES

Talli Yehuda Rosenbaum is the only AASECT certified sex therapist, who is also a pelvic floor physical therapist and an internationally recognized expert on the role of combined physical therapy and sex therapy in the treatment of sexual pain disorders. In her practice, she combines sex therapy, couples counseling, and physical therapy to help women to enjoy a meaningful, pain-free, and satisfying sexual life.

By Rafeef Al-Juraifani
SPTWH Group
Saudi Arabia

I believe that you are one of the first physical therapists who became involved in sexual health, how did this interest start?

Before answering that, I would first like to thank you for inviting me for this interview. I am thrilled that the IOPTWH is devoting a newsletter to the relevant and important topic of sexual health. It makes so much sense that physiotherapists involved in urogenital treatment would be confronted regularly with the need to address sexuality. However, I really believe that all physical therapists should address sexual function, as neurological, musculoskeletal and cardiovascular systems are all involved in healthy sexuality. Sex, after all, is an ADL too.

To address your question, I believe that physical therapists have been involved in sexual health for as long as pelvic floor physical therapy has been around, and I guess I am old enough to have been around then. I was actively involved in women’s health beginning from the late 1980’s. My practice began to include patients with dyspareunia and vaginismus quite early in my career, and I really felt that I needed more tools to be able to address my patient’s concerns and their distress around sex. I began to attend multi-disciplinary sexual
health conferences and while I was interested in learning from others, I also found that attendees from various disciplines were very interested in knowing what physical therapists have to offer.

So, please tell us about how do you see the role of a pelvic floor physical therapist in sexual health and/or dysfunction?

This is a great question and one that I have spent a great part of my career attempting to demonstrate. As I mentioned, I think general physical therapists have a great deal to offer patients by giving them permission to ask about this, and offering limited information and specific suggestions and exercises. The literature demonstrates that health professionals don't sufficiently address sexual concerns with their clients and the stated reasons include lack of time, feeling uncomfortable with the topic, assuming clients are not sexually active due to disability or age, or not knowing what to do with the information once the questions are answered. But sex is a part of most people's lives and the literature also shows that patients would like to be asked about these concerns and have them addressed. If a women gets a hip replaced, she usually is offered specific instruction regarding how to get off the toilet, how to get out of bed and what positions to avoid, but how often is sexual activity, which generally requires some amount of hip mobility, discussed?

Pelvic floor physical therapists play an important role in promoting sexual health and addressing sexual problems. Bowel and bladder symptoms, incontinence, urgency and frequency negatively affect quality of life, affects mood, and limit recreational and social activity. But mostly, sexual quality of life is affected by these symptoms. So, treating pelvic floor complaints can directly improve sexual health. Many physical therapists encounter women who complain of specific sexual function problems, such as pain with intercourse or difficulty achieving orgasm. With sufficient education and supervision, pelvic floor physical therapists are in an optimal position to provide behavioral suggestions and advice, which is in fact the role of a sexual counselor.

There is another point to make here that needs emphasizing. The multidisciplinary model attributes treatment of the medical components of sexual problems to physicians, and treatment of psychological and sexual issues to psychotherapists and sex therapists. The perceived role of the physical therapist is that they treat only the pelvic floor muscles. The problem with this model is that it fails to consider that pelvic floor dysfunction is not simply a mechanical condition, but that often the pelvic floor is a physical manifestation of an emotional state. Anxiety, aversion and pain avoidance are commonly seen in women with sexual pain and physical therapists, who treat physically “hands on” and examine women, are likely to confront these emotions in the clinic. Physical therapy, when combined with clinical tools, such as mindfulness, breathing and relaxation techniques, can address com-
“Female sexual dysfunction” tends to attribute sole responsibility to the woman, who often feels enough guilt and responsibility as well.

You are a sex therapist in addition to being a pelvic floor physical therapist, how much has this background influenced your work with women?

