



International Organization of Physical Therapists in Women's Health

A sub-group of WCPT



PRESIDENT'S REPORT

Dear friends and colleagues,

We are all gearing up for the WCPT congress in Vancouver June 2nd through 6th, 2007, less than 9 months from now! IOPTWH will have a large presence at the congress and we hope most of our member countries and Friends will be well represented there. I have two important requests to make regarding the congress at this time:

First, we will be holding **elections** at the IOPTWH business meeting. The meeting will be on Monday the 4th of June in the afternoon followed by a reception. Please consider nominating someone to run for an Executive Committee Position or running yourself! All five offices are open (President, Vice-President, Treasurer, Secretary, and Member-At-Large). Running for President requires past participation as a committee chairperson or delegate from a member-country. One must be a member of your national and sub-group and that sub-group must be a current member in good standing in IOPTWH. Nominations require a letter from your sub-group president stating the nominee has support of the sub-group. The letter can be sent to me, electronically or by mail.

Second, we are making a formal call for **motion items** for the general meeting. Motions must be sent out to the organization's membership six months in advance in order for the motion to be voted upon at the meeting. Please send any motions to Rebecca Stephenson, IOPTWH Secretary, (rgspt@comcast.net) by November 20, 2006. Agenda items not requiring a formal motion should also be sent to Rebecca, though the time frame is a bit looser (get them to her by March 1st, 2007).

IOPTWH will be sponsoring a pre-congress course on June 2nd on Osteoporosis (**Prevention and Management of Osteoporotic Fractures**).

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Please see the announcement on the course outline later in the newsletter. Registration for the pre-congress course and for the Congress can be found at www.wcpt.org. During the course of the congress IOPTWH will sponsor a 2-hour block where we will briefly go over the new strategic plan and mission of the organization followed by a participatory pelvic floor exercise class led by IOPTWH Vice-President, Dr. Kari Bø. Some of you have had the opportunity to experience this class in seminars Dr. Bø has taught, but it is always a great learning experience and lots of fun! Join us there, won't you!

There will be a great deal of women's health programming within the Congress including a workshop on breast cancer and posters and platform presentations on the full spectrum of gynecologic, obstetric, and general women's health topics. Social outings are plentiful and can be found on the WPCT web site.

On another topic, the Practice Committee, now chaired by Ruth Broom of New Zealand, has been working on a way to disseminate the position stance IOPTWH took in Barcelona against Female Genital Mutilation. A final draft has been sent to WCPT for consideration as to how to best proceed. You may remember that we formally moved to support the WHO in their stance against FGM and now we need to add our names to other organizations doing the same. Look for a copy of this position paper on our website soon.

I continue to be involved in planning the Congress via my participation on the International Scientific Committee of the WCPT. I am enjoying my work with colleagues around the globe as we strive to put together a representational and exciting conference. As always, feel free to contact me if there is anything on your mind related to IOPTWH or the Congress.

All the best,
Jill Boissonnault, President, IOPTWH



RISK FACTORS FOR DIASTASIS OF THE RECTI ABDOMINIS

G. Candido, T. Lo, P.A. Janssen, *Journal of the Association of Chartered Physiotherapists in Women's Health*, Autumn 2005, 97, p49-54

Reprinted with permission from the editor of the *JACPWH*. For a full copy of article with charts, tables and references contact Shannon Michels, IOPTWH Newsletter Editor.

