

Is Pelvic Floor Dysfunction an Independent Threat to Sexual Function? A Cross-Sectional Study in Women With Pelvic Floor Dysfunction

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ABSTRACT

Introduction: Prior studies have reported an association of sexual dysfunction with pelvic floor dysfunction (PFD), but without defining causation.

Aim: To investigate predictors of sexual function in women with PFD, including pelvic organ prolapse, stress urinary incontinence, overactive bladder, obstructed defecation, and fecal incontinence.

Methods: This retrospective cross-sectional study included 755 women (mean age = 56 years, 68% postmenopausal) referred for PFD (2008–2013). Subjects underwent standardized history and examination, including demographics and assessment of pelvic floor function and sexual function using validated quality-of-life instruments. The physical examination included body mass index, Pelvic Organ Prolapse Quantification measurements, and pelvic muscle strength (Oxford scale). Proportional odds regression analysis tested patient characteristics, PFD, and other determinants of sexual dysfunction as predictors of sexual function.

Main Outcome Measures: The Pelvic Floor Distress Inventory (PFDI-20) and Pelvic Floor Impact Questionnaire (PFIQ-7) to assess PFD and the Short Personal Experiences Questionnaire to assess sexual function.

Results: The prevalence of PFD included pelvic organ prolapse (72%), stress urinary incontinence (66%), overactive bladder (78%), fecal incontinence (41%), and obstructed defecation (70%). Most subjects (74%) had a sexual partner and most (56%) reported recent sexual intercourse. Participants reported a low level of sexual desire and sexual enjoyment and moderate levels of sexual arousal and orgasm. When stratified by sexual enjoyment, 46% enjoyed sex and this group had lower PFDI and PFIQ scores, reflecting less quality-of-life burden. Pelvic organ prolapse, obstructed defecation, and fecal incontinence were associated with not enjoying sex. However, when adjusted for other determinants of sexual dysfunction (eg, aging, dyspareunia, atrophy, and partner issues), these associations disappeared.

Conclusion: Women with PFD also have a large burden of sexual dysfunction, although this appears to be mediated by factors not unique to PFD.

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Key Words: Pelvic Floor Dysfunction; Incontinence; Pelvic Organ Prolapse; Female Sexual Dysfunction; Menopause; Sexual Desire

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INTRODUCTION

Sexual dysfunction is an umbrella term used to describe different disorders that negatively affect a person's ability to respond sexually.¹ Sexual dysfunction is a common finding in women older than 40 years seeking routine gynecologic care, because 65.8% of women report at least one complaint.² It can have a profound effect on health-related quality of life, interpersonal relationships, and individual perception of psychological well-being.³

In parallel, at least one in three aging women has pelvic floor dysfunction (PFD).⁴ PFD includes involuntary leakage of urine with increased intra-abdominal pressure (stress urinary incontinence; SUI), urinary urgency and frequency (overactive bladder;

OAB), pelvic organ prolapse (POP), fecal incontinence (FI), and obstructed defecation (OD). PFD has been associated with decreased sexual function, including decreased sexual arousal, decreased orgasm frequency, and dyspareunia.⁵ Given the proximity of the organs affected by PFD to the reproductive tract, it is not surprising that PFD would be associated with sexual dysfunction, although the mechanism for this association is unknown and is likely multifactorial. The objective of this study was to describe sexual function in a large cohort of women with PFD and to evaluate some specific predictors of sexual dysfunction in a sample of women with PFD.

METHODS

This was a retrospective cross-sectional study that was approved by the Providence Health Care Research Ethics Board (H15-00726), an affiliate of the University of British Columbia research ethics board. To assess sexual function in women with PFD, we used a sample drawn from women with PFD who were referred for consultation by one of two urogynecologists at the Centre for Pelvic Floor at St Paul's Hospital (Vancouver, BC, Canada) from January 2008 through August 2013. Inclusion criteria included a completed Short Form of the Personal Experiences Questionnaire (SPEQ) and symptomatic PFD based on the completed validated short form of the Pelvic Floor Distress Inventory (PFDI-20) and Pelvic Floor Impact Questionnaire (PFIQ-7).^{6,7} The studied PFD types included SUI, OAB, POP, FI, and, OD. Blank questionnaires or the need for an English interpreter during consultation were exclusion criteria. This was a retrospective investigation of information routinely collected for clinical assessment of patients presenting for PFD. Given the nature of the practice that is focused on PFD, a control group without PFD was not feasible.