For many years, since 2005, I was certified by AASECT (American Association of Sex Educators, Counselors and Therapists) as a sexual counselor, and this is a role I encourage all pelvic floor physical therapists to pursue. According to what is known as the PLISSIT model, counseling allows practitioners to provide (P) permission, (L) limited information, and (S) specific suggestions. The IT stands for intensive therapy, which only sex therapists can provide. I went back for a master in counseling and had to do a great deal of psychotherapy training and supervision in order to become certified as a sex therapist last year, and of course, this has changed how I work, as I now provide the intensive therapy component. Physical therapists, even those who do counsel patients, should refer out to a psychotherapist, sex therapist or couples therapist as needed. It is a good idea to network with sex therapists in your area. You need them, and they certainly need and appreciate what you do.

The term “female sexual dysfunction” has been attacked by a group of health care professionals, what are your views on this issue?

The term has been attacked because of the concern that sexual problems were being medicalized so that ultimately, drug companies could benefit. If sexual problems can be pathologized and reduced to a blood flow or hormonal issue, then finding the right medication could be a huge potential market. In fact, female sexual problems have not thus far been demonstrated to be easily resolved with medication, certainly not as effectively as PDE-5 inhibitors (Viagra, Cialis, etc.) have improved men’s erectile problems. What we do know is that there are a variety of factors that contribute to sexual problems and one of the big ones is what is going on in the relationship. So, those who attack the term, do so because they recognize that the relationship components should be addressed and that referring to a problem as “female sexual dysfunction” tends to attribute sole responsibility to the woman, who often feels enough guilt and responsibility as it is. This view also attempts to normalize the experiences of women by elucidating that many women respond differently than men and that rather than experience spontaneous desire, the sexual response of women is driven by more cognitive motivation and knowledge of reward, as well as the desire for intimacy. A woman may not be in the mood going in, but once she is open to it, she experiences arousal, then the desire kicks in and the experience overall is a satisfying one. This is the circular model introduced by Rosemary Basson, who attempted to demonstrate that not having spontaneous desire or awareness of being “in the mood” is not, for women, a sexual dysfunction as long as they are receptive to sex and end up enjoying it.

I certainly subscribe to the view that prevents

“Pelvic floor dysfunction is not simply a mechanical condition, but that often the pelvic floor is a physical manifestation of an emotional state.”
pathologizing women. But we also have to validate the real concerns of women who are severely distressed by a reduced sexual response. Biologically, there are many factors that can contribute to this including cardiovascular problems, diabetes, menopause, neurological problems, musculoskeletal problems, urogenital problems, cancer and other chronic illnesses. Medications can have an adverse affect on the sexual response as well. So, if a medication can be found that would significantly help women with their drive, arousal or ability to achieve orgasm, I would certainly not oppose it. Why not help women (and couples) achieve what they want?

As renowned researcher in the field, is the evidence on our side?

This is an important question and a wonderful opportunity for me to make a plug for research. I currently serve as associate editor for the Journal of Sexual Medicine. As such, I receive manuscripts, many of which relate to physical therapy and/or the pelvic floor, and my responsibility is to send them to peer reviewers. I would hereby like to call out to all women's health physical therapists interested in becoming peer reviewers to send an email to me with your CV, so I can add you to the reviewers list. Moreover, please consider submitting your research to our journal. The evidence is on our side, but we need more. There are several double blind controlled studies that have demonstrated that women undergoing pelvic floor muscle training reported improvement in sexual function. There are also some studies demonstrating that while pelvic floor muscle training improved urinary symptoms, sexual function was not reported to change. As usual with studies in women's sexuality, which is so multi-factorial, it is difficult to isolate the factors contributing to or detracting from, optimal sexual health.

What do you think are the challenges that
“Pelvic floor physical therapists deal with the most intimate of situations and often develop meaningful therapeutic relationships with their clients, to the extent that clients may reveal their feelings or past experiences, even traumatic ones.”

Facing physical therapists specialized in this field?