Introduction

Diastasis, or separation, of the recti abdominis is known to occur in pregnancy, appearing in the second, or more frequently, the third trimester (Boissonnault and Blaschak 1988). Hormonal and mechanical stresses placed upon the structures of the abdominal wall are believed to play an important role in causing the rectus muscle to separate (Noble, 1988). The diastasis may range from a small vertical gap 2-3 cm wide and 12-15 cm long to a space measuring 12-20 cm in width and extending nearly the whole length of the recti muscles (Polden and Mantle, 1990). Gilleard and Brown (1996) demonstrated that, even among healthy fit women, there were gross morphological changes in the rectus abdominis and the ability of the abdominal muscles to stabilize the pelvis against resistance was compromised in most women at 8 weeks postpartum. Failure to treat diastasis recti abdominis (DRA) successfully can lead to long-term sequelae, including abnormal posture (Boissonnault and Blaschak 1988), back pain (Porterfield 1985) and cosmetic defects (Elbaz and Flagueul 1976). To date, research on risk factors for this debilitating condition has been limited to studies of less than 50 women (Boissonnault and Blaschak 1988). The purpose of the present study was to determine the prevalence of DRA in the early postpartum period in an unselected population of women and to de-

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scribe associated risk factors.

The study took place at BC Women's Hospital, Vancouver, British Columbia, Canada. BC Women's is the largest maternity centre in Canada and the only maternity hospital with a dedicated physiotherapy department. The hospital provides primary and secondary care to women living in the geographical catchment area of southwestern British Columbia and tertiary care for women in the Province of British Columbia. Seventy-two percent of births in the City of Vancouver take place at BC Women's Hospital.

Subjects

Women who had given birth in the preceding 48 hours at BC Women's Hospital were recruited between April 3, 1998 and October 1, 1999. At the time of the study, the average length of postpartum stay for an uncomplicated vaginal delivery was 72 hours. Exclusion criteria included endometriosis or abdominal infection, spinal headache, physical handicap or obstetrical conditions that would preclude participating in a treatment programme. Eligible patients were approached for consent by one of two physiotherapists. Previous work has reported a correlation (r) of 0.75 for measurement of diastasis using the finger-width method between two experienced physiotherapists (Bursch 1987). During a brief interview, women were asked their occupation and whether or not they performed: (1) housework; (2) childcare; (3) activities of daily living; and (4) exercise, both before and during pregnancy. In addition, they were asked what type of exercise they undertook, and the duration and frequency. The women were also asked if they had a past history of abdominal, neck or back surgery. Other variables of interest were ascertained from the patient chart, such as age, height, pre-pregnancy weight, weight gain during pregnancy, parity, gestation age at delivery, complication of pregnancy including twin gestation and diabetes, and mode of delivery. Ethnicity was observed during the examination. Following the interview, the physiotherapist examined study subjects for the presence of DRA.

Protocol

In a supine position with knees bent and feet resting comfortably on the bed, the subject was asked

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IOPTWH TREASURER'S REPORT FALL 2006

A big 'thank-you' to the chief delegates for ensuring prompt payment of the 2006 dues. There is now only one outstanding, but I won't cause embarrassment by naming names here!

The past few months have been quiet, but I anticipate a considerable increase in activity as the IOPTWH study day and WCPT Congress in Vancouver next June draw nearer. We are currently negotiating sponsorship of the website, and advertising in the newsletter, both of which will bring welcome revenue.

Outgoings since I last reported have been on the website, newsletter, executive expenses and administrative costs. Income has been from dues and bank interest. Income and expenditure since 31st January 2006 are as follows:-

Income:	£4,197.43
Expenditure:	£1,935.22
Funds at 8 th August 2006:	£12,637.94

Gill Brook
Treasurer



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to raise her head and shoulders off the bed with arms extended, reaching towards the knees until the spine of the scapula was off the bed. The physiotherapist observed the abdominal wall and palpated along the linea alba beneath the xiphoid process to above the symphysis pubis. Measurement between the border of the two bellies of the recti abdominis muscle at the umbilicus and at the widest gap above and below the umbilicus was undertaken using a tape measure. Diastasis was classified as follows:

- 1) normal: any separation above, below or at the umbilicus of <2.5 cm with no bulging
- 2) mild: any separation, above, below or at the umbilicus of ≥ 2.5 cm and <3.5 cm, or bulging with separation <2.5 cm;
- 3) moderate: any separation of ≥ 3.5 cm and <5 cm with or without bulging; and
- 4) severe: any separation of ≥ 5.0 cm.

