Prevalence of Multidisciplinary Symptomatology in Patients with Pelvic Floor Disorders

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HYPOTHESIS

- Benign pelvic floor disorders include incontinence, pelvic pain, prolapse, constipation, LUTS and sexual dysfunction
- Patients often present to a single specialty provider for evaluation for only one of these conditions
- Our practice is to screen patients for co-morbid symptomatology to enable multi-specialty evaluation and optimized symptom management

METHODS

- Institutional Review Board approval was obtained. Observational, prospective, single-institution cohort study of 251 patients.
- All new patients of any gender over age 18 entering subspecialized Urology Urogynecology and Reconstructive Pelvic Surgery and a Multidisciplinary Pelvic Pain Clinic were offered a comprehensive multidisciplinary electronic intake form.
- Patients were excluded if:
  - Question as to whether they had pelvic pain unanswered
  - they chose a paper intake form
  - they completed no intake information.
- Statistical analysis: chi-square, binary logistical regression and two-sample t-tests.

Pelvic Symptomatology	Validated Scoring	Cut-offs
Urinary	UDI-6 and AUASS	UDI-6 score ≥ 25 or AUASS ≥ 8
Bowel	CRAD-8	Score > 25
Sexual	PISQR and AUASS	PISQR score ≤ 2.68 or AUASS < 5
Autonomic	Autonomic Symptom Tally	Score ≥ 5
Prolapse	POPDI-6	Score ≥ 25

Table 1: Pelvic symptomatology, validated scoring systems and binary cut-off for presence or absence of predominant organ-specific symptomatology.

	Pelvic Pain Present Mean (%)	Pelvic Pain Absent Mean (%)	P value
Urinary Symptoms			
Presence (UDI-6 ≥ 25 or AUA SS ≥ 8)	84 (36.1%)	60 (25.8%)	
Absence (UDI-6 < 25 and AUA SS <8)	18 (7.7%)	71 (30.4%)	<0.001
Bowel Symptoms			
Presence (CRAD-8 > 25)	56 (23%)	32 (13.1%)	
Absence(CRAD-8 ≤ 25)	54 (22.1%)	102 (41.8%)	<0.001
Sexual Symptoms			
Presence (PISQIR ≤ 2.68, Hardness < 5)	50 (26.5%)	48 (25.4%)	
Absence (PISQIR > 2.68, Hardness ≥ 5)	48 (25.4%)	43 (22.7%)	0.874
Autonomic Review of Systems (ROS)			
Yes (Autonomic ROS ≥ 5)	40 (23%)	32 (18%)	
No (Autonomic ROS <5)	34 (20%)	68 (39%)	0.005
Prolapse Symptoms (Females)			
Presence (POPDI-6 ≥ 25)	69 (32.7%)	35 (16.6%)	
No (POPDI-6 <25)	25 (11.8%)	82 (38.9%)	<0.001

Table 2: Co-existing urinary, bowel, prolapse, pain, autonomic and neurological symptoms were highly prevalent. These associations were significant across all pelvic symptomatology and even more pronounced in individuals with pelvic pain

RESULTS

Distribution of # of symptom categories versus # of patients