I think that physical therapists struggle with opportunities to gain more education and skills in addressing sexuality, as well as with opportunities to gain recognition as such. Pelvic floor physical therapists deal with the most intimate of situations and often develop meaningful therapeutic relationships with their clients, to the extent that clients may reveal their feelings or past experiences, even traumatic ones. This often works because of the intuitive nature that many PTs have to be empathic and contain their clients. But unfortunately, counseling skills are not sufficiently taught in most physical therapy curricula and many PTs struggle with their professional boundaries. It is for this reason that I have begun to commit myself to teaching psychosocial and sexual counseling skills to physical therapists in various forums. Here in Israel, I co-coordinate the bi-annual 100-hour pelvic floor course with my colleague, Neta Beyar, (who is an skillful teacher of pelvic floor functional anatomy and biomechanics). I make sure to provide a full day of sexual related information and material about pelvic and genital pain, and how it affects sexuality and frequently relate to the psychosocial issues surrounding all pelvic floor complaints. This includes how to take a sexual history, how to deal with revelations of sexual abuse and how to be sensitive to cultural differences. I am

The International Society for the Study of Women’s Sexual Health (ISSWSH)
www.issswsh.org
This is an international, multidisciplinary organization dedicated to providing opportunities for education and communication among scholars, researchers, and practitioners about women’s sexual function and sexual experience. I highly recommend attending their courses and conferences and owe much of my professional success to my involvement with this organization and the people I have met there, in particular, Dr. Irwin Goldstein, the current editor of the Journal of Sexual Medicine. Last February I was honored to host an international ISSWSH conference right here in Jerusalem, Israel. ISSWSH offers the opportunity for researchers, psychotherapists and educators, physicians, nurses, and physical therapists to become fellows. You can read about how to become a fellow on the ISSWSH website.

American Association of Sexuality Educators, Counselors and Therapists (AASECT)
www.aasect.org
Despite the name, AASECT is an international organization with members throughout the globe. As the current International Regional Membership Chair, I am involved in communicating with international members and can assist with becoming a member. Physical therapists have already begun to follow my lead in pursuing certification with AASECT for the title of sexual counselor. The certification guidelines are listed on the AASECT site.

International Society for Sexual Medicine (ISSM)
www.issm.info
This past August I had the honor of being invited to present at the World Sexual Medicine Conference in Chicago hosted by ISSM and Sexual Medicine Society of North America (SMSNA). I spoke of the role of physical therapy in addressing pain, as well as anxiety, in women with sexual pain disorders.
honored to have been invited by Fatima Sancho this fall to Portugal, to teach a day course to women’s health physical therapists and look forward to more international teaching opportunities in the future.

It is also for this reason that I would like to use this forum to let physical therapists know about some of the opportunities available to join sexual health organizations and learn more about sexual health. These are just a few of many sexual health organizations, but I highlight these because of their openness to various disciplines, particularly physical therapy.

Finally, in your opinion, how can IOPTWH support physical therapists interested in female sexual health?

Well, this newsletter is a great start and I applaud your initiative on this. I was happy to have been invited to the IOPTWH conference in 2009 to give a keynote address on the role of the core in sexual health and encourage more sexually related conference content in the future. Joining with other organizations, much like we do with ICS (International Continence Society) and presenting at each others conferences is also a potential direction to explore, and one which I would be happy to facilitate.

Continuing Medical Education

Managing Pregnancy and Delivery in Women with Sexual Pain Disorders

Talli Y. Rosenbaum, MSc* and Anna Padoa, MD†
*Department of Physical and Sexual Therapy, Inner Stability Ltd., Bet Shemesh, Israel; †Department of Obstetrics and Gynecology, Assaf Harofe Medical Center, Zrifin, Israel

ABSTRACT

Introduction. Vaginismus and dyspareunia most commonly affect women in their childbearing years, yet sexual function, and not childbirth, has been the focus of most research.
Aim. The aim of this study is to discuss pregnancy and birth outcomes in women with sexual pain disorders (SPDs) and address practical concerns of patients and practitioners regarding management during pregnancy, pelvic examination, labor, and delivery.
Methods. Review of the relevant literature and recommendations based on clinical expertise of the authors.
Results. A review of SPD, conception, and birth outcomes is provided as well as clinical recommendations for prenatal, labor, and delivery management of women with SPD.
Key Words. Vaginismus; Vulvodynia; Pregnancy; Sexual Pain; Penetration Anxiety; Labor and Delivery; Dyspareunia; Pelvic Floor
Female Sexual Dysfunction
Defined as a departure from normal sensation and/or function experienced by a woman during sexual activity.
(Haylen 2010)

