Physiotherapy and Prostate Cancer

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## C&WH Physiotherapy

<table>
<thead>
<tr>
<th>CONTINENCE &amp;</th>
<th>WOMEN’S HEALTH</th>
<th>PHYSIOTHERAPY</th>
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<tbody>
<tr>
<td>• Bladder/urinary dysfunction</td>
<td>• ‘obs &amp; gynae’ physio Conditions</td>
<td>• Pelvic and sexual pain</td>
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<tr>
<td>• Bowel/anorectal dysfunction</td>
<td>• unique to women</td>
<td>• Pelvic-girdle pain</td>
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<tr>
<td>• related pain conditions</td>
<td>• more prevalent in women</td>
<td>• Musculoskeletal issues</td>
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<tr>
<td>• Women</td>
<td>• with specific-to-women risk factors requiring different assessment and treatment</td>
<td>• Other physiotherapy</td>
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<tr>
<td>• Men</td>
<td></td>
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<td>• Children</td>
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C&WH Physiotherapy

Specialised area of PT
1. Post-grad studies
2. Special-interest in C&WH
   • Further studies encouraged
Physiotherapy & Prostate Cancer

**Multidisciplinary Team**
- Patient (+/- partner/carer)
- GP
- Urologist
- Urology Cancer Nurse
- C&WH Physiotherapist
- Continence Nurse
- Sexual Health Physician
- Clinical Psychologist (WAPOS)
- Oncology exercise classes
- +/- Radiation Oncologist...
- +/- Support groups
Physiotherapy & Prostate Cancer

Radical prostatectomy

• Ideally, assess, educate and train at least 6-8 weeks pre-op
• **Assessment** of
  • Prostate cancer history, patient’s journey
  • Medical and surgical Hx
  • Urinary symptoms – fluids, frequency, voiding issues, any UI...
  • Anorectal symptoms – constipation/defaecation difficulties, FI
  • Sexual dysfunction – ED, PE, pain
  • General fitness, psychological well being
  • PFM – using real-time ultrasound, ?need for DPR Ax
PFM – Real-Time Ultrasound Assessment

- Transabdominal

ICS 2013, pg 328

- Transperineal

(Stafford et al 2012)
PFM Exercises

• Correct technique of isolated PFM contraction AND relaxation
• Assumption that normal muscle tone is present
• No abdominal muscles – but lower abdominals co-contraction
• No leg muscles, no diaphragmatic bracing – must continue breathing

• Good patient awareness – if not confident/ if patient unsure – poor compliance with PFMEx
• Elevation
• Repetitions
• Fast
• Endurance
• Co-contraction
• Timing
Aim- Prepare for RP & Optimise Recovery

• Educate on:
  • Surgery, post-op events/recovery
  • Post-prostatectomy UI and ED
  • Continence products
  • Post-op recovery – balance activity, safe exercise and rest
  • Prevention and management of post-op constipation

• Address any identified problems pre-op incl comorbidities

• Optimise general exercise/physical activity – fitness

• Lose weight, stop smoking  🏃‍♂️ịnh  🏃‍♀️ (AIHW, 2011)  🚴‍♂️  🛏️  🛏️
Aim- Prepare for RP & Optimise Recovery

• **Optimise PFM performance**
  • Individualised HEP based on Ax
    • Strengthen and increase awareness of PFM
  • No PFMEx while catheter in
  • Early start following catheter removal including functional use with activities causing PPUI (SUI)

• **Post-op support team/contacts** – GP, C&WH physio, continence nurse, Urology Cancer Nurse, Urologist
Physiotherapy post-Radical Prostatectomy

• TOV with Continence Nurse → PPUI – varied severity
  • From continuous loss (no voiding) to few drops with activity
• On removal of catheter
  • 91% wet (Van Kampen et al 2000)
  • 93% wet (Overgard et al 2008)
  • 78% wet (Wille et al 2003)
  • 76% controls & 64% PFMT group (Centemero et al 2010)
• Reminded to re-start PFMEx and to use PFM functionally
• F/up with physiotherapist - seen within 5-10 days post-TOV
Physiotherapy Assessment post-RP

Subjective Ax

- Surgery details and post-op developments - ?UTI, any complications
- UI – severity, any changes, provoking activities
- r/v and discuss 3DBC

- Pads / Continence products
- Voiding function / difficulties
- Ano-rectal function
- Pain
- Sleep
- Coping with condition
Physiotherapy Assessment post-RP

Objective Ax

• Inspect incision scars
• RTUS
  • Bladder volume - relate it to the last void & 3DBC
  • PVR check if suspecting retention
  • PFM Ax and review of home exercises
Physiotherapy Treatment Aims post-RP

• Early PFM training after r/o IDC
  • Do no harm
  • The Knack
  • PFMEx x 3-4/day + functional use (‘the knack’)
• Optimise / normalise bladder and bowel function
• Optimise post-op recovery
• Gradual return to physical activity and exercise
• Psychological support +/- professional counselling
• Optimise general health & well being
Physiotherapy Treatment post-RP

- Reassure re-UI
- Reinforce education on
  - Continence products
  - Balancing of rest & activity
  - Safe general exercise
- Address constipation if not Mx well by the patient

- Reinforce good bladder habits, avoidance of JIC to prevent UI
- Pain – ?possible infection, check aggravating factors, manage accordingly
- Wean off pads as able
- ED – PLISSERT re-penis rehab
PFM Exercise Progression

• Strengthening and hypertrophy
• Endurance – resistance to fatigue and hold time
• Fast recruitment
• Automatic recruitment before and during rises in IAP

• Challenges with activities of daily living, work, sport...
For persisting PPUI

- Objective **measure of severity** – e.g. 24hrs/pad weight test
- **Review compliance** with PFM training
  - Adherence strategies
- **DPR exam** to assess PFM strength, tone, ability to relax... - **modify** PFM training if required, consider EMG biofeedback...
- Review if PPUI=SUI or some UUI present – investigate and collaborate with Urology team
  - Optimal fluids, bladder calming strategies, bladder training, TENS...
- Improve QoL – consider urodome sheaths, penile clamp vs pads
Thank you