Women who were found to have diastasis (mild, moderate or severe) were offered treatment in an outpatient rehabilitation programme offered by the physiotherapy department.

Data analysis

Diastasis was analyzed as a dichotomous outcome. Women with and without DRA were compared with respect to risk factors using the chi-square statistic for categorical exposure variables and the t-test for continuous exposure variables. Alpha (type I error) was set at $P < 0.05$. In addition, women were compared according to degree of diastasis: none or mild versus moderate or severe. Predictive models for diastasis were constructed using logistic regression. Odds ratios and 95% confidence intervals were estimated for individual predictors using model parameters. Variables were entered into the model one at a time. The variable associated with the largest value for the chi-square statistic for the model was retained, and then the other variables added one at a time. Variables were retained in the model if their addition changed the beta-parameters by 10% or more (Maldonado and Greenland 1993). Model fit was examined using the chi-square

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statistic for the model.

Prior to commencement, the study was granted a Certificate of Ethical Approval from the University of British Columbia Clinical Ethics Committee and from the BC Women's Hospital Research Review Committee.

Results

A total of 210 women were approached to participate in the present study and 208 agreed. Overall, the prevalence of DRA was 34.9% (n=76). Women with and without DRA did not differ significantly with respect to age, ethnicity, height, history of abdominal surgery or back or neck injury, weight gain during pregnancy, pre-pregnancy weight parity, gestational age at delivery, method of delivery (spontaneous vaginal, assisted vaginal or Caesarean section), or rates of multiple pregnancy or diabetes (gestational or pre-existing) (Table 1). Multiparous women were asked whether they took care of their children throughout the day. Among multiparous women, women with DRA were significantly more likely to be providing childcare (P<0.001).

Women with no or mild diastasis were compared with women with moderate or severe diastasis, since mild diastasis often resolves without intervention. One additional risk factor emerged during this analysis: women with no or only mild diastasis were more often engaged in vigorous regular (three times a week or more) or regular walking or exercise (once or twice a week) during pregnancy compared to women with moderate or severe diastasis (Table 2).

Given the strong association of provision of childcare with diastasis among multiparous women, separate predication models were created for primiparous versus mutiparous women. Among primiparous women, in a multivariate model, Caucasian women were more likely to experience diastasis [adjusted odds ratio (OR)=2.68, 95% confidence interval (CI) =1.16-6.20]. Exercise was protective for diastasis since women who did not exercise regularly experienced a twofold increase in the odds of diastasis (adjusted OR=2.02, 95%

CI=0.87-4.69), although this difference was not statistically significant in the present study (Table 3).

Among multiparous women, in a multivariate model, provision of childcare was significantly associated with diastasis (adjusted OR=11.82, 95% CI=3.20-43.6). The addition of pre-pregnancy to the model (OR=1.01, 95% CI=0.95-1.07) significantly improved the model fit (χ^2 for model change=1, d.f.=4.49, p<0.05) (Table 4). Pre-pregnancy weight is significantly associated with diastasis, therefore, after adjustment for childcare.

Discussion

In a prospective study, the present authors report a prevalence of DRA within 48 h of giving birth of 34.9%. Boissonnault and Blaschak (1988) reported a prevalence of 53% based on a sample of eight women. The present authors could find no other prevalence studies for the purposes of comparison.

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EXCITING OPPORTUNITIES AWAIT YOU!!!!



IOPTWH will hold elections for the Executive Committee at our general business meeting in Vancouver. A formal call for nominations will occur in the fall. Please place this important item on your organizations' business meeting agendas so we may gather many qualified nominees! Please read our constitution's requirements for these positions and eligibility, as well. Help IOPTWH serve our profession!