Association of Reproductive Health Professionals (ARHP).
http://www.arhp.org
The Women’s Sexual Health Foundation.
http://www.twshf.org
The Kinsey Institute for Research in Sex, Gender, and Reproduction.
http://www.kinseyinstitute.org
The Society for the Scientific Study of Sexuality.
http://www.sexscience.org/index.php

Editorial Statement
IOPTWH members and friends are invited to submit contributions directly to the Editor. Contributions may include members’ reports, book reviews, research abstracts, or any reports that members and friends would like to share. Photographs can be included to enrich reports. All submissions are subject to editing. Keep those reports coming!

Initiating the Discussion of Sexual Dysfunction

- Include sexual questions on history taking questionnaire (Brotto 2012)
- Sexual pain history taking
- It is imperative the therapist learns to read a patient’s body language and responses
- Physical examination – be aware of the possibility of past sexual abuse, even if the patient reports a negative history
Problems with sexual function are a common, significant cause for distress in individuals and often have a negative impact on relationships. Sexual dysfunction is a broad term which includes difficulties with sexual desire, arousal and orgasm as well as the many and varied presentations/diagnoses of pelvic/genital pain and changes in sensory response in both men and women.

Treatment of sexual dysfunction requires a multi disciplinary approach. Successful therapy often requires more than one type of intervention at the same time. (1)

The problems faced by these patients can be complex. When primary health practitioners are not comfortable discussing sexual issues, or do not recognize and understand the symptoms, this can lead to delayed diagnosis and a struggle to find effective treatment. (2) As a result, people with sexual dysfunction often experience a decrease in quality of life and an increase in relationship conflict. (3) This can be devastating to the patient’s confidence and ability to move forward.

Existing treatments are commonly administered by individual clinicians working in isolation, often with limited benefit (4) and at varied intervals on the continuum of the patient’s interaction with health professionals. Adopting an integrated approach requires humility and a willingness to see your own limits and to acknowledge other health professionals contributions (5)

It is important to recognize that sexual dysfunction and associated pain is often a centrally mediated process (6) in combination with local symptoms. In simplified terms, sexual dysfunction involves sensory and motor nerves, muscle balance and tonicity, pelvic organs/soft tissue and joints. There are local and global implications with peripheral and central nervous/endocrine system involvement and autonomically mediated pain.

As women’s health physiotherapists, our clinical intervention has broadened in scope over the last ten years. With advanced diagnostic methods, we are treating a wider variety of conditions and are learning to utilize new technology in our clinical practice.

*Physiotherapist specializing in pelvic health, member of the NZ Physiotherapy Society special interest group for continence and women’s health

When accepting referrals and requests for treatment of women with sexual dysfunction, it is best to take a considered and careful look at what we have to offer. Our colleagues who work in musculoskeletal physiotherapy and chronic pain have experience and skills that can be of value.

We need to take care that, just because we are women’s physiotherapists (and it is usual that we want to offer some help to any person referred to our service) we do not say “yes, I will have go at treating this” without prior clinical training, experience and supervision in treating the range of contributing factors to sexual dysfunction.

As more physiotherapists move into the area of health prevention and continence management, it is important that they recognize that what they know about continence – related pelvic floor rehabilitation is not necessarily directly transferable to working with patients with sexual dysfunction. Before we can begin the complex challenge of treating women with sexual dysfunction, we must continue to first ask ourselves the question: “Can I help?” And then, if our answer is “yes”, we must ask: “How, and based on what evi-
dence?” Otherwise, the feedback from women, about physiotherapy intervention, may be just another “Oh I tried that and it did not work”

Our aim is to help restore normal function and sensation while attempting to reduce the psychological impact.

Physiotherapy research has been conducted on the benefits of biofeedback (5) and specific treatment techniques for the pelvic floor for sexual dysfunction (2, 7, 8, 9). However, a systematic review of the effectiveness of biofeedback showed no evidence of improved outcomes using this treatment method (10). It is interesting that much of the research published on this topic refers to “pelvic floor” physiotherapists, consequently minimizing potential understanding of the broad range of skills we can offer.

