



# International Organization of Physical Therapists in Women's Health

A sub-group of WCPT



## EXECUTIVE TREASURER'S REPORT



Dear Friends and Colleagues,

I am delighted to have this opportunity to deliver an extended report, and allow President, Jill Boissonault a well-deserved rest. I hope my offering compares favourably with her past contributions. I shall update you on my activities as Treasurer, and also appeal for your help – so please read on!

The weeks following our conference in Slovenia were a busy time for me. There was cash to be banked, bills to pay, sponsorship money to be collected, and receipts to issue. Being an international group, this involved not only GB pounds, but also euros and Slovenian tolar. Thank goodness for online currency converters! Thanks to the generosity of our sponsors, and the delegates' fees, little if any Organization money was required to cover the costs of either the conference itself, or the executive meetings we held in Ljubljana.



The role of the IOPTWH Treasurer is not an arduous one, though it does require my regular attention. Annually there is, of course, a call to the member countries for their dues, followed by some 'gentle' reminders until they have all been paid. This money is our lifeline. Although we hope that we shall always be able to attract sponsorship for our courses, there is often an initial outlay necessary before such monies and delegate fees have come in. Then, of course, there are our regular outgoings including the production of this newsletter, management of the website, and pay for our administrative secretary.

So, a big **thank-you** to those responsible for paying your country's dues. Remember that this year's are due by 31<sup>st</sup> March. I have already contacted the chief delegates and will be sending out a reminder soon.

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As reported in the last newsletter, I agreed to take over the role of Chair of Publications and 'webmaster' following Beth Shelly's resignation last September. I would welcome any ideas for the website. I am happy to monitor the content, and postings on the listservs, but I am sure there is huge potential for further development. Can you help? Do you have experience of developing a website? If so, please contact me. Coincidentally, I have recently been contacted by a company who are interested in sponsoring the site, and this will be discussed by the executive committee.



Plans are well under way for our next conference, to be held in conjunction with the WCPT Congress in Vancouver next year. Once again, sponsors will be sought. If you know of any potential benefactors – possibly companies involved with osteoporosis care – please let me know. It promises to be an exciting Conference and Congress, and I look forward to meeting some of you there.

In my other role of chief UK delegate to IOPTWH, I can report that our national group, the Association of Chartered Physiotherapists in Women's Health (ACPWH) is thriving. We are one of the oldest clinical interest groups of the Chartered Society of Physiotherapy, and will celebrate our 60<sup>th</sup> anniversary in 2008. We have approximately 700 members who fall mainly into the categories of 'affiliate member' or 'member'. The latter must have completed a recognised course or been accepted by submission of portfolio. We also have a sizeable overseas membership, several of whom have attended our annual conference. If you would like further information about the Association please visit [www.acpwh.org.uk](http://www.acpwh.org.uk)



Happy reading,

Gill Brook  
IOPTWH Treasurer



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## FEATURE ARTICLE INTRODUCTION: WOMEN'S CARDIAC REHABILITATION

'Women's Health' is more than incontinence, osteoporosis, breast cancer and pregnancy related issues. Any condition that disproportionately affects women or is worse in women should be considered a women's health issue. It is not just **what** we do that makes a Women's Health physiotherapist special but **how** we do it that sets us apart from others. Being able to respect and accommodate women's social responsibilities/expectations and emotional needs into delivering client-centered care for biological issues is essential in delivering comprehensive, effective and well attended programs.

The following article is an excellent example of how the Principles of Women's Health can be used effectively in cardiac rehabilitation program development, evaluation and delivery. The Principles the Women's Cardiovascular Health Initiative embodies are transferable to other biological conditions and program frameworks. The body of the article is largely excerpted directly from an original article in the *Canadian Journal of Cardiovascular Nursing* with the addition of expanded pieces on the role of the physiotherapist within the program and its development and evolution.