PREVENTION AND MANAGEMENT OF OSTEOPOROTIC FRACTURES

SATURDAY JUNE 2, 2007-WCPT



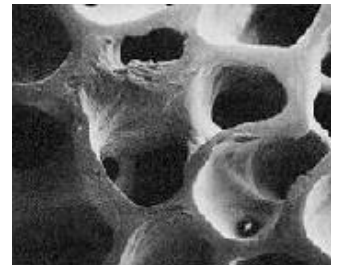
The Executive Committee and Programs Committee are excited to announce the speakers and tentative outline of the course being hosted by IOPTWH in Vancouver 2007.

Dr. Meena Sran PT, PhD is a Canadian Institutes of Health Research (CIHR) and Michael Smith Foundation for Health Research Postdoctoral Fellow at Simon Fraser University in Burnaby, and a Physiotherapist in the Osteoporosis Program at the British Columbia Women's Health Centre in Vancouver.

Meena completed her Doctor of Philosophy in Experimental Medicine (2005) in the Faculty of Medicine at the University of British Columbia, including one year at the University of Calgary in the CIHR Alberta Bone and Joint Health Training Program. In addition to her research, clinical and teaching activities, Dr. Sran serves on the executive committee of the International Organization of Physical Therapists in Women's Health and the Board of Directors (current Vice-president) of the Physiotherapy Association of British Columbia.

Kathy M. Shipp, PT, MHS, Ph.D.

- Assistant Research Professor
- Oberlin College, Oberlin, Ohio B.A.1976
- Sociology Univ. of North Carolina, Chapel Hill, NCB.S.1985
- Physical Therapy Duke University, Durham, NCM.H.S.1998 Biometry
- Univ. of North Carolina, Chapel Hill, NCPH.D.2001 Epidemiology



Presenter: Meena Sran PT, Ph.D.

9:00-9:15: Introduction and Overview of the Course

9:15-10:00: Background (bone loss, diagnosis of osteoporosis, components of comprehensive management)

10:00-11:00: The Effects of Mechanical Loading on Bone—What is the optimal stimulus for bone formation? Exercise Prescription for Bone Health Across the Lifespan

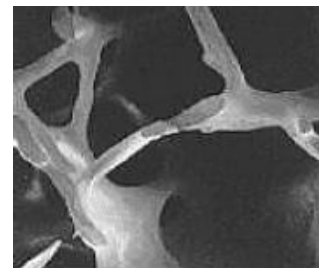
11:00-11:20: Break

11:20-12:00: Biomechanics of Falls and Novel Strategies for Fracture Prevention

12:00-12:30: Safety of Physiotherapy for Individuals with Osteoporosis

12:30-12:45: Questions

12:45-1:30: Lunch



Presenter: Kathy Shipp PT, Ph.D.

1:30-2:15: Fracture Incidence Across the Lifespan and in Common Clinical Populations

2:15-3:00: Impact of Fractures (including clinical vs. radiographic)

3:00-3:20: Break

3:20-4:00: Evidence for Physiotherapy Interventions to Change Parameters along Disability Model

4:00-4:45: Acute Vertebral Fracture Management

4:45-5:00: Final Question Period



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In addition, the present authors report an association of DRA during pregnancy with Caucasian ethnicity and a lack of regular exercise during pregnancy. Among multiparous women, they report a strong association between provision of childcare and DRA during pregnancy.

These findings have not been reported before to the present authors' knowledge. The role of exercise in the prevention of DRA has not been studied to date. The present data suggest that exercise itself may be a protective factor, or alternatively, women who exercise during pregnancy may have healthier lifestyles, which, in turn, have ensured healthier tissues. Exercise prior to pregnancy may also play an important role. In the present study, 19.1% of women with no or mild diastasis were vigorous exercisers versus 11.8% of women with moderate or severe diastasis. This association needs to be explored further in a study designed to have adequate power to address this important variable. The association of diastasis with Caucasian ethnicity also needs to be explored in future studies. The only other ethnic group of substantial size in the present study was East Asian, largely made up of women of Chinese descent. Chinese women in the present setting tend to live with or associate closely with their extended family, and therefore, may be protected during pregnancy from strenuous household or paid work, which could, in turn, promote diastasis or prevent the complete healing of diastasis from prior pregnancies.