These approaches are only a few of the wider group of treatment options that we, as physiotherapists, can offer at various stages along the journey to recovery. I would recommend that we continue to learn techniques and skills from chronic pain and musculoskeletal physiotherapists. (11)

Detailed history and assessment with the patient needs to be carried out with sensitivity and may continue over a few sessions making a comprehensive analysis of the physiological/mechanical problems (2). Treatment techniques may be trialed for a short time and put aside until another session; some will work for a time and some will need to be offered later. The techniques may include soft tissue techniques, muscle awareness/balance, relaxation/breathing, desensitization of nerve response, restoring normal muscle tone (2) and a more global approach including spinal and pelvic girdle function (11). Thoracic work can be effective in altering abnormal autonomic response. (11)

I always refer to the work that we do as a journey through a dense forest: it is difficult to see the end due to the twisting and winding nature of the path, and we may have to circle back on the same ground a few times; but both the patient and I know what the goals are and where we want to be.

Remember, we are an integral part of the multi-disciplinary team of consultants, psychologists and sexual health practitioners (4) who care for people with sexual dysfunction.

We have the opportunity and skills to address issues for women with sexual difficulties, but we need the experience, diagnostic and analytical ability to apply this appropriately. We must prioritize as well as evaluate and revisit techniques as indicated while walking the forest path alongside the patient, offering support and options for recovery.

Although we cannot always guarantee a successful outcome, we can contribute to patient satisfaction, hope and well being.

References:
2. Hartmann D Chronic vulvar pain from a physical therapy perspective Dermatologic Therapy 2012; 23: 505-513
Abstract
Pelvic girdle pain (PGP) is experienced between the posterior iliac crest and the gluteal fold, particularly in the vicinity of the sacroiliac joints. The pain may radiate in the posterior thigh, and can also occur in conjunction with or separately in the symphysis. The pain or functional disturbances that are related to this condition must be reproducible by specific clinical tests for a definitive diagnosis to be made. Despite the fact that pregnancy-related PGP is a common ailment, it is still poorly described and understood. Studies have shown that it is a relatively common problem in many countries. It has been estimated that approximately 20–25% of all pregnant women suffer from PGP that is sufficiently serious to require medical help. The majority of women with the condition recover spontaneously soon after delivery; however, 7% report serious problems resulting from persistent PGP that last for many years. The aetiology and pathogenesis of pregnancy-related PGP is unclear. In diagnosing this condition, a thorough history and physical examination should be carried out in order to differentiate between low back pain and PGP, assess the underlying pain disorder and disability, and formulate an individualized management plan. The European guidelines for the diagnosis and treatment PGP recommend individualized exercises in pregnancy, an adequate supply of information about the condition, and reassurance for patients as part of a multifactorial treatment focusing on specific exercises for motor control and stability postpartum. In order to improve the quality of treatment, physiotherapists must have evidence-based skills, listen attentively and individualize treatment. Outcome measures are needed to adequately evaluate interventions. The Pelvic Girdle Questionnaire, a condition-specific measure, has recently been developed for pregnant and non-pregnant women with PGP.

Keywords: diagnostics, guidelines, pelvic girdle pain, physiotherapy, treatment.

Journal of the Association of Chartered Physiotherapists in Women’s Health, Autumn 2012, 111, 5–12

Safe use of transcutaneous electrical nerve stimulation for musculoskeletal pain during pregnancy

E. Crothers, Y. Coldron, T. Cook, T. Watson & W. Notcutt

Abstract
Transcutaneous electrical nerve stimulation (TENS) has been used by pregnant women for many years without any reported side effects for either mother or baby. In clinical practice, TENS is not the first treatment of choice for women presenting with musculoskeletal pain during pregnancy. However, if pain remains a significant factor, then TENS is preferable to the use of strong medication that could cross the placental barrier and affect the foetus. When a pregnant woman presents with low back pain and/or pelvic girdle pain, including symphysis pubis dysfunction, TENS may be beneficial if the pain is persistent or is a hindrance to further improvement, especially when the alternative is medication that would cross the placental barrier. Although no side effects from the use of TENS during pregnancy have been reported in the literature, specific potential areas of concern are the induction of uterine contractions, the effects on foetal heart conduction and the possibility of teratogenic effects induced in the foetus. This paper presents guidelines for the safe use of TENS for musculoskeletal pain during pregnancy.

