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OPTIMISING UPTAKE AND IMPLEMENTATION OF PELVIC FLOOR MUSCLE TRAINING EXERCISE PROGRAMS FOR PEOPLE WITH URINARY INCONTINENCE: A QUALITATIVE STUDY

Hypothesis / aims of study

This novel research is the first time standardisation of exercise reporting details for pelvic floor muscle training interventions (PFMT) has been attempted and mapped against an internationally recommended exercise reporting guideline. Level 1 evidence underpins the recommendation for pelvic floor muscle training (PFMT) as the first line intervention in the treatment of urinary incontinence (UI) (1).Evidence from a meta-epidemiological study indicates that exercise programs are poorly reported for a range of health conditions (2). Our exploratory examination of PFMT systematic reviews indicates that intervention reporting is insufficient to: draw conclusions about exercise program elements that are important; make comparisons with other studies; and replicate and facilitate uptake in clinical practice with fidelity to the interventions that were tested in the research. This hampers translation and implementation of effective PFMT into clinical practice.

The internationally-endorsed Consensus on Exercise Reporting Template (CERT) was developed by exercise expert consensus in a modified Delphi process, informed by recommendations of the Equator network, and addressed the problem of incomplete reporting of exercise interventions (3). We propose that clinicians would be able to more accurately interpret, and then apply, the evidence in their clinical practice if they had more complete descriptions of PFMT exercise programmes. We hypothesise that clinicians will be able to provide us with suggestions about the information they need in PFMT descriptions in order to implement this effective therapy.

The primary aim was to explore the beliefs and practices of clinicians who use PFMT for people with UI in order to understand what barriers, or enablers, may exist for clinicians to translate research evidence into practice. The secondary aims were to summarise the elements of PFMT programs that clinicians believe require explicit description and make any modifications to the CERT checklist and Explanation and Elaboration Statement to customise it to PFMT.

Study design, materials and methods

We recruited Continence Physiotherapists and Nurses from our publicly available membership registers. Interested participants were given an Explanatory Statement and provided a signed Consent Form prior to participation. We used qualitative focus group and interview methods conducted by an experienced facilitator with a pre-determined set of questions. The sessions were audio-recorded and transcribed verbatim for independent analysis of emergent themes by at least two researchers. The data were analysed using thematic analysis within a Grounded Theory framework. Study rigour was enhanced by *a priori* eligibility criteria, explicit data collection and analysis steps, participants giving opinions freely and results linked to the participant data.

Results

The pilot data have included 13 participants (twelve physiotherapists with post-graduate pelvic floor qualifications and one continence nurse) and the following themes have been identified: 1. Detailed descriptions of the content of PFMT interventions are required; 2. PFMT needs to be tailored to the individual with UI; 3. There are specific cues and language that engage people in PFMT; 4. Limited access to the published research and the large size of clinical guidelines are barriers to translation

Clinicians reported that PFMT programs are not comprehensively described in research reports and that they need to seek advice from experts when they are unable to access or interpret the literature. In the absence of published information clinicians default to clinical reasoning and first principles of exercise physiology which is often derived from the sports medicine resistance training literature. Clinicians considered that the language used to assist PFMT performance is unique to this area of practice. They expressed that they would benefit from an “information bank” of terms to facilitate pelvic floor muscle contractile response that is not currently provided in the literature. To engage the pelvic floor muscles they suggested phrases and imagery such as ““imagine drawing the saddle area up and away from your underwear” or “pulling the saddle area up with a piece of string or through a straw” and “imagine walking into cold water and pulling back the testicles” (for men). These sources of imagery were derived from colleagues or through post-graduate teaching. Clinical practice guidelines are inconsistently used because they are time-consuming to read, not user-friendly and do not contain specific exercise dosages and progressions.

Interpretation of results

The 16 items contained in the CERT appear to be applicable to descriptions required of PFMT programs that have been reported as effective. The pilot data from this qualitative study indicate that a PFMT-specific amendment is required for the Explanation and Elaboration Statement to guide explicit reporting and requirements that are specific to PFMT. This includes PFMT-specific guidance on exercise equipment (e.g. weighted cones, real-time ultrasound); decision rules for program commencement level (e.g. maximum voluntary contraction (MVC)) and progression (number of MVC until fatigue; change in urine leakage or continence

pads used) and incorporation into functional activities; motivation and engagement strategies (e.g. verbal cues, phrases, language; explicit descriptions of functional or applied exercises and not the popular name such as “the knack”; explicit descriptions of dosage including number of repetitions, sets, frequency and duration and structure of online appendices to include text and diagrams, photos and videos of exercise positions to assist exercise reproduction.

Concluding message

Clinicians who use PFMT for the management of UI have indicated that they need explicit details of the interventions that have been tested in the research and reported as effective in research reports. Currently this is lacking in the published research and clinicians must defer to their experience, clinical reasoning and mentors. We encourage journal editors and authors to provide explicit details and this could be by application of the Consensus on Exercise Reporting Template in protocol and manuscript construction and online appendices.

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