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Poster digest

Introduction

The 2016 POGP Annual Conference in Liverpool attracted a fantastic array of posters, some of which were published in the Spring edition of the journal. We are delighted to publish four more here, including one co-authored by Natasha Chesler and Lisa Heald that won the POGP poster competition, and formed the basis of their full-length paper published in this issue (see pp. 59–63). We have printed short summaries and thumbnail versions of each poster. The full-sized versions can be viewed on the POGP microsite (http://pogp.csp.org.uk/). Congratulations to everyone who presented posters at Conference.

Shirley Bustard
Clinical Editor

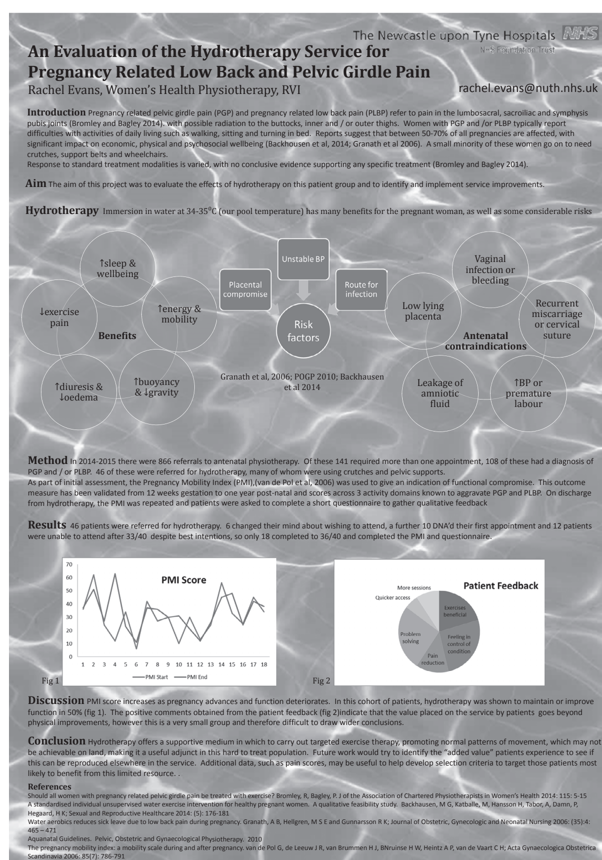

Figure 1. "An evaluation of the hydrotherapy service for pregnancy related low back and pelvic girdle pain" poster.

An evaluation of the hydrotherapy service for pregnancy-related low back and pelvic girdle pain

The terms pregnancy-related low back pain (PLBP) and pelvic girdle pain (PPGP) refer to types of pain that are located in the lumbosacral, sacroiliac and symphysis pubis joints (Bromley & Bagley 2014), and may possibly radiate to the buttocks, and/or the inner and outer thighs. These common complaints affect up to 70% of all pregnant women (Backhausen *et al.* 2014). Simple activities of daily living, such as dressing, turning in bed, sitting and walking, are frequently affected, and PLBP and PPGP may have an impact upon individual's economic, physical and psychosocial well-being (Granath *et al.* 2006; Backhausen *et al.* 2014). For a small number of women, these effects can be significant, and supportive measures such as crutches, support belts and wheelchairs may be required.

Patient responses to standard modalities, such as exercise, lifestyle modifications, acupuncture and mobilizations, are mixed, and there is no conclusive evidence to support the use of one method over another (Bromley & Bagley 2014).

The combination of reduced axial loading that results from immersion and buoyancy indicates that exercise in water is a safe option for pregnant women since both the spine and pelvis are supported (Waller *et al.* 2009), and having access to a hydrotherapy pool has enabled the present author's department to develop this service. Women who do not respond to simple exercise and lifestyle advice, require extra support and are unable to walk unaided without limping, have a visual analogue scale pain score of ≥ 7, and have high scores on the Pregnancy Mobility Index (PMI) (Van de Pol *et al.* 2006) are targeted. A review of those individuals who completed hydrotherapy was carried out in order to determine the progress of the condition, and establish how much patients value the service.