Journal of the Association of Chartered Physiotherapists in Women’s Health, Autumn 2012, 111, 22–26
Vaginal Dilators in Oncology Related Sexual Dysfunction: Is there a Place for Physiotherapy?

Anne-Florence Plante
B.Sc. PT (Paris).

This article aims at updating physiotherapist’s knowledge on the current use of dilators in treating dyspareunia for oncology patients after chemotherapy and radiotherapy.

In survivors of cancer, the premature ovarian failure as a result of chemotherapy or pelvic radiation is frequently associated with sexual dysfunction. This occurs particularly when hormone replacement is contraindicated, because the malignancy is hormonally sensitive (Schover 1997). Up to 50%–75% of breast cancer survivors also experience one or more urogenital symptoms (Ganz et al 1998). Women with early-stage cervical carcinoma who have undergone radical hysterectomy, report severe orgasmic problems and uncomfortable sexual intercourse due to the reduced vaginal size during the first 6 months after surgery (Pieterse et al 2006). Treatment with both chemotherapy and Tamoxifen® seems to compound the severity of symptoms versus treatment with either agent alone (Bakewell & Volker 2005). After pelvic radiotherapy, the incidence of vaginal stenosis and shortening is hard to quantify, and ranges from 1.2% to 88% (Brunner et al 1993). The severity of vaginal stenosis appears to be related to a higher radiation dose and a smaller diameter (<20 mm) of the brachytherapy applicator (Nunns et al 2000).

There is limited evidence to support the role of physiotherapy in sexual dysfunction, particularly dyspareunia, following different cancer treatments. However there is substantial evidence to support the role of physiotherapy in the treatment of dyspareunia in general.

Dyspareunia associated with pelvic floor dysfunctions such as vaginismus and vulvodynia, is significantly improved by pelvic floor muscle (PFM) resting tone reduction. (Rosenbaum 2008). The use of dilators in the treatment of dyspareunia is cognitive-behavioural and is designed to initiate a desensitisation process (Lamont 1979). In dyspareunia, sexual penetration is associated with pain or fear, and has become a conditioned stimulus/response, so a vicious fear-pain-tension circle is created. Goldfinger et al (2009) proposed that PFM tension begins as a protective guarding response to pain.

Therapeutic treatments for dyspareunia aim for systematic desensitisation, and include the use of dilators either for increasing vaginal diameters (Lamont 1979; Barnes 1985; Scholl 1988; Schneider et al 1998; Har-Toov et al 2001; Seo et al 2005) or for behavioural modification by exploration and neural desensitisation rather than stretching of a vagina that is too small (Reamy 1982).

Therefore dilators aim to achieve different goals, including:
1. Progressive de-sensitisation at the vaginal entry (pain education and treatment for superficial dyspareunia),
2. Progressive aperture enlargement,
3. Progressive aperture enlargement,
4. Progressive tolerance to vaginal penetration,

Chemotherapy and radiotherapy related dyspareunia
It has been proposed that oestrogen deprivation plays a major role in dyspareunia. The effects of oestrogen include maintainance of acid mucopolysaccharides, which keep epithelial surfaces moist, and maintain optimal vaginal blood flow. Oestrogen deprivation in chemotherapy might eventually lead to dyspareunia due to vaginal dryness. There are few studies to date investigating the
use of dilators in this patient population.

Patients undergoing radiotherapy or brachytherapy are at risk of vaginal stenosis and shrinkage of the vaginal vault. There is evidence that sexual function is correlated with vaginal length (Bergmark, 1999) therefore avoiding stenosis and maintaining length may relevant management. Dilator therapy in this cohort has been introduced in an ambivalent way, as patients often do not perceive the extent of risk that radiation carries to their sexual life, and therefore lack demand or motivation for preventative treatment. Patients may have fear of pain without experiencing the reality of pain during sexual intercourse. This may be an area of treatment where trained physiotherapist could be useful and play a significant therapeutic role.

