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FAILURE TO COMPLETE PHYSIOTHERAPY FOR STRESS INCONTINENCE AND PROLAPSE - PREDICTORS AND CONSEQUENCES.

Hypothesis / aims of study

Physiotherapy is an effective and relatively inexpensive treatment for stress incontinence[1] and prolapse which many women fail to complete, or even to attend at all. This is frustrating for therapists and medical staff, and a waste of scarce healthcare resources. Rates for failure to complete a course of outpatient musculoskeletal physiotherapy range from 7.2% to 14.3%, with missed first appointments ranging from 5.8% to 10.68%[2]. Predictive factors previously identified include age and ethnicity[2]. These have not yet been investigated for urogynaecology physiotherapy. The aims of this study were to determine the characteristics of women who failed to complete physiotherapy, and the consequences of this failed attendance.

Study design, materials and methods

A retrospective audit was carried out for women with stress incontinence or prolapse. All were referred from medical staff in the urogynaecology clinic to a specialist physiotherapist over an 18 month period. The predictive factors of age, site of initial physiotherapy appointment (either in the urogynaecology clinic at the time of referral, or in the physiotherapy department after an 8-week wait), ethnicity and interpreter use were recorded for all patients. Parity and impact on quality of life were recorded at initial contact, using the Incontinence Impact Questionnaire and Urogenital Distress Inventory combined short forms. Women who failed to attend an appointment and did not make any further contact within one month were discharged in line with departmental policy. Subsequent attendance at the urogynaecology clinic and having or being booked for surgery were recorded for all women.

Results

Records were available for 233 women. 88 women (37.84%) did not complete physiotherapy. This represents 38.03% of women seen initially in the urogynaecology clinic, and 37.65% of women seen initially in the physiotherapy department. This included 25 women (10.73%) who did not attend their first appointment in the physiotherapy department. 17 women (7%) failed to attend the urogynaecology clinic after discharge from physiotherapy; 4 of these women had not completed physiotherapy. 28 women (12%) were booked for or had surgery; 11 of these women had not completed physiotherapy. Results were analysed by Chi square and ANOVA analyses. Failure to complete physiotherapy was not predicted by age, parity, site of initial physiotherapy appointment, ethnicity or interpreter use. 149 women completed quality of life impact questionnaires. Women who did not complete physiotherapy had significantly higher quality of life impact scores (perceived their symptoms as more severely affecting their quality of life) than women who completed physiotherapy ($p=0.003$). Failure to complete physiotherapy did not result in failure to attend the urogynaecology clinic or having surgery. Women who failed to complete physiotherapy but continued to attend the urogynaecology clinic had significantly higher quality of life impact scores than women who attended both physiotherapy and the urogynaecology clinic ($p=0.009$).

Interpretation of results

Urogynaecology physiotherapy suffers from a higher rate of failure to complete a course of treatment than general musculoskeletal outpatient physiotherapy departments. Women with higher quality of life impact scores are less likely to complete physiotherapy, but will continue to attend the urogynaecology clinic. This is in keeping with the findings of other specialties, where patients with worse symptoms and functional abilities have been found to be less likely to attend for treatment[3]. Appropriately, women with lower quality of life impact scores (and milder symptoms) are more likely to attend physiotherapy.

Concluding message

Women with higher quality of life impact scores, who may or may not need surgery, need to be encouraged to complete physiotherapy in the first instance, where it is appropriate. This

would reduce financial and resource implications for an already limited service, enable further clinical evaluation and improve the health of the individual.

References

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