Happy reading,  
Debbie Childerhose, PT with the Women's Cardiovascular Health Initiative (WCHI)  
Mireille Landry, PT with the WCHI  
Shannon Michels, IOPTWH Newsletter editor

## **WOMEN'S CARDIAC REHABILITATION: IMPROVING ACCESS USING PRINCIPLES OF WOMEN'S HEALTH**

Jennifer Price, RN, MScN, ACNP; Mireille Landry, BScPT, Danielle Rolfe, BPHE, Faith Delos-Reyes, BPHE, Libby Groff, RRT, BHA, and Leonard Sternberg, MD, FRCPC

Excerpted from *Canadian Journal of Cardiovascular Nursing* (2005) 15:3, 32-41

There is growing awareness among health care providers, government and community organizations that sex and gender are relevant to issues of health. Cardiovascular disease (CVD) is one area that has been in the spotlight with respect to sex and gender differences. The myth that CVD is a 'man's disease' has been thoroughly debunked and it is now acknowledged that CVD is the number one killer of women in Canada. Despite this, cardiac rehabilitation (CR) programs are largely under-utilized by women. **This paper (the original article) presents a case study of a CR program in Toronto and describes how one hospital has used their Principles of Women's Health (PWH) to address barriers to CR for women. The Principles of Women's Health are described, program elements that embody these principles are reviewed and implications for the future of CR for women are discussed.**

In response to contemporary issues in women's health care, the Women's Cardiovascular Health Initiative (WCHI) was developed, opening its doors to women in 1996. It runs out of Women's College Hospital in downtown Toronto, Ontario. The WCHI is a unique, comprehensive CR program for women only, developed to assist women with the integration of necessary lifestyle changes into their daily routine. During the development phase of the program, individual interviews and focus groups were conducted with approximately 100 female patients. The overwhelming response was that women wanted to meet other women with CVD, and were looking for support, education and safety. These findings, hospital stakeholder input and expert opinion from CR professionals in Toronto were then used to develop the content of a CR program for women, that was guided by the PWH.

Two different outpatient programs, CR and primary prevention (PP), are currently offered and are based on the input of women involved in the development phase. The PP program is designed to reduce patient cardiac risk factors and includes a three-month exercise program, while the CR

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program aims to increase the functional capacity of women with a cardiac diagnosis and includes a six-month exercise program. Both programs include group education classes and individual counseling to provide patients with CVD education, individualized exercise prescription and training, psychosocial support and links to community resources. The PWH are integral to the delivery of these services.

## **APPLICATION OF THE PRINCIPLES OF WOMEN'S HEALTH**

### **EMPOWERMENT**

Empowerment involves the disruption of an inherent power structure such that less advantaged groups or individuals. (including women) mobilize power to their advantage (Currie and Wiesenberg, 2003). Raeburn and Rootman, 1998). Empowerment is a tenet intrinsic to the goals of the women's health movement (Stein, 1997). Empowerment of women involves informed participative decision-making, community input and includes continuous quality improvement based on input from its users (Lippman, 1998). Relationships, respectful partnerships and women's sense of program ownership are essential to women's health and wellness (Raeburn and Rootman, 1998). Theories of women's empowerment are often not put into practice, particularly within a health care system that has originated from a male, biomedical mode. Unfortunately, many women remain reluctant to make their own decisions, and feelings of powerlessness have led many women to be dependent on their male physicians, partners and or parents to make decisions affecting their own health (Currie and Wiesenberg, 2003).

The acquisition of independence and autonomy is fundamental to women's empowerment if women are to take control of their health and be active decision-makers directing the course of their health care. Cooperation and interdependence between health care providers and women is required in order to increase women's knowledge, initiate action and to effect necessary improvements in women's health. Women's em-

powerment in health necessarily involves the validation and valuing of women's experiences is actively sought with the perspective that each woman is an expert on her mental and physical experiences, and that she best appreciates her self-identified needs. Health professionals can contribute to women's empowerment by facilitating instead of directing women's decision-making.