Multiparous women have previously been reported to have an increased incidence of diastasis (Lo et al 1999). Frequent lifting and carrying of young children increases strain on the abdominal wall and increased loading of the already weakened abdominal muscles during pregnancy may favor development of DRA (Barton 2004). In addition, many women tend to employ the Valsalva maneuver when lifting. This puts pressure on the abdominal wall musculature, and can contribute to straining and widening of the DRA (Barton 204). Fatigue may also play a role, making women more likely to assume poor posture or use inadequate body mechanics. Multiparous women

may also be exacerbating diastasis persisting for a prior pregnancy. If separation of the recti bellies persists, even to a mild degree after the first pregnancy, mechanical stresses on the abdominal wall associated with pregnancy combined with additional hormonal effects will probably increase the diastasis.

While larger than other prevalence studies to date, the present study was still limited by its small size. The sample was drawn from a general population of women giving birth in a hospital serving 75% of the population of a major city. This approach, while improving on generalizability, did not sample a referred population as was the case in the present authors' previous work (Lo et al. 1999), and therefore, was not as definitive in its ability to delineate risk factors. For example, there were only 10 women in the present study with multiple pregnancies, making this potential risk factor too uncommon to study in a prospective fashion.

Assessment for diastasis of the recti abdominis should be incorporated into the obstetric care of all women. The influence of ethnicity and culture on diastasis needs to be further explored in order to distinguish between biological versus lifestyle influences. The role of exercise as a protective factor has been reported previously (Lo et al. 1999) and the present findings further support the importance of fitness during pregnancy. Among multiparous women, the emergence of providing childcare during pregnancy as a strong risk factor for diastasis should encourage providers of prenatal care to teach women to guard against undue stress on their abdominal muscles while tending to children.

G. Candido, Department of Physiotherapy, Children's and Women's Health Centre of British Columbia, Vancouver, British Columbia, Canada

T. Lo, City Square Physiotherapy Centre and Fairchild Square Physiotherapy Centre, Vancouver, British Columbia, Canada

P.A. Janssen, Department of Health Care and Epidemiology, University of British Columbia, Vancouver, British Columbia, Canada



Book review-Still Sexy After All These Years? The 9 Unspoken Truths About Women's Desire Beyond 50

By Leah Kliger & Deborah Nedelman

A Perigee Book, Penguin Group, New York, NY, 2006, 219 pages, paperback, \$14.95

ISBN 0-399-53217-X

The authors of this book are a healthcare educator and a clinical psychologist, with a history of counselling, public speaking and publication on the topic of sexual health. Kliger and Nedelman recognized that there was a paucity of information about sexual desire in older women, and over several years, canvassed the views of hundreds of women in the USA using a three pronged approach: a 32-question survey, in-depth interviews and group discussions. They gathered a wealth of information from a diverse group of women – heterosexual and gay; single, married, divorced and widowed; mothers or childless – from a range of racial, cultural, religious, political and socioeconomic backgrounds. Following analysis, discussion and reflection, *Still Sexy After All These Years?* was written. The chapters reflect the nine truths of the title: older women can't be pigeonholed; sexy is different after 50; less can be more after 50; desire can surprise you after 50; masturbation can keep you independent; same-sex relationships don't scare older women; sexual vitality can thrive despite ill health; women over 50 can redefine intimacy; and it's never too late to celebrate your sexuality.