In a review of Australian practices by Lancaster et al (2004), patients were found to be more likely to start dilator therapy prior to brachytherapy or within 2 weeks of completion. However, dosage varied considerably. Eight centres recommended 2 to 3 times a week, with a median time of insertion of dilators of 5 to 10 minutes, and duration of the treatment was from 6 weeks to indefinitely. Velaskar (2007), demonstrated that vaginal dilators increased median length of the vagina from 6 to 10 cm after dilator treatment and that 50% of these women with stage 3 cervix cancer treated by radiotherapy and chemotherapy were able to accommodate larger dilators after 1 year of follow up.

Despite this encouraging research, current recommendations are not very positive with regard to the use of dilators in post radiotherapy patients. The latest Cochrane review (Miles et al 2010) found that dilator therapy during or immediately after radiotherapy could cause damage to vaginal tissues, and there was a lack of evidence that it prevented stenosis. Discussion was that radiotherapy is associated with cellular damage and subsequent inflammation. Many women reported bleeding and pain, presumably caused by damage to the epithelium. Persistently interfering with the vagina during the inflammatory phase of radiotherapy treatment might cause additional scarring and promote additional damage, both physically and psychologically. Fistulae have occurred after treatment (Hoffman 2003). The authors stated five reasons why dilator therapy should be discouraged:

- Psychological sequelae.
- Trauma during healing increasing fibrosis.
- Anatomical damage and fistulae.
- Health economics.
- Lack of data to support its use.

In summary, physiotherapy treatment, including dilator therapy, aims to reduce fear of penetration and a fear-avoidance pattern, relax hypertonic pelvic floor muscles, reduce pain intensity, prevent tissue shortening, and thus improve global sexual function (Desrochers, 2010). These aims are achieved by a process of tissue desensitisation and pacing strategies. Although there are few research publications to date, we can hypothesise that physiotherapy treatment with dilators may be appropriate in patients with oestrogen deprivation dyspareunia, as improvement of sexual function is the aim of the treatment. Women who receive radiation should be educated regarding the use of vaginal dilators after the initial inflammatory period. Post-radio or chemotherapy dilator treatment will therefore require specific guidelines to be developed. It is a very different approach to introduce the use of dilators for a sexual dysfunction that patient acknowledges and wants treated, compared to a preventive intervention that patient may not ready to accept physically and psychologically.

Our focus has to be clear, as physiotherapy treatment is a package that includes physical and cognitive intervention. Treatment for dyspareunia in an oncology setting should be managed as a pain treatment, hence should be primarily a multidisciplinary treatment that includes a sexual counselor or a sexual health specialist.

Correspondence:
Royal Women’s Hospital, Melbourne, Australia
anneflorenciplante@thewomens.org.au
### Causes of Female Sexual Dysfunction

<table>
<thead>
<tr>
<th>Cause</th>
<th>Examples</th>
<th>Sexual Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hormonal/Endocrine</strong></td>
<td>Hypothalamic-pituitary axis dysfunction, menstrual, chronic oral contraceptive use, premature ovarian failure</td>
<td>Decreased libido/desire, vaginal dryness, lack of arousal</td>
</tr>
<tr>
<td><strong>Musculogenic</strong></td>
<td>Over activity or under activity of pelvic floor musculature</td>
<td>Over activity (hypertonicity): Sexual pain disorders</td>
</tr>
</tbody>
</table>
|                               |                                                                          | Under activity (hypotonicity): Vaginal hypoesthesia, coital anorgasmus, UI with sexual activity | Anorgasm +
| **Neurogenic**                | Spinal cord injury, disorders of the central or peripheral nervous system (i.e. diabetes, upper motor neuron injury) | Decreased libido/desire, decreased arousal, hypoesthesia, anorgasmia            |
| **Psychogenic**               | Relationship problems, poor body image, decreased self-esteem, mood disorders, adverse effect of medication use | Vaginal dryness, dyspareunia                                                     |
| **Vasculogenic**              | Diminished blood flow to genitals secondary to atherosclerosis, hormonal influences, trauma |                                                                             |

References:
INTERNATIONAL PHYSICAL THERAPY CONFERENCE
Topics on Women's Health and Aging in Men and Women
April 26 – 28, 2013 (Friday-Sunday)
REGISTER ONLINE MID SEPTEMBER

IOPTWH  Where: The Conference Center at Harvard Medical School 77 Avenue Louis Pasteur Boston, Ma (USA)

Early Registration Deadline December 10, 2012

This is the first combined international course for physical therapists working with women and the aging population.

