

CO-OCCURRENCE OF PELVIC FLOOR DISORDERS AND THE SYMPTOM THAT CAUSES MORE BOTHER, IN PATIENTS SEEKING CARE IN A GYNECOLOGICAL CLINICS.

Hypothesis / aims of study

Prevalence of pelvic floor disorders (PFD) and the reported co-occurrence of these conditions in community-dwelling women is high (1). Health care provision and access to treatment for women with PFD is heterogeneous and creates uncertainties for physicians, specially in countries without the subspecialty of urogynaecology officially recognized and this may affect women on its standards of care. Gynaecologists are often consulted due to their accessibility by women (2), little is known about the co-occurrence of PFD in women referred to gynaecologists.

The aim of this study was to analyse the co-occurrence of pelvic floor disorders in patients seeking care in a gynaecological clinics attending only these conditions and the symptoms that causes more bother, when more than one disorder coexist

Study design, materials and methods

Spanish multicentric cross-sectional study of 521 women seeking care for pelvic floor problems in 35 specialized gynecological clinics around the country. Patients answered the Spanish validated version of the Epidemiology of Prolapse and Incontinence Questionnaire (EPIQ), a psychometrically validated screening instrument that was developed to screen for female PFD. The EPIQ questions address symptoms of prolapse, urinary incontinence (stress and urge), urinary urgency without incontinence, and anal incontinence. Each pelvic floor symptom was categorized as "present" or "absent" based on patient's responses and they scored the degree of bother 0 to 10. Patient's information on pregnancies, route of delivery, birth weight, and other delivery variables were included, as well as demographic questions about race/ethnicity, socioeconomic status, and education (3). A priori definitions for pelvic organ prolapse (POP), stress urinary incontinence (SUI), urgency and urge urinary incontinence (overactive bladder (OAB), and anal incontinence (AI), were agreed upon by the investigators, and also the objective measures necessary for the diagnosis. The clinical diagnosis were:

SUI: Symptom of involuntary loss of urine with cough, sneeze, strain one or more times per month and a positive stress test on examination or urodynamic testing.

OAB: Either urinary urgency (UU) and/or urgency incontinence (UUI) one or more times per month and/or uninhibited detrusor contractions with or without leakage on urodynamic testing.

POP: Symptoms of vaginal bulge, or protrusion, with prolapse measured at or beyond 0 cm from the hymen or asymptomatic but prolapse measured beyond the hymen.

AI: Either flatal and/or fecal incontinence, involuntary loss of gas one or more times per month

Results: Sample description is shown in table 1. 466 of the all 521 women, had low urinary tract symptoms (LUTS.)

Table1:

Age: mean (S.D)	58.14 (12.54)
BMI: mean (S.D)	27.6 (4.8)
Overweight: n (%)	195 (37.2)
Obesity: n (%)	171 (32.6)
Vaginal delivery (N=473): mean (S.D)	2.54 (1.32)
Episiotomy: n (%)	322 (68.1)
Tears: n (%)	65 (13.7)
Cesarean delivery (N=49): mean (S.D)	1.33 (0.60)
Menopausal: n (%)	373 (71.6)
Hormone replacement therapy: n (%)	73 (19.6)
Hysterectomy: n (%)	83 (15.9)

The frequency of each of the clinical diagnoses a priori defined, are shown in table 2. Among 521 women included in this study, the most frequent clinical diagnoses was OAB (with or without urgency incontinence) 74,09%, POP and SUI in about half of the patients. Only a small proportion of these patients had a single diagnosis

Table 2

clinical diagnoses	N (%)	"single" diagnoses
OAB	386 (74.09)	Only OAB: 71 (18.39)
SUI	273 (52.40)	Only SUI : 66 (24.18)
POP	277 (53.17)	Only POP: 33 (11.91)
AI	90 (17.27)	Only AI : 0 (0.00)

In table 3 we can observe the co-occurrence of more than one diagnosis in each group. Women with a diagnosis of prolapse, more than 50 % have SUI. The group with SUI, 70% had OAB associated. Women with a clinical diagnosis of AI, more than 40% had a mixed urinary incontinence. Symptoms of AI are the more bothersome when are present in patients with complex PFDs.

Table 3:

Combination of clinical diagnoses	N (%)	Symptom with highest bother (EPIQ score: 0-10)
POP (n= 277)		
- POP + OAB	201 (72.6)	<i>Urgency urinary incontinence (7.9)</i>
- POP+ SUI	144 (52.0)	<i>Stress urinary incontinence (7.8)</i>
- POP+SUI+ OAB	107 (38.6)	<i>Stress urinary incontinence (7.8)</i>
- POP + AI	56 (20.2)	Anal incontinence (9.6)
SUI (n= 273)		
- SUI + OAB	193 (70.7)	Urgency urinary incontinence (7.9)
- SUI + AI	48 (17.6)	Anal incontinence (9.6)
OAB (n= 386)		
- OAB + AI	76 (16.7)	Anal incontinence (9.6)
AI (n= 90)		
- AI+ SUI+ OAB	39 (43.3)	Anal incontinence (9.6)

Interpretation of results

Only a few proportion of women who are seeking care in a specialized gynaecological clinic, have a single clinical diagnosis. One of four patients with diagnosis of SUI, not had other PDF. Patients with a clinical diagnosis of POP have to be considered that they have a complex pelvic floor disorder. AI may coexist with all other PFDs.

Concluding message

There is high co-occurrence of pelvic floor disorders in women seeking care for any pelvic floor symptom in gynaecological clinics. The evaluation and management of these women may require a multidisciplinary approach

References

1. Obstet Gynecol 2008;111:678–85
2. Maturitas. 2005 Nov 30;52 Suppl 2:S3-12
3. Int Urogynecol J Pelvic Floor Dysfunct. 2005 ;16(4):272-84

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<i>Was the Declaration of Helsinki followed?</i>	Yes
<i>Was informed consent obtained from the patients?</i>	Yes