6° CONGRESSO NAZIONALE SICCR

LA CENTRALITÀ DEL PAZIENTE
Qualità, Multidisciplinarietà, Management

Treviso 4-7 ottobre 2015

CORSI PRE-CONGRESSUALI TEORICO PRATICI
Domenica 4 ottobre 2015

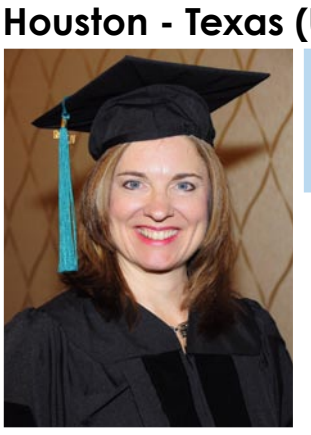
Tutti i corsi sono a numero chiuso. I posti per i seguenti corsi sono esauriti:

C1 - ECOGRAFIA PAVIMENTO PELVICO
C4 - CHIRURGIA PLASTICA RICOSTRUTTIVA PERINEALE
C8 - TRANSANAL ENDOSCOPIC MICROSURGERY (T.E.M.)

Pochi posti sono ancora disponibili per gli altri corsi:

C2 - NEUROMODULAZIONE SACRALE
C3 - CHIRURGIA LAPAROSCOPICA 2D E 3D
C5 - NUOVE TECNOLOGIE NEL TRATTAMENTO DELLE FISTOLE ANALI
C6 - MICROFLORA BATTERICA E FISIOPATOLOGIA INTESTINALI
C7 - RIABILITAZIONE PELVICA: WORK-UP E TECNICHE
C9 - METODICHE THD PER IL TRATTAMENTO DELLA PATOLOGIA EMORROIDARIA E GATEKEEPER PER L'INCONTINENZA ANALE

Intervista alla dr.ssa Lyne Archambault-Ezenwa Doctor of Physical Therapy Houston - Texas (USA)



Lack of high quality data on treatment of fecal incontinence, and most of the recommendations from the SICCR and French National society of coloproctology are based on low grade recommendation. Do you believe that treatment should be more widely used?

The Hippocratic oath stipulates: "nil nocere-do no harm". Conservative treatments, such as physical therapy, brings no harm to the patient, and clinically has shown significant improvements in patients' quality of life. Therefore, incorporating physical therapy assessment and intervention as a first line of treatment should be advocated. The primary limitations for obtaining a general consensus on the benefits of conservative management include the lack of assessment and treatment standardization, and homogeneity in the quality of care rendered, partially due to limited educational trainning and trained therapists in pelvic floor rehabilitation. Highly skilled therapists can reach outstanding treatment outcomes. Low grade recommendation in regards to physical therapy should be the "brain stimulant" to create high quality randomized clinical trials and not be considered as inefficacy.
The physical findings obtained from a multisystem physical therapy assessment provide critical information to the multidisciplinary team and should guide the implementation of the patient's plan of care. Rehabilitation should be defined into 3 categories: 1. Corrective, 2. Supportive, and 3. Preventative. Corrective would include conservative treatments that would yield the attainment of the patient's goal, such as pelvic floor rehabilitation and biofeedback, leading to the control of fecal incontinence. Supportive would be performed pre-surgically. The pelvic floor is rehabilitated prior to a necessary surgery, to improve post-surgical outcomes. For example, strengthening, and correcting hypertonicity and dyssynergic patterns of the pelvic floor in a patient suffering from constipation would be beneficial prior to a rectocele repair to prevent future complications and shorten the recovery period. Lastly, Preventative should be incorporated post-surgery to minimize side effects of surgery such as treatment to reduce scar tissue formation and pain control. Each type of rehabilitation extends the arms of care of the physicians' practice and leads to high patient satisfaction. Pelvic floor dysfunction, including fecal incontinence, is often multifactorial, thus our primary goal should always be to attain the maximal potential return to pelvic floor health and function prior to most surgical intervention and/or more invasive treatment.

The causes leading to fecal incontinence are so many and often multifactorial, and the techniques for perineal rehabilitation are not standardized. How to go out this tunnel of confusion?

I believe that the building blocks of ideal standardization is unity! The first step in the development of a consensus in the standardization process is to unify an international multidisciplinary team of inspired and forward thinking health care providers including physicians, professors, physical therapists, osteopaths, nursing, and their associated societies, association and/or universities. Once mutual understanding and respect is achieved from each discipline, assessment and treatment protocols can then be developed. Some standards are already in place depending of the country of origin, however in order to bridge the gap between the clinical and scientific community building international ties is important. Standardization provides the basics on how we must approach pelvic floor dysfunction and should be ever-changing according to the based-evidence (research and clinical). Furthermore, incorporating pelvic floor rehabilitation into the physical therapy university curriculum is primordial. Teaching must focus on pelvic floor function in its entirety to minimize a compartmentalization approach. Clinically, we have observed the interrelationship between systems: some individuals suffering from fecal incontinence can also report urinary incontinence, and patient suffering from constipation may also report dyspareunia. Thus, standardization must include the assessment and treatment of all compartments. As of recently, with the access of the internet, the patient takes an active participation in their care and can request specific conservative treatment options. Thus, education is key. Education to the medical community and the community at large in the benefits of pelvic rehabilitation may aid in the development of research and standardization. The SICCR and the publication of its members has shown great interest in the potential of rehabilitation. Dedication, open-mindedness, patience, and a clear vision will be allies in this long and arduous process. And a bit of faith as well!

Scarica curriculum

Per iscrizioni e prenotazioni alberghiere
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