The International Organization of Physical Therapists in Women’s Health (IOPTWH) and The International Association of Physical Therapists working with Older People (IPTOP) have joined together to offer this unique program in late April 2013 in Boston, Massachusetts.

These sub groups from the World Confederation for Physical Therapy (WCPT) have brought together a distinguished course faculty that will present topics of interest to physical therapists working with women and the aging population.

Hotels: The Best Western The Inn at Longwood Medical
Phone: 617-731-4700
www.innatlongwood.com

Holiday Inn Boston-Brookline 1200 Beacon Street Brookline, Ma 02446
Phone: 617-277-1200

For more Information go to: www.ioptwh.org OR www.wcpt.org/iptop
INTERNATIONAL PHYSICAL THERAPY CONFERENCE
Topics on Women's Health and Aging in Men and Women

April 26 – 28, 2013 (Friday-Sunday) The Conference Center at Harvard Medical School, 77 Avenue Louis Pasteur, Boston, Ma (USA)

Fees: Early bird registration $380 by Dec 10 - After Dec 10 $395 - On site $415

Friday April 26, 2013
AM IOPTWH and IPTOP Board Meetings 3 hours at the hotels
5:00 pm Check in at conference site
5:00-8:00 pm Reception cocktails and snacks reception
5:00-8:00 pm Vendor Exhibits

Saturday April 27, 2013
8:00 - 8:30 am Registration continental breakfast
8:30 - 8:45 am Opening
Dr. Rebecca Stephenson President IOPTWH
Dr. Jennifer Bottomley President IPTOP
Anne Hartstein - Massachusetts Secretary of Elder Affairs
8:45 - 9:45 am WCPT President opening remarks-Trends in World Aging for Men & Women - Dr. Marilyn Moffat
9:45 -11:00 am Physiotherapy and Osteoporosis: Goals and Strategies for Women and Older People - Dr. Meena Sran
11:00 -11:15 am Break
11:15 -12:15 am Communication Skills: Working with the Older Adult - Dr. Jennifer Bottomley
12:15 -1:15 pm LUNCH
1:15 - 3:15 pm Incontinence and Pelvic Organ Prolapse and its Implications in Aging - Dr. Meghan Markowski
3:15 - 3:30 pm Vendor Break
3:30 - 4:30 pm IOPTWH Case Study Presentations
Gill Brook
Dr. Rebecca Stephenson
5:30 - 6:30 pm Cocktails- Longwood Inn
6:30 - 8:00 pm Dinner and Keynote Speaker at the Longwood Inn

Sunday April 28, 2013
8:30 - 9:00 am Continental breakfast
9:00 -10:00 am Nutrition and Exercise in Aging - Bhanu Ramsey
10:00 -11:00 am Understanding the Lastest in Urogynecological Surgeries - Dr. Neeraj Kohli
11:00 -11:15 am Break
11:15 -12:00 pm Sexual Changes in Women and Men as They Age - Dr. Sharon Bober
12:00 -1:00 pm Lunch
1:00 - 3:00 pm The Aging Breast: At Risk for Breast Cancer - Dr. Nancy Roberge
3:00 - 3:15 pm Break
3:15 -4:15 pm Active Aging - Dr. Marilyn Moffat
4:45 pm Closing

Go to www.ioptwh.org to register. Registration will be available online mid September.
President
Rebecca G. Stephenson, USA
rstephenson1@partners.org

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gill.brook@lineone.net

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IOPTWH Office:

IOPTWH
Gill Brook
Burras Lynd
Burras Lane
Otley, West Yorkshire
LS21 3ET
England
UK