All patients underwent a standardized history and examination. The history included the PFDI-20, PFIQ-7, SPEQ, and questions pertaining to age, menopausal status, obstetric history, previous gynecologic surgeries, hormone replacement therapy, smoking and alcohol habits, ethnicity, and relationship status. Patients underwent a standardized physical examination, including height, weight, and body mass index measurements, bimanual examination, rectal examination, Pelvic Organ Prolapse Quantification (POP-Q) measurements, pelvic muscle strength testing (Oxford scale), cough stress test, and postvoid residual measurement.^{8,9} The information from paper questionnaires was entered into a database by uniformly trained research assistants. Validity of the database was confirmed by random spot checks of 5% of the data in which the coder was evaluating accuracy.

PFD was defined from PFDI responses and physical examination findings. The PFDI-20 and PFIQ-7 are validated condition-specific quality-of-life instruments for measuring PFD symptoms, associated bother, and impact on quality of life.⁶ We

chose them because they provide widely recognized objective definitions of different types of PFD. SUI was defined as a non-zero answer to the question, "Do you usually experience urine leakage related to coughing, sneezing, or laughing?" (PFDI-20 question 17), or the presence of a clinically demonstrable positive stress test result at physical examination. OAB was defined as a positive response to symptoms of frequent urination or urine leakage associated with feelings of urgency (PFDI-20 questions 15 and 16). We defined POP in patients with a POP-Q score of 0 (beyond the hymen) or more in the anterior, apical, and posterior vaginal compartments (POP-Q points Aa, Ba, Ap, Bp, C, or D) and a positive response to any question on the Pelvic Organ Prolapse Distress Inventory (PFDI-20 questions 1–6). OD was defined as a positive response to "the feeling of incomplete bowel emptying" or the need to "push on the vagina or around the rectum to have or complete a bowel movement" (PFDI-20 questions 4 and 8), and FI was defined as a positive response to "symptomatic loss of stool beyond a patient's control" (PFDI-20 questions 9–11).

We calculated the PFDI-20 and PFIQ-7 scores and subscale scores according to the original description.⁶ For example, the PFDI-20 score was calculated as a summative score from the three subscale components, the pelvic organ prolapse subscale (POPDI), colorectal-anal subscale (CRADI), and urinary distress subscale (UDI). The subscale scores were the mean of the answered questions included in the subscales multiplied by 25 to produce a subscale score of 1 to 100, and the total score of the PFDI-20 scale was up to 300. The PFIQ scores were determined in a similar fashion, that is, as a summative score of the subscales.

To assess sexual function, we used the SPEQ, a validated psychometric tool developed to measure sexual function in women for population-based and clinical trial research.⁷ We chose this instrument because it includes questions about all phases of female sexual response, desire, arousal, and orgasm but also measures sexual enjoyment and the frequency of sexual activities. It also addresses key determinants of female sexual dysfunction, for example, partner-related problems, which are addressed by four questions related to the presence of a partner, feelings for the partner, sexual function of the partner, and satisfaction with the partner.^{7,10} To broaden the utility of the questionnaire, we added a question to clarify whether they had intercourse with the partner. The SPEQ also addresses another important determinant of sexual function, the presence of dyspareunia. Given the demographics of our population, symptoms related to genital atrophy or poor lubrication also could be important determinants of sexual function; therefore, we further augmented the SPEQ with a question about vaginal dryness. We added questions to determine the importance of future sexual function and whether surgical management that precluded future sexual function was acceptable.

To describe sexual function in this population of women with PFD, we report overall enjoyment with sexual activities, frequency of sexual activity, and three domains of sexual function,

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