The majority of the text is given over to descriptions of the women surveyed and interviewed (e.g. 'Glenda, a lovely 58-year-old African-American woman' and 'Sadie, Jewish divorcee, New Jersey'), and their thoughts and experiences. As you would expect, these are very diverse. The text is broken every page or two by a box, which might contain a quote from a woman, or on occasion, a joke (the one on page 80 was my favourite, but I'm afraid you'll have to see the book if you want to know what it was!). Some chapters include suggestions (e.g. how to talk to your doctor about sexual issues if you wish to do so) and questions to ask yourself to assess your own sexual self-esteem, and I particularly liked considerations for women buying a vibrator (e.g. are you latex sensitive? How to clean it? Is noise a factor? Do you prefer a zingy feel or a rumbly feel?).

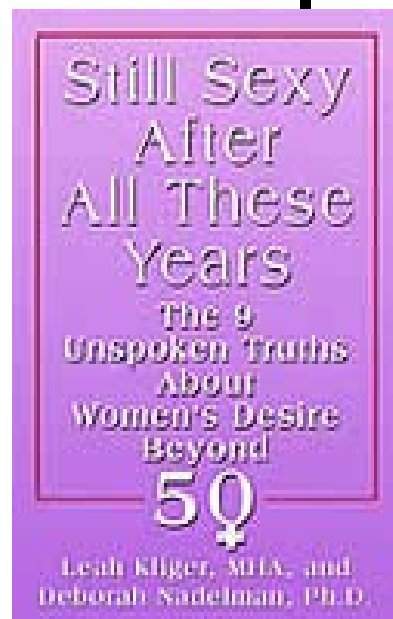
The book also includes (within the text and towards to end) extensive suggestions for further reading and useful websites. There is a comprehensive index, which would help direct women to an area of particular interest.

Since I was reviewing *Still Sexy After All These Years?*, I read it from cover to cover, and I'm sure that there would be some who would choose to do this, whilst others might pick a section of particular interest, and yet others still might prefer to just flick through and read the occasional anecdote. In the right location, this would be an excellent coffee table book. The tone is relaxed, humorous where appropriate, non-medical and non-judgemental. The language is Americanized in places (e.g. flashes instead of hot flushes), but not to the extent that it would be alien to readers within the UK or elsewhere. At times, I would have liked a more formal presentation (e.g. tables or graphs of the authors' findings). In places, the statistics are there, but not always evident. I appreciate that this is my opinion as a health professional rather than a laywoman – possibly the result of reading too many medical journals!

There is mention of incontinence, and I was pleased to see that not only were pelvic floor muscle (Kegel) exercises suggested, but also getting help from a specially trained physical therapist.

I felt the message of this book was summed up in the following passage:

'[W]e have reached the unambiguous conclusion that the loss of sexual vibrancy and self-esteem is *not* an inevitable consequence of growing old. Yes, sexy is different after 50. Desire waxes and wanes, illnesses and injuries impede our ability to engage in sexual activity, partners die or divorce us, and we wonder if it is truly possible to have low libido and still exude sexual self-confidence. But reconnecting with our sexual selves can lead us to an appreciation for the future. The pleasures we can anticipate enjoying into our 90s are not privileges granted only to the young but are rights that



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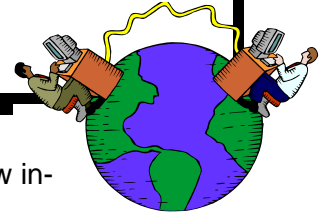
we older women need to seize with confidence. It's neither sinful nor sordid to have desire, nor is it a crime to place the sex act itself in the past if that is what we choose.'

I think that most if not all women within the target audience (and probably many who have not yet reached that age) would find something within this book that strikes a chord with them. This might be the endorsement that their feelings and experiences are 'normal', whether they are currently sexually active, seeking to become so or finding fulfillment within their life by other means.

I feel that *Still Sexy After All These Years?* represents good value for money, and would be a useful addition to the women's health physiotherapist's library. I would be happy to share it with some of the women I advise.

Still Sexy After All These Years? is available via <www.womenbeyond50.com>. Click on the link to Amazon.com.

