



Pelvic floor symptoms and severity of pelvic organ prolapse in women seeking care for pelvic floor problems



Montserrat Espuña-Pons^{a,*}, Manuel Fillol^b, María A. Pascual^c, Pablo Rebollo^d, Ana M. Mora^e on behalf of the Female Pelvic Floor Dysfunction Research Group (Grupo de Investigación en Disfunciones del Suelo Pélvico en la Mujer-GISPEM)

^a Hospital Clinic i Provincial, Barcelona, Spain

^b Hospital de la Plana, Castellón, Spain

^c Hospital Universitario de Canarias, Tenerife, Spain

^d BAP Health Outcomes, Oviedo, Spain

^e Astellas Pharma, Madrid, Spain

ARTICLE INFO

Article history:

Received 1 April 2013

Received in revised form 10 February 2014

Accepted 31 March 2014

Keywords:

Pelvic organ prolapse

Pelvic floor disorders

Women

Urinary incontinence

Sexual dysfunction

ABSTRACT

Objective: The aim of the study was to estimate whether POP severity is related to lower urinary tract symptoms (LUTS) and symptoms of sexual difficulties, when evaluated with validated questionnaires.

Study design: Multicentric cross-sectional study of 521 women seeking care for PFD in 35 specialized urogynecological clinics. Patients answered the EPIQ to detect symptoms of PFD. The severity of urinary incontinence and the OAB symptoms were measured by ICIQ-UI SF and BSAQ. POP anatomic severity was measured by the anatomic stage of each compartment, determined in pelvic examination in accordance with the IUGA-ICS terminology. A maximum POP stage (M-POP-S) was assigned to each patient: Group A, patients with no POP (stage 0–I); group B, M-POP-S stage II; and group C, M-POP-S stage III–IV.

Results: Pelvic examination demonstrated anatomic POP in 224 patients (stage from II to IV). 288 women (56.25%) were classified in group A (no prolapse); 102 (19.92%) group B (stage II); and 122 (28.83%) group C (stage III–IV). Several associations were found between studied variables and M-POP-S (age < 55 years, menopause, number of vaginal deliveries, symptom of vaginal bulge, feeling of a bulge makes it difficult to have sexual relations, symptoms of stress urinary incontinence, nocturia and voiding difficulties), but the only variables independently associated were age, symptom of vaginal bulge and difficulty in having sexual relations due to feeling of a bulge.

Conclusions: In patients seeking care for PFD, LUTS are not independently associated to the prolapse stage.

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1. Introduction

Pelvic organ prolapse (POP) is a condition related to pelvic floor dysfunction and often associated with symptoms of urinary incontinence (UI), impaired bladder emptying, obstructive defecation and sexual problems [1]. According to a previous publication [2], more than 50% of women with symptoms of POP report at least one symptom of another pelvic floor disorder: stress urinary incontinence (SUI), anal incontinence (AI) and/or overactive bladder (OAB). Among urinary incontinence (UI) symptoms

declared by women with POP, mixed UI (72%) and only urgency urinary incontinence (UUI) (24%) are more frequent than stress-only UI (<1%) [3]. Nevertheless, only weak correlations have been found between the type and severity of the POP and symptoms of other pelvic floor disorders [4].

Women with advanced POP are less likely to have SUI but more likely to have voiding difficulties. However, Brubaker et al. [5], analysing data from two large female SUI surgical cohorts, found that POP stage was not strongly associated with urinary incontinence severity. Slieker-ten Hove et al. [6] carried out a study in a general female population sample of 2979 women aged 45–85 years old, in which they found associations of POP stage with parity and vaginal bulging, but not with symptoms of bladder and/or bowel disorders. These two studies included few patients with POP stage III–IV.

Although levels of early POP have not been associated with most pelvic floor symptoms [4,7], a stronger link has been

* Corresponding author at: ICGON, Hospital Clinic i Provincial, C/ Villarroel 170, 08036 Barcelona, Spain. Tel.: +34 932275436.

E-mail addresses: 12922mep@comb.es, mespuna@clinic.ub.es (M. Espuña-Pons).

demonstrated between bladder and bowel symptoms and vaginal descent progression over time in postmenopausal women with stages I–II POP [8].

Miedel et al. investigated whether the nature of the anatomic defects in POP are associated with different pelvic floor symptoms [9]. They found that these symptoms do not predict the anatomic location of the POP in women with mild to moderate prolapse. The feeling of vaginal bulge was specific to POP but not to any particular compartment. Urge urinary incontinence tended to be linked to POP in either the anterior or posterior wall, but the association was stronger with anterior-wall prolapse. SUI was strongly linked to posterior-wall prolapse. Self-reports of hard/lumpy stools and difficult or painful defecation tended to be associated with anterior-wall prolapse but without consistent relationships with stage. Painful defecation was the only bowel symptom significantly linked to posterior-wall prolapse.

The high co-occurrence of pelvic floor disorders suggests that physicians seeing women seeking care for one condition should inquire about symptoms of other disorders [2]. But data about the relationship between the severity of prolapse in women with advanced POP and reported lower urinary tract symptoms (LUTS) and other pelvic floor symptoms are very sparse. As it has been noticed in the previous paragraphs, published studies on this topic, have included few patients with POP stage III–IV. Their conclusions are based on small groups of patients or subjects from general population, in which the stage II is the most frequent POP stage. From the clinical point of view, it would be interesting to know if there are differences in the association of LUTS with POP according to the POP stage (stage II symptomatic or asymptomatic vs stage III–IV). The aim of the study was to estimate whether POP severity (anatomic stage) is related to different low urinary tract symptoms and sexual difficulties, when evaluated with validated questionnaires.