Hydrotherapy is poorly reported in this population. Studies tend to focus more on "aquanatal" or "water aerobics" classes, which generally emphasize group sessions or self-management, and cardiovascular exercise, and are aimed at the general population of pregnant women rather than those with more-limited mobility (Granath *et al.* 2006; Smith & Michel 2006; Backhausen *et al.* 2014). However, the literature indicates

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that pregnant women experience improved mobility (Smith & Michel 2006) and report reduced sick leave (Granath *et al.* 2006).

The present service was initially set up in accordance with the Association of Chartered Physiotherapists in Women's Health (now Pelvic, Obstetric and Gynaecology Physiotherapy) aquanatal booklet (ACPWH 2010), local departmental guidelines, discussion with local obstetric consultants, and Royal College of Obstetricians and Gynaecologists exercise guidelines (RCOG 2006). Following a risk assessment related to the temperature of the pool (34–35 °C), it was decided that the service would not be offered to women who had not received their 20-week scan and had their placental lie confirmed. It is acknowledged that there is no evidence to suggest that there is an increased likelihood of bleeding as a result of the increased pressure and thermal changes resulting from immersion in warm water, but the practicalities of managing a bleed while in the pool influenced the decision to not offer hydrotherapy to any women to whom this applied. If the placenta has moved by the time of rescanning at 32 weeks, then hydrotherapy will begin at that stage, should this be clinically indicated. In the meantime, "standard treatment" is given.

Hydrotherapy requires one qualified member of staff and an assistant to run the session. Everyone is assessed prior to entering the pool to confirm that they remain fit and well enough to receive treatment. Each session is 20 min long and consists of targeted exercises that address: spinal alignment and motion; muscle balance, particularly of the pelvic and shoulder girdles; and faulty movement patterns, particularly gait. Buoyancy, resistance, flow and turbulence are utilized to provide appropriately graded exercises. Sessions are delivered according to clinical need and ability to attend, with some patients attending once or twice, and then continuing independently with open access to return, while others will attend twice a week from referral to week 36 of gestation.

In 2014–2015, of the 866 antenatal referrals to physiotherapy, 46 patients were recommended for hydrotherapy. Of these, only 18 attended on a regular basis until week 36 of gestation and were included in the present review. Pregnancy Mobility Index scores were maintained or improved in 50% of these patients. Since the usual trend is for PMI scores to deteriorate with advancing pregnancy, these women demonstrated how function can be managed and maintained throughout pregnancy with hydrotherapy.

In addition, a short questionnaire was issued in order to establish the value that the women placed on the service. This demonstrated that, although they often found that the hydrotherapy exercises were hard, they found these easier than doing the same type of training on land, and reported that the exercises helped to reduce their pain levels. In addition, regular contact with the physiotherapist made them feel that they were in control of their condition, especially as this enabled them to problem-solve throughout their pregnancy.

The main barriers to treatment were related to the timing of sessions, car parking and childcare.

Overall, the hydrotherapy service provides a means of maintaining function, and is highly valued by its users, both in terms of the ease of the exercises, and the regular contact and support received.

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Patients' perspectives on obesity advice and management in pregnancy and how this may influence policy

Obesity in pregnancy is associated with many adverse outcomes. Women should be informed about how to minimize risk by a trained healthcare professional. Is a specialist antenatal clinic the most appropriate setting for this? The aim of this study was to gather patients' views on when, where and how they should be managed.

Closed-ended questionnaires were distributed to women with a body mass index of > 30 who presented to an antenatal clinic over a 2-month period.

Sixty-six questionnaires were returned. Twenty-two women (33%) stated that they would like help with weight management during pregnancy, while 34 (52%) maintained that they would welcome postnatal assistance. Most patients wanted advice either at a consultation or in writing (35% for both methods), while 10 (15%) would attend groups and three (4.5%) would receive telephone advice. Thirty-three (50%) women preferred advice in a primary care setting, four (6%) wanted help in a hospital setting and two (3%) would have liked this in another convenient location. Thirty-three (50%) patients wanted guidance about postnatal exercise, 23 (35%) were after dietary advice, 21 (32%) would have liked information about exercise during pregnancy and 13 (19.7%) wanted assistance with increasing daily activity. Twenty-two (33%) women had never received any weight loss advice, while eight (12%) said that they had, and of these, seven had found it helpful.

Fewer patients would attempt weight loss during pregnancy than in the postnatal period, and this may be a useful area for further exploration. It appears that most women would prefer personal consultations, or written advice on diet and exercise. However, the majority would choose to receive this care within general practice rather than an antenatal clinic, which should be considered when creating guidelines.