Gill Brook (aged 50 years and 3 weeks)
Bradford, UK



The following discussion is excerpted from the *IOPTWH listserv* and an example of how informative this forum can be.

Hello everyone,

I have a friend (I have not evaluated her) whose doctor has recommended surgery for her diastasis as soon as possible. She delivered twins in mid July, babies were 5 lbs 15 oz and 5 lbs 6 oz. Per self report she has 4 finger width separation (previously 5) at the umbilicus and has had "significant" LBP since mid Sept when the babies topped 12 lbs each.

She has been doing abdominal binding with head lift and will be scheduling an evaluation with a local PT experienced in women's health.

My questions are:

- 1. Does anyone know of solid research regarding surgery for post partum diastasis*
- 2. Has anyone had a patient/patients who have undergone this procedure*

Much thanks.

'One of the responses was forwarded from an existing case study with similar findings'

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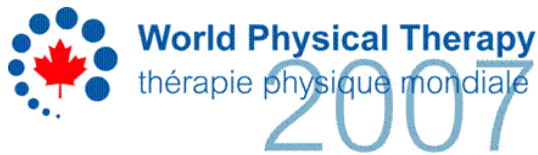
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The primary task of a joint complex is to effectively transfer load during static and dynamic activities. Optimal load transfer or stability, is dependent upon several components; form closure, force closure, appropriate neuromuscular control of the closure....

(Continued on page 12)



World Physical Therapy 2007 Clinical Visits and Optional Social Programme and Tours Announced

Clinical Visits

The Local Organising Committee has arranged for public and private institutions in the Physical Therapy Care field to open their doors to visits by WCPT attendees. You can register for a visit by area of interest. The women's health facility is currently scheduled to be BC Women's Hospital where there is active involvement of physiotherapists in the spectrum of care across programs.

For full details including the participating institutions and areas of interest please visit <http://www.wcpt.org/congress/programme/clinicalvisits.php>

Optional Social Programme and Tours

Of course no Congress would be complete without a social programme.

A variety of social events that showcase the diversity and richness of Canadian culture have been planned along with optional tours that are available both pre and post Congress as well as during Congress. These tours will provide an opportunity to experience the natural beauty of Vancouver and the surrounding area.

Find full details of the social events and tours at <http://www.wcpt.org/congress/social/index/php>.

Don't forget that full details of all **registration fees**, plus online registration and hotel booking are available at www.wcpt.org/congress.

IOPTWH Events

The IOPTWH is pleased to announce a pre-congress course on osteoporosis and that the business meeting on Monday, June 4th will be followed by a reception open to delegates from the member countries and Friends of IOPTWH. Details will be available closer to the date.

The Congress program has many women's health topics, posters, platform presentations and workshops so watch the WCPT website for more specifics and plan to attend.



Video Review-Pilates for Moms by Lindsey Jackson

www.enhance-wellbeing.com \$25.00

This DVD is created by a Pilates instructor with input from a Yoga instructor and a women's health Physiotherapist all from the UK. It is broken down into four sections (exercises, yoga breathing, relaxation and ask the expert). The DVD has been endorsed by the UK Association of Chartered Physiotherapists in Women's Health. The DVD plays well on a lap top and IBM desk top. I had a little trouble pausing and restarting. This is may be helpful as some of the sections are long and it may be necessary for the new mom to stop and start.

Exercises are divided in to four section (0 to 6 weeks, multilevel warm up, 6 weeks to 4 months, and 4 months and beyond). Each section is approximately 30 minutes long and includes a good mix of stretching, strengthening, pelvic floor, abdominals. All well instructed and of appropriate difficulty. It is easy for Pilates to become too hard (especially for post partum women with poor core stability); Lindsey has done a great job of providing an appropriate level of difficulty with a well rounded program and good instructions.