Given this perspective, it must be considered that women accessing health care providers are seeking the information and knowledge required by them to make informed choices relevant to their capacity to engage in practices to improve their own health (Currie and Wiesenberg, 2003). Health professionals can enable women to control and improve their health by helping women to explore and identify their personal preferences, motivations, competencies and skills with which they can address their personal lifestyles and situation. Furthermore, professionals play a role in collaborating with women to identify, articulate and address the barriers they face in constructing healthful lives. Empowerment of women can thus only be achieved if the traditional hierarchical structure of the health care sector is transparent and open to change. While we recognize the institutions/programs hold the balance of power, it is used positively to advocate for our individual clients and groups (Raeburn and Rootman, 1998). For example, the nurse practitioner at WCHI assists patients obtain referrals by advocating for them, by communicating directly with their GP's regarding health concerns, as well as obtaining referrals to high-demand health care programs and services beyond CR.

The physiotherapist acknowledges the multiple roles, responsibilities and experiences that women bring with them into the program, and uses that when developing lifestyle modification tactics. It is important to be sensitive to the context of their lives when they enter the program and collaboration with the women is key to identify, articulate and address the barriers they face in their rehabilita-

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tion efforts. The team physiotherapist facilitates personal goal setting, rather than dictates client's goals. Also, our physiotherapist is busy with attending many annual Women's Health events promoting women, heart health and healthy living to a variety of community groups.

#### BROAD DEFINITION OF HEALTH

As stated earlier, the philosophy of health care for women has evolved from a reproduction-centred medical model to a broader biopsychosocial model of women's health. This broad definition of health care includes disease prevention and health promotion programs, flexible models of care and the provision of care appropriate to different stages in a women's life cycle. There is a focus on independence and wellness as defined by women, with recognition that health is more than the absence of disease or disability, but is rather the maintenance of psychosocial well being in addition to physical health. Traditional and complementary practices are also supported through innovative, flexible approaches to care.

The WCHI offers both Primary Prevention (PP) and CR programs, so that any woman can access the program regardless of experiencing a cardiac event. Within the CR stream, all cardiac diagnoses are eligible for participation and are not limited to acute events. Within both the CR and PP programs, the focus is not only on CV health, but included other health concerns, such as breast health, osteoporosis, incontinence and body image. Lifestyle changes are encouraged within the context of each woman's life experiences, though there is an appreciation that there may be an interaction among many of the determinants health, with social processes either aggravating or improving health impacts. The highly interactive nature of the determinants of women's health may be illustrated by an example. Stress has adverse physical outcomes for both men and women but, in many cases, may have particular origins in women's social-structural roles. Stress can be occasioned both by the financial pressures of pay inequity and single parent-

hood, and by the double burden of paid and unpaid work, which, in turn, may lead to time stress and unhealthy lifestyle behaviours. In this case, a wide range of health determinants, including employment, income, gender, lifestyle, marital status and stress may interact to produce physical health problems. This indicates clearly that these indicators should not be seen in isolation, but as highly dynamic and interactive (Health Canada, 2003)

Disease prevention and health promotion programs are key elements top the rehab program. We acknowledge that many women referred to the program may have other comorbidities that they are dealing with. Our physiotherapist addresses psychological, physical and social issues as appropriate. Formal and informal education is provided, encompassing broad health topics such as risk factor management, osteoporosis and osteoarthritis prevention, and maintaining inde-

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#### **The Definition and Principles of Women's Health**

*Sunnybrook and Women's Definition of Women's Health:* Women's health involves women's emotional, social, cultural, spiritual and physical well-being and is determined by the social, political and economic context of women's lives, as well as by biology. This broad definition recognizes the validity of women's life experiences of health. Every woman should be provided with the opportunity to sustain and maintain health as defined by that woman herself to her full potential.

Source: Originated by the McMaster University Women's Health Office. Adopted by Health Canada and by the Gender Issues Committee of the Council of Ontario Faculties of Medicine.

*The Principles of Women's Health are* empowerment, accessible programs, broad definition of health care, high quality of health care, collaborative planning, innovative and creative approaches.

## PREVENTION AND MANAGEMENT OF OSTEOPOROTIC FRACTURES

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.