2. Materials and methods

A multicentre cross-sectional study of 521 consecutive women seeking care for pelvic floor problems (first visit to the specialist) was carried out in 35 specialized urogynecological clinics during 6 months. Patients who were unable to understand the questionnaires of the study were excluded. After giving informed consent, patients answered a validated version of the following questionnaires: (1) Epidemiology of Prolapse and Incontinence Questionnaire (EPIQ) [10,11] to detect symptoms of POP, SUI, OAB, sexual problems and other pelvic floor symptoms; (2) International Consultation on Incontinence Questionnaire-Urinary Incontinence short form (ICIQ-UI SF) [12,13], to measure symptom severity and bother of the urinary incontinence (UI); and (3) Bladder Control Self-Assessment Questionnaire (BSAQ) [14,15], to measure the OAB symptoms and bother. The study was approved by the Ethics Committee of Clinical Research of the “Hospital Clinic I Provincial” from Barcelona, Spain.

The EPIQ has been developed and validated in the United States as a screening tool of pelvic floor disorders [10], and validated in Spanish (Spain) [11]. The questionnaire consists of 54 questions, in part taken from previously validated instruments and partially developed specifically for the questionnaire. It contains the following sections: general information and history of childbirth, menopause data and gynaecological history, general health information, questions about overactive bladder syndrome, questions about SUI, questions about impact on quality of life, questions about genital prolapse, anal incontinence questions, questions about sexual relationships and sociodemographic data. Of the 54 questions, the 22 referring to the impact on the lives caused by pelvic floor problems form the questionnaire score.

The ICIQ-UI SF is a questionnaire that is aimed at detecting UI in any healthcare setting. The final version of the questionnaire, which

has been translated and culturally adapted in various countries, consists of three items (“Frequency”, “Amount” and “Impact”), plus a group of 8 questions related to the type of UI that are not part of the questionnaire score, and have only descriptive purposes. The total score resulting from the sum of the first three items ranges from 0 to 21 points. The Spanish version of this questionnaire has demonstrated adequate psychometric properties [12,13].

The BSAQ was designed with the goal of it being possible to identify women answering the questionnaire as having OAB symptoms or not. This is a simple questionnaire with only 8 items grouped into two scales (“impact” and “symptoms”). It was developed following the standard methodology, including the completion of a patient and expert panel, reducing the original number of questions to the 8 items of the final version. The questionnaire was originally developed and validated in English [15]. For the Spanish version used in this study, a cultural adaptation including a double process of forward and backward translation was carried out by two bilingual translators; the final Spanish version was formally validated and demonstrated adequate psychometric properties [14]. The score of each of the two dimensions that comprise the questionnaire (“impact” and “symptoms”) ranges between 0 and 12 points.

The POP anatomic severity was measured by means of the anatomic stage of the POP, determined in pelvic examination in accordance with the IUGA-ICS terminology [16]. All pelvic examinations were performed in dorsal lithotomy position, during a maximum Valsalva manoeuvre. According to the position of the most distal portion of the prolapse, the POP stages were classified as follows: stage 0 (no prolapse); stage I (more than 1 cm above the level of the hymen); stage II (1 cm or less proximal to or distal to the plane of the hymen); stage III (more than 1 cm below the plane of the hymen) and stage IV (complete eversion of the total length of the lower genital tract). Based on the POP quantification examination values, stages 0–IV were assigned to each vaginal compartment (anterior, posterior, uterus-cervix, or the apex of the vagina) in each patient. A maximum POP stage (M-POP-S) was assigned to each defect and to each patient. For the analyses, the patients were distributed into three groups according to the M-POP-S, in one or more of the three compartments. Group A consisted of patients with no POP (stage 0–I); group B, patients with M-POP-S of stage II, and group C, patients with M-POP-S of stage III or IV.

2.1. Statistical analysis

Statistical analyses were carried out to investigate the variables associated to the M-POP-S; chi-square test was used for categorical variables: age over 55 years; menopause (yes/no); obstetric personal history – numbers of vaginal deliveries (1, 2, 3 or more), caesareans (yes/no), forceps (yes/no), episiotomy (yes/no), tears (yes/no) –; symptom of vaginal bulge (yes/no); symptom of vaginal bulge during sexual intercourse (yes/no); symptoms of low urinary tract symptoms and anorectal symptoms (yes/no): stress urinary incontinence, urgency, frequency, nocturia, urgency urinary incontinence, voiding difficulty and obstructed defecation and AI symptoms. Kruskal–Wallis test was used for ICIQ-UI SF and BSAQ scores. Finally, an ordered logistic regression analysis was fitted for the M-POP-S, entering all the variables with statistically significant association with M-POP-S in the univariate analysis ($N = 10$). In the final model only those with statistical significance were included. Statistical significance level was set at 0.05.

3. Results

The mean age (standard deviation) of patients was 58.14 (12.54) years and 32.6% of them were obese according to the Body

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