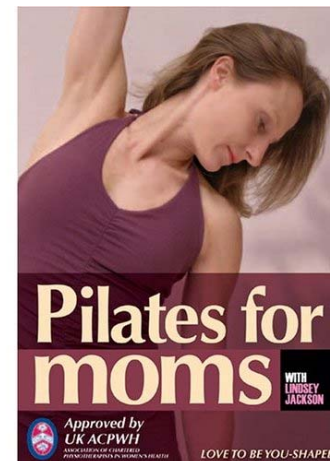
The first exercise section is for women 0 to 6 weeks post partum. All women are encouraged to start with this section even if they have been delivered longer than 6 months. This section is a one-on-one instruction in topics and exercises very appropriate for this stage. Instruction in diastais measurements is well done but the visual is only fair. Patients are encouraged to see a PT or DR if the separation is 2 or 3 fingers. Exercises are very gentle and include: posture and neutral spine, upper back, low back stretch, abdominal contraction, pelvic tilt, quad stretch and bent knee fall out abdominal contraction. Pelvic floor muscle contractions are verbally instructed with a written disclaimer that the best way to test is with a finger palpating inside the vagina.

The multilevel warm up is about 16 minutes. It is also a good start for beginners. The routine is done by three ladies (all thin) each performing a different level (beginner, intermediate and advanced). Instructions are clear and safe. The next section (6 weeks to 4 months) shows easy and intermediate techniques. And the third section (4 months and onward) shows intermediate and advanced techniques.

The yoga breathing is approximately 8 minutes long and does a very good job of instructing diaphragm breathing. The relaxation section is 10 minutes long and also does a great job at instructing relaxation and breathing. Both these sections are very well done and could be used by prenatal as well as the general population. Ask the expert is a 15 minute discussion with a women's health physiotherapist discussing pelvic floor muscle exercise and body mechanics. Patients are encouraged to seek PT input and the APTA SOWH web site is listed.

The DVD was created in the UK and all of the ladies have an English accent. Some of the terms used are specific to that local and may be a bit difficult for some in the US. Most of the ladies in the DVD are thin, this may discourage some who are not thin. Patient testimony is interspersed throughout. Overall, I would highly recommend this DVD for postpartum women in general and in conjunction with PT.

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UPCOMING EVENTS



This year the International Continence Society Meeting is in Christchurch New Zealand, Nov 26 – Dec 2. There are many pre-conference workshops and conference presentations of high level interest to pelvic floor physiotherapists.

The ICS meeting so rarely appears in the Southern Hemisphere, it is a great opportunity for northern hemisphere physiotherapists to visit this part of the world and gather for this excellent event. The website to visit is: www.ics2006.co.nz

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TREATMENT (used in the case scenario)

As indicated in the objective findings (the client) initially presented with two major deficits in her force closure mechanism; first an inability to activate her transversus abdominis and pelvic floor muscles and secondly a significant deficiency in her midline abdominal fascia in the form of a diastasis.

Treatment has focused on optimizing the force closure of the right sacroiliac joint. This has involved three components.

1. Improve the ability to isolate and then control the muscles that make up the deep stabilizing system. In particular our focus has been on the pelvic floor and transversus abdominis musculature.
2. Decrease the hypertonicity found in the global muscle system.
3. Use of external means to compress the sacro-iliac joint during functional activities, particularly those which involve vertical loading...

Interestingly, when the fascia deficit is held closed and (the client) recruits her deep stabilizing muscles the stability tests of the right sacro-iliac joint are normalized. This would suggest that surgical closure of the fascial deficit should result in considerable improvement in the stability of the (SIJ and lumbar segments) preventing future exacerbations of low back pain and restore (her) functional ability.

Good luck.

Another theme in responses was....

What strikes me about this is the advice to have the procedure "as soon as possible". I've known a few women who had the surgery and did quite well, but each of them tried conservative measures for a few years (off/ on therapy and exercise) first. Is there a hernia present that would make this more urgent? If not, I'd advise her to try therapy for a good while- most 4 finger diastases heal up just fine.

