

DEBATING THE ISSUES AROUND PELVIC FLOOR ASSESSMENT

In this new regular *Continence UK* feature, two expert practitioners in the field of continence, Alison Bardsley and Jeanette Haslam, debate the issues surrounding pelvic floor examinations in women with urinary incontinence. They address questions dealing with assessment, referral, patient teaching, the effect of examinations on outcome and ethics.

Can a full assessment without a pelvic floor examination indicate a treatment pathway?

JH: A full assessment of a person with bladder symptomology has many component parts. It includes history taking, the results of any investigations and previous treatments, urinalysis to exclude urinary tract infections or other pathology, bladder charting and physical examination. If any of these component parts are omitted an incorrect treatment pathway may be taken, wasting time for both patient and clinician and possibly causing harm. The National Institute for Health and Clinical Excellence (NICE) (2006) has recently stated that 'digital assessment of the pelvic floor should be undertaken before the use of supervised pelvic floor muscle training [PFMT] for the treatment of urinary incontinence'. PFMT underpins the conservative management of many bladder conditions.

AB: History taking is the cornerstone of assessment in urinary incontinence. A comprehensive assessment includes previous medical history as well as a

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physical examination where required. A group of randomised control trials that evaluated PFMT all showed the efficacy of active treatment compared with control, whether or not pelvic floor muscle contraction was assessed before treatment (Berghmans et al, 1998; Hay-Smith and Dumoulin, 2006). This would indicate that a vaginal assessment is not essential to commencing PFMT.

A full assessment, based on the women's reported symptoms, has been demonstrated to indicate a pathway for conservative treatment. In mixed incontinence, treatment should be directed towards the symptom reported as most troublesome.

Should all women with stress incontinence symptoms be referred to a specialist service?

JH: A high proportion of women experience stress urinary incontinence at some time in their lives and it is unreasonable to expect all to be seen in a specialist service. However, all healthcare professionals that are involved in female health should ideally be taught basic examination techniques, at least to ensure that the patient is performing the correct pelvic floor muscle contraction. Obviously, midwives and nurses who take cervical smears, should be taught pelvic floor muscle assessment as they are experienced in vaginal anatomy and have skills in vaginal assessment. Those women with more persistent or greater problems could then be referred to a specialist.

AB: The reality is that there are few specialists in this area. If all women with symptoms of pelvic floor dysfunction were referred to a specialist this would lead to an increase in waiting lists

and longer treatment delays. Since it is widely accepted that commencing conservative therapies following assessment is safe and beneficial, not all women should be referred initially for specialist care. There is also a deficit of training in bi-manual pelvic floor assessment and what is available can be expensive.

There is also a lack of evidence supporting the cost-effectiveness of physical therapies. It would be better to provide all women experiencing symptoms a basic standard of care and provide greater access to those who require specialist care.

Can leaflets about pelvic floor exercises be an effective teaching aid?

JH: Any method that encourages women to perform pelvic floor muscle exercises is to be applauded. However, there are dangers in relying on a leaflet by itself, even when verbal instructions are also given. It has been shown that if a physical examination of the pelvic floor muscles is not undertaken, only 25% of women will perform the appropriate contraction (Bump et al, 1991). Therefore, if a woman is referred for stress urinary incontinence treatment, a pelvic floor muscle exercise leaflet should be regarded only as an adjunct to a bespoke exercise programme determined after a pelvic floor muscle assessment.

AB: Many women perform well with verbal instructions and a leaflet as back up. Women do not always feel comfortable in presenting to a healthcare professional regarding their continence problems but may pick up an anonymous leaflet. This allows them to educate

JH: It would seem, therefore, that recommending supervised pelvic floor muscle exercises for patients without a pelvic floor muscle examination is unethical.

AB: As there are currently insufficient numbers of specialists, insisting on examination before treatment would lead to further treatment delays and apply further pressure on over-stretched resources.

themselves about pelvic floor exercises and, for some, this may be sufficient. Leaflets provide a cost-effective way of providing information to a large number of women and can be a very effective teaching aid.

Does pelvic floor examination affect outcomes?

JH: As of yet there has been no trial that has randomised two groups to pelvic floor muscle exercises, one with a pelvic floor examination and one without. However, most quality randomised controlled trials state that they have performed a pelvic floor muscle assessment before any intervention. Following general principles of muscle physiology, in order to improve muscle there needs to be specificity and overload of muscle activity. Specificity means that the correct muscle group must be used in a functional fashion and made to overload so that they work harder than usual. Without assessment neither of these factors can be assumed.

AB: Pelvic floor examination includes digital palpation and perineometry. Women often measure their own subjective improvement by reporting reductions in pad usage and improved quality of life. Physical examination can be carried out to guide diagnosis and management but is not essential in commencing conservative treatment. Although a physical bi-manual assessment can indicate co-existing conditions, such as pelvic organ prolapse, atrophic changes and uterine and ovarian enlargement, there is no evidence to assess whether treatment outcomes are affected. The NICE guidelines on women's

incontinence (NICE, 2006) only attach a low-level evidence recommendation for routine digital assessment before supervised PFMT alongside a recommendation for further research in this area. Until further research is available to support additional resources, current practice should allow for PFMT to be taught without the need for bi-manual examination.

Is it ethical to commence supervised pelvic floor muscle exercises without a pelvic floor muscle vaginal assessment?

JH: There are four basic ethical principles that should be adhered to when treating patients. We must do no harm, avoid any preventable harm by our actions, respect the patient's self-determination and ensure that there is fairness in how patients are treated (Wall, 2007). On all four counts it is possible to be unethical in commencing supervised pelvic floor muscle exercises without a pelvic floor muscle examination. To ensure that this is not the case, healthcare professionals must have adequate training in the procedure and follow the guidance of their respective professional organisations. For example, Rule 1 of the physiotherapists' code of practice states that the patient should fully understand and be able to carry out what is expected of them, i.e. not bearing down when attempting a pelvic floor muscle contraction. It would seem, therefore, that recommending supervised pelvic floor muscle exercises without a pelvic floor muscle examination is unethical.

AB: In the absence of evidence to suggest that undertaking a vaginal assessment makes a significant difference to outcomes, it is practical for the

collective good of the majority of women to commence PFMT without examination. Good practice determines that women should be reviewed four weeks from commencement of treatment. This allows for any women who are not making progress to be reviewed and examined where appropriate. As there are currently insufficient numbers of specialists or suitably qualified professionals, insisting on examination before treatment would lead to further treatment delays and apply further pressure on over-stretched resources. The critical role of ethics in healthcare is to provide sound justification for the value judgements we make. Where insufficient evidence exists, decisions need to be based on the accepted expert practice and the principal of doing no harm. **CUK**

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