556

Kapoor D[1], Ness W[1], Addison R[1], Abulafi M[1], Swift I[1], Thakar R[1], Sultan A[1]
1. Mayday University Hospital

COMBINED PELVIC FLOOR CLINIC: A FOUR- YEAR REVIEW

Hypothesis / aims of study

Childbirth has been implicated as a major contributory factor in pelvic floor dysfunction[1]. It has also been noted that the presentation in different compartments of the pelvic floor maybe metachronous rather than synchronous. Furthermore, surgical repair in one compartment may distort anatomy and lead to *de novo* dysfunction in another compartment.

Multicompartment disorders have a serious impact on quality of life and may therefore require prolonged surveillance and specialised care that would be difficult to provide in a general outpatient setting. Multi-compartment pelvic floor disorders are now increasingly being evaluated and managed jointly by urogynaecologists and colorectal surgeons [2]. However there is paucity of data on the evaluation and management of these complex problems. Although there are perceived benefits associated with joint pelvic floor clinics there are no published data regarding patient satisfaction

Our aims were:

1) to audit referral patterns, symptom clusters and treatment outcomes of patients seen in the Combined Pelvic Floor Clinic.
2) To conduct a survey of patient satisfaction with this service.

Study design, materials and methods

All patients were seen by either of two teams, each consisting of a urogynaecologist, colorectal surgeon, and a nurse specialist. Patients were reviewed by the same team, thereby ensuring continuity of care. Symptoms were self-recorded by patients on the Addison Symptom Severity Questionnaire (SSQ). Investigations included endoanal ultrasound, anorectal manometry, and multichannel cystometry. Defaecating proctography, pudendal nerve terminal motor latency studies, colonic transit studies and colonoscopy were performed when indicated.

A patient satisfaction questionnaire was devised and mailed to all patients who attended the clinic.

Results

Between 1999 to 2003, 106 new cases were referred to the clinic. Median age was 54 yrs (range 27-92).

Table 1. Previous surgery

Type	
abdominal hysterectomy	28%
vaginal hysterectomy	8%
pelvic floor repair	14%
colposuspension	7%
others	5%

Table2. Referral complaints

urinary+ anal incontinence/ evacuation problems	72%
obstructed defecation with a suspected rectocele	26%
urinary and prolapse complaints in isolation	2%

Table 3. Symptoms

overactive bladder	52%
stress incontinence	43%
uterovaginal prolapse	9%
flatus incontinence	46%
faecal incontinence	25%
faecal urgency	41%
evacuation difficulties	36%
constipation	25%
digitation	18%

Symptom clusters of urinary and faecal incontinence occurred in 31% and combined urinary and faecal urgency in 22%

Table 4. Investigations

low anal squeeze pressures	38%
delayed pudendal nerve motor latencies	16%
rectocele on proctography	27%
delayed colonic transit	6%
urodynamic stress incontinence (USI)	15%
detrusor overactivity incontinence (DOI)	10%

Treatment

Treatment was based on the severity of individual symptoms and their impact on quality of life. Conservative modalities including pelvic floor exercises, biofeedback, electrical stimulation of the anal sphincter, and anticholinergics were used in 63% of patients. 39 patients underwent surgery. There were no major complications in those who had surgery.

Table 5. Surgery

combined colorectal and urogynaecologic procedure	38%
colorectal procedure	36%
Urogynaecological procedure	26%

Patient satisfaction

To date, 57 replies have been received. 94% benefited from being seen by both the consultants and nurse specialist at the same time. Of these, 74% felt they saved on the number of hospital visits, 68% found it beneficial to be examined and have their treatment plan finalised in the same sitting. 61% felt it was advantageous to see the nurse specialist at the same time. Of the 60% who had or were awaiting joint surgery, 82% saw a benefit in terms of having both problems dealt with simultaneously, under a single anaesthetic, and with a single recuperation period. 72% felt the overall care they received was excellent or good, 11% found it satisfactory, and 7% found the care to be unsatisfactory.

Interpretation of results

This is the first study to evaluate patients' perseption of the combined pelvic floor service. As described above patients rated this service very highly. Patients seen in this clnic had complex symptoms involving to multiple compartments. From the clinicians perspective we found all referrals but one to be appropriate. Joint assessment ensured a unified management plan. Periodic reappraisal was provided by continuity of care. This approach of joint consultation also results in minimal disruption to patients work and social life.

Concluding message

Complex pelvic floor problems are best approached by a multidisciplinary team. This enables clearer communication between specialists and considerable cost savings with combined surgery and recuperation. We therefore advocate a holistic approach to complex pelvic floor disorders and provide a working model that could be replicated in other centres.

References

1. Unifying concept of pelvic floor disorders and incontinence. J R Soc Med 1985;78:906-11.
2. Management of pelvic floor dysfunction. Lancet 1997;350:1751.