### Speakers

#### **Meena Manindra Sran PT, Ph.D.**

- Education-Simon Fraser University, Burnaby, BC Faculty of Applied Science, Injury Prevention & Mobility
- Laboratory-CIHR and MSFHR Post-doctoral Fellow
- Clinical Experience-BC Women's Hospital & Health Centre, Osteoporosis Program, Physiotherapist, Vancouver, BC
- Manuscript Reviewer for the *International Journal of Sports Medicine*, *Physiotherapy Canada* and *Clinical Biomechanics*
- International Organization of Physical Therapists in Women's Health, official sub-group of the World Confederation for Physical Therapy, Executive Committee, June 2003- present
- Chief Delegate for Canada to the International Organization of Physical Therapists in Women's Health (2000-2003)
- Women's Health Division of the Canadian Physiotherapy Association, Executive Committee

#### **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

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pendence and wellness with age. Formal and informal education is provided. Acceptance on alternative health treatments is provided as well as education on evidence-based protocols.

### ACCESSIBILITY

Accessibility of programs, through flexible schedules, sensitivity to cultural and language issues and self-referral to programs as appropriate, is an essential principle of women's health. Accessibility is operationalized at the WCHI by being conveniently located downtown and accessible by public transportation, offering clients flexible hours and schedules (i.e. morning, afternoon and evening classes) and short wait times for initial assessment and enrolment. Subsidies for program cost are provided for low-income clients so that no one is denied participation or care be-

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**Friday June 1, 2007**  
**Prevention and Management of Osteoporotic Fractures**

Presenter: Meena M. 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

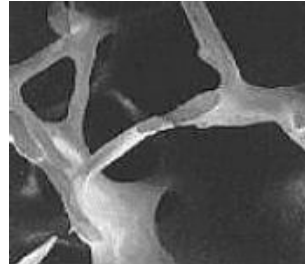
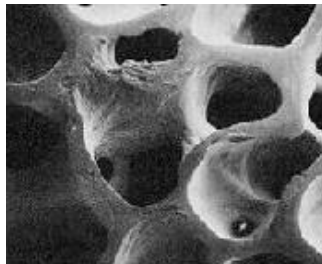
2:15-3:00: Impact of Fractures (including clinical vs. radiographic)

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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cause of financial constraints. Interpreters are also available for participants who do not speak or understand English. The core education workshops are offered during each separate class time in order to allow women to attend without having to disrupt schedules, and special topics are offered on alternative days and times over the course of a year.

Community outreach has been one avenue that we have been involved in. For one example, one of our physiotherapists has gone and done talks at a local South East Asian Centre, providing education regarding risk factors for heart disease and benefits of exercise. Acknowledging that navigation through the Canadian Health Care system can be hard for new immigrants, access to the program and services are explained. Accessibility is also demonstrated through flexible hours and schedules, sensitivity to language preferences (using multiple language health education in-

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formation when appropriate), and subsidies of cost of the program. We have a convenient location, short wait times and easy to get to by public transportation.

#### HIGH QUALITY CARE

Canadian women have questioned some of the fundamental approaches to how health care services are delivered and may professionally accepted assumptions of 'high quality care' (Tudiver and Hall, 1996). High quality of care refers to care that is compassionate, empathetic and that acknowledges the choices individuals make based on their own unique experiences and perceptions. However, women routinely identify: differentials of power and authority between the roles of doctor (both male and female) and patient, feeling intimidated to question professional expertise or refuse treatment; sexist and paternalistic attitudes and behaviours that may influence interactions with male doctors and may affect treatments (such as referral for cardiac diagnostic testing or rehabilitation; severe time constraints on most medical encounters which limit communication between patient and caregiver; lack of sufficient information and access to resources to make informed decisions about proposed treatments and fragmented care so that a patient feels she is no more than the sum of her body parts (Currie and Wiesenberg, 2003; Health Canada 2002; Tassone et al, 2004; Tudiver and Hall, 1996).

At the WCHI, clinical services and facilities are designed to be women-centred and care is evidence-based. In practice, this care includes an hour-long intake assessment with the nurse practitioner (NP), a full medical history, physical and medical examination and exercise treadmill test and personalized orientation once enrolled in one of the programs. A cardiologist reviews the case with the NP and acts as a consultant for the program.

One of the physiotherapist's roles is to develop and supervise the exercise classes. These are informal and highly interactive within a small

group setting (eight to nine women). Exercise Specialist are also utilized in the exercise sessions. This high participant to exercise staff ratio (4:1) is maintained in order to optimize opportunities for social and supportive interaction during the class sessions, an element of programming that is often taken for granted but, for women is the most valued (Lensky, 2003). The comprehensive exercise program is designed to provide personal, supervised treatment within a non-competitive atmosphere. Aerobic activity, the primary focus of the program, is performed in short bouts with frequent, short rest breaks between exercises (circuit training). Strength training is introduced to participants using body weight, free weights, Therabands', tubing and stability balls. Significant attention is paid to exercise safety and movement skills such as flexibility, coordination, posture, core stability and balance as these skills relevant to many women who may be postmenopausal, at risk for or living with osteoporosis and for whom falling can be life-threatening if they often live or travel alone (Stevens and Olson, 2000). In addition, the majority of the CR participants are older with co-morbidities that require them to exercise at low to moderate intensity with an emphasis on strength training, a factor that may play a large role in women maintaining their independent living (Arthur, H personal communication, 2005, Pollock et al, 2000). Methods of stress reduction are also practiced and include progressive muscular relaxation, deep breathing and mediation.

#### COLLABORATIVE PLANNING

The principle of collaborative planning is demonstrated by the provision of health care by an interdisciplinary team in conjunction with community partnership with the participant as an active member of the team. The WCHI team comprises cardiologists, a NP, physiotherapists, exercise specialists, a respiratory therapist, registered dietitian, social worker and the participant. This team collaborates with a commitment to the philoso-

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phy of women-centred care, guided by client-identified goals. Collaboration is initiated at the intake appointment with the participant as they are asked for their expectations of the program and their health-related goals. Staff communicate with each other in either a formal client case meeting or on an individual referral basis with a women-centred framework at its core. Participants are linked and referred to internal and external programs with the larger health care system. These programs and services include smoking cessation, health weight management, nutrition and social work counseling, cognitive behavior therapy, mental health and diabetes education programs. Throughout a client's participation in the WCHI, these programs are recommended and discussed as appropriate. Women may request a referral (or self-refer if available) to these programs at any time during or after their participation. All client updates and information pertaining to test results and progress are communicated to their referring physicians upon intake, at mid-term, discharge and follow-up assessments. Participants are also connected within the community to continue their health and fitness goals. This is an active process starting at entry to the program and allows each client to actively engage in the process of finding programs and services in the community to assist her in maintaining a heart health lifestyle. Community links may be culturally and language specific and may include walking and exercise programs, community centers, women's only facilities, social services and support groups.

In this cardiac rehab setting, we provide an informal, highly interactive small group setting that is protected and safe, compassionate and empathetic. Individual choices made by clients, based on their own unique experiences and perceptions, are respected. A non-competitive atmosphere encourages a personalized exercise program that emphasizes exercise safety, monitoring, movement skills, variety and enjoyment of exercise, minimizing discomfort and musculoskeletal injuries. Our physio takes the appropriate length of time for an intake assessment and orientation followed by goal setting

once enrolled in the program.

All clients updates and information pertaining to test results and progress are communicated to their referring physicians upon intake, at mid-term, discharge and follow-up assessments. A close interdisciplinary team communicates frequently regarding client's care and our physiotherapist is a key player in asking clients what their expectations of the program/treatment and their health related goals are as a commitment to the philosophy of women-centered care. Participants are also connected within the community early on in the program to assist them in a successful transition at discharge while continuing their health and fitness goals.

#### INNOVATIVE AND CREATIVE APPROACHES

The final principle of women's health is to be innovative and have creative approaches to current women's health and research issues. For example, by embracing a broader definition of health and using the concept of empowerment one can facilitate innovative and creative approaches to developing and implementing services and research that considers gender issues. Using unique models of care for disease prevention and health promotion, appropriate to different stages in a woman's life and her experiences, can also lead to alternative methods of providing quality health care. The WCHI exemplifies this principle. A gender lens is applied to all research in which the WCHI is engaged. The WCHI incorporates into its practice the findings of current scientific literature on women and CVD, thereby offering evidence-based care. This is established by providing care under current guidelines for CR and CVD prevention and risk factor identification and management. Evidence specific to cardiac care for women is sought out and used when available. Innovative and creative strategies provide risk factor and lifestyle modification through women-focused content and delivery.

A gender lens is applied to all research re-

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viewed for evidence-based client care. Women's health research at the WCHI strives to shape research and services of women, rather than to reshape women to fit established models of care. We also provide risk factor and lifestyle modification through women-focused content and delivery. An example, would be to education about immersing risk factors that are sensitive to women, handout material is geared toward women's preferences.

Consideration of gender-specific variables should be realized and incorporated into any clinical practice. We feel that physiotherapists are ideally suited to understand and implement the Principles of Women's Health. "Physiotherapists are independent and caring individuals who seek to provide safe, quality centered services that respect the autonomy and dignity of the recipient through a commitment to service availability, accessibility and excellence." (CPA website)

## **DISCUSSION**

Consideration of gender-specific variables when designing and implementing CR and PP programs at the WCHI has led to significant improvements in women's exercise capacity and quality of life. Though the WCHI sees fewer clients per year than average CR programs, outcome measures and compliance rates are noteworthy. From November 1, 1996 to May 31, 2004 the compliance rate for both groups was 85%, much higher than previously reported (Boogaard, 1984; Oldridge, 1988). These statistics are encouraging for the development of programs similar to the WCHI but language and education level barriers continue to exist.

## **CONCLUSION**

The Principles of Women's Health reflect women's values in health care practice. The WCHI has embraced these principles in order to provide a unique service that is sensitive to women's needs. As a result, the program is able to accommodate women facing typical barriers to CR and exercise (i.e. referral bias, busy schedules, care-taking responsibilities). Consideration of these principles should be incorporated into the development of similar CR and PP programs. There may be a greater benefit to women involved in a women-only CR program where disparities in women's health and access to CR may be identified and eliminated. It is the success of programs like the WCHI that will serve to encourage other health care providers, especially Physiotherapists, to take the lead in forging the gap between women's health and CR care. It also demonstrates how the PRW can be implemented to a multi disciplinary program for other women's issues such as continence and osteoporosis. We feel that physiotherapists are a well-rounded profession that utilizing the women' health principles would come naturally.

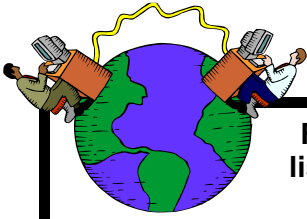
### **PHYSIOTHERAPY PRACTICAL POINTS:**

The CJCN article presents a case study in which reflection on the gendered nature for the care environment led to the development of an innovative and highly successful cardiac rehab and primary prevention program. The description of the development of the program educates readers about the principles of women's health while providing an example in which the principles are applied to serve women's interest in an outpatient, cardiovascular care setting. Many practical elements can be taken away by physiotherapists, and can be applied to a range of health issues in a variety of settings. The following practical elements illustrate how the physiotherapists at the WCHI implement the Principles of Women's Health.

Any questions can be sent to the authors at:

Mireille.Landry@sw.ca or Debbie.Childerhose@sw.ca





Following are examples of the benefits of participating on the IOPTWH listserv's. These examples only contain one to two responses, but as demonstrated, have readily applicable suggestions.

----- Original Message -----

**From:** JH

**To:** pelvicpain@ioptwh.org

**Sent:** Monday, February 27, 2006 7:43 PM

**Subject:** {IOPTWH-Pelvic list} an article

Hello all-I am looking for some information for a local women's group, could someone list or forward to me an article about the correlation of doing Kegels and having stronger orgasms?

Thanks for the help. **J. USA**

**Response 1.**

Bo K, Talseth T, Vinsnes A., Randomized controlled trial on the effect of pelvic floor muscle training on quality of life and sexual problems in genuine stress incontinent women. Acta Obstet Gynecol Scand. 2000 Jul;79(7):598-603.

Beji NK, Yalcin O, Erkan HA The effect of pelvic floor training on sexual function of treated patients, Int Urogynecol J Pelvic Floor Dysfunct. 2003 Oct;14(4):234-8

Chambless DL, Sultan FE, Stern TE, O'Neill C, Garrison S, Jackson A. Effect of pubococcygeal exercise on coital orgasm in women J Consilt Clin Psychol1984: Feb;52(1): 114-8

Graber G. & Kline-Graber G. Female orgasm: role of the pubococcygeus muscle. J Clin Psychiat 40:348-351 1979.

Good luck. **TYR, Israel**

**Response 2.**

**J,** Here is the "classic reference" on PFM and sexual function. I have not done a literature search recently on the topic. A lot of the literature relates dysfunction to poor sexual appreciation.

Kegel, A. (1952). "Sexual Functions of the Pubococcygeus Muscle." West. J of Surg Ob and Gyn Oct: 521-524.

**KW, USA**

-----Original Message-----

**From:** moderator@ioptwh.org [mailto:moderator@ioptwh.org]

**Sent:** Thursday, February 09, 2006 3:43 PM

**To:** pelvicpain@ioptwh.org

**Subject:** Re: {IOPTWH-Pelvic list}

\*International Organization of Physical Therapists in Women's Health\* Pelvic Pain LISTSERV

Hi, I have a patient who is one week post partum who has difficulty walking. She says her left lower extremity feels dead and heavy. She hip hikes on that side and drags her leg. Pain is in the groin and down the entire leg. She walks like a person who has CP. Her leg also feels heavy. This problem started 1 week prior to delivery. Normal vaginal delivery. She cannot really walk unaided. She is unable to lift her left leg, has difficulty bridging, and with any movement that involves the lower extremities. She had a left upslip which I balanced with M.E. techniques. Working on the piriformis seems to be a key area. The hip joint also seems to be painful. Any thoughts or ideas appreciated. I have only seen her twice.

**S**

**Response 1.**

I have seen a patient with similar complaints. She had obturator nerve injury from delivery. Unfortunately, she moved out of state and I do not know how her treatment outcome. Here is a great link for nerve entrapments that create many pelvic pains- let's hope your patient doesn't have nerve damage, but look for it early.

<http://www.emedicine.com/orthoped/topic422.html>

## UPCOMING EVENTS



Athens will host the **31st annual meeting of the International Urogynecological Association**. It will be an outstanding opportunity to learn about new developments in Urogynecology, to meet old colleagues and to make new friends. Athens will provide the perfect background for the scientific program and social activities of our congress.

Our hosts in Athens under the direction of Dr. Stavros Athanasiou together with the Scientific Committee of IUGA under the chairmanship of Dr. Heinz Koelbl, are putting together an attractive program of workshops, lectures, debates, and oral, poster and video presentations. One highlight will certainly be this year's Ulf Ulmsten lecture with the title "The rise and fall of surgical procedures" given by Dr. Karl Tamussino.

The IOPTWH Executive Committee and Programs Committee are excited to announce Dr. Meena Sran and Dr. Kathy Shipp as speakers on the Prevention and Management of Osteoporotic Fractures as a course at WCPT, Vancouver 2007. Continue to check this website for registration and further details as they become available.



**The Association of Chartered Physiotherapists in Women's Health**, [www.acpwh.org.uk](http://www.acpwh.org.uk) is excited to announce the Annual Conference, 22 – 24 September 2006. The theme for this year is "**Hormones to Happiness**" at The Copthorne Hotel, Cardiff. For further information or application forms please contact: Stacy Martin, Fitwise Management Ltd, Drumcross Hall, Bathgate EH48 4JT Tel: 01506 811077 fax: 01506 811477 email: [stacy@fitwise.co.uk](mailto:stacy@fitwise.co.uk).

IOPTWH is considering a new mission and strategic plan, and the Executive Committee needs your input! Chief Delegates will receive a draft very soon with a request for comments due back to the Executive Secretary's office in early fall. Help us make this a document that pleases all our member organizations by participating in the process!



**Sincerely,**  
**Jill Boissonnault, President IOPTWH**

## EXCITING OPPORTUNITIES AWAIT YOU!!!!



### ELECTIONS!

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!