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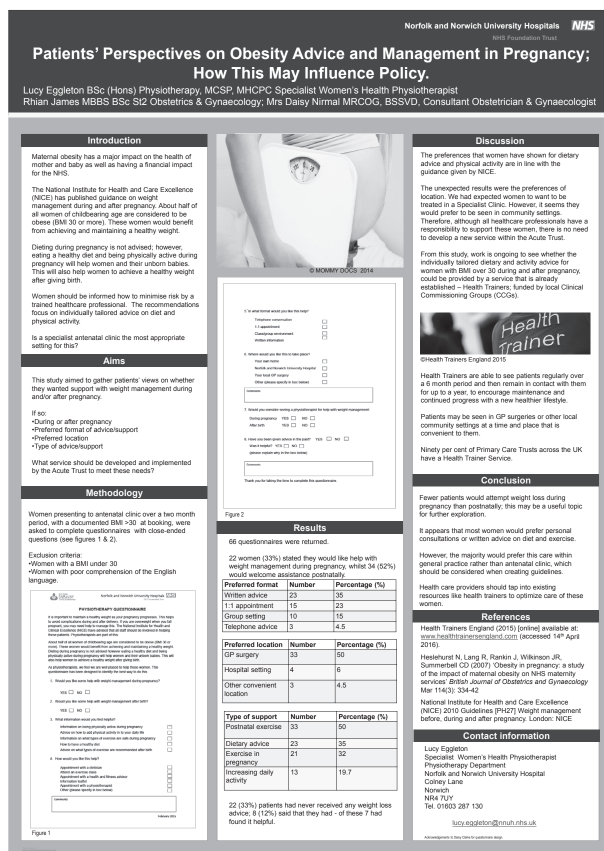

Figure 2. "Patients' perspectives on obesity advice and management in pregnancy; how this may influence policy" poster.

The lived experience of postnatal anal incontinence

Anal incontinence is a potential consequence of childbirth, and has been shown to have a significant impact on quality-of-life scores. It has been suggested that qualitative enquiry may provide greater depth to understanding the true impact and meaning of anal incontinence for an individual's health and well-being.

The aim of this study was to explore the early (< 12 months) postnatal experiences of women who have undergone anal incontinence following a vaginal delivery. The study adopted an existential phenomenological approach that was underpinned by the philosophy of Maurice Merleau-Ponty.

Three participants were purposefully recruited, and open, in-depth interviews were conducted. The transcribed interviews were then analysed using the descriptive phenomenological method developed by Giorgi (2009).

Tentative results suggest that the essential structure of postnatal anal incontinence includes the key constituents of "the changed bodily self", "an evolving sense of self", "a sense of becoming familiar", "a sense of hope", "emotional engagement" and an overriding "sense of putting

Figure 3. "The lived experience of postnatal anal incontinence" poster.

baby first". Following the descriptive analysis, an interpretation is offered in the form of a poem.

It is hoped that the results will add to the evidence base, and contribute to improving care for these women and developing services that meet their needs.

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Electroacupuncture for the treatment of refractory overactive bladder and urge faecal incontinence: a cost-effective option?

Overactive bladder (OAB) and faecal incontinence (FI) affect millions of people worldwide, and have profound economic and social implications. Physiotherapy, including assessment and treatment of pelvic floor muscle (PFM) function, bladder training, and behavioural techniques, is the first-line treatment for women with OAB. Physiotherapy, including anal sphincter and PFM exercises, and behavioural techniques, is a specialized form of management for individuals with faecal incontinence. Despite physiotherapy intervention, some adults experience refractory (persistent) symptoms. Research suggests that percutaneous tibial nerve stimulation (PTNS) is an effective second-line treatment option for OAB and urge FI (UFI). Current research also indicates that electroacupuncture (EA) is an alternative, and studies have found no significant difference between PTNS and sham electrical stimulation. Percutaneous tibial nerve stimulation is more expensive than EA. This review focuses on a local service's development of an alternative, cost-effective treatment option to standard PTNS for the management of refractory OAB and UFI using EA.

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Figure 4. "Electro-acupuncture for the treatment of refractory overactive bladder (OAB) and urge faecal incontinence (FI) – a cost effective option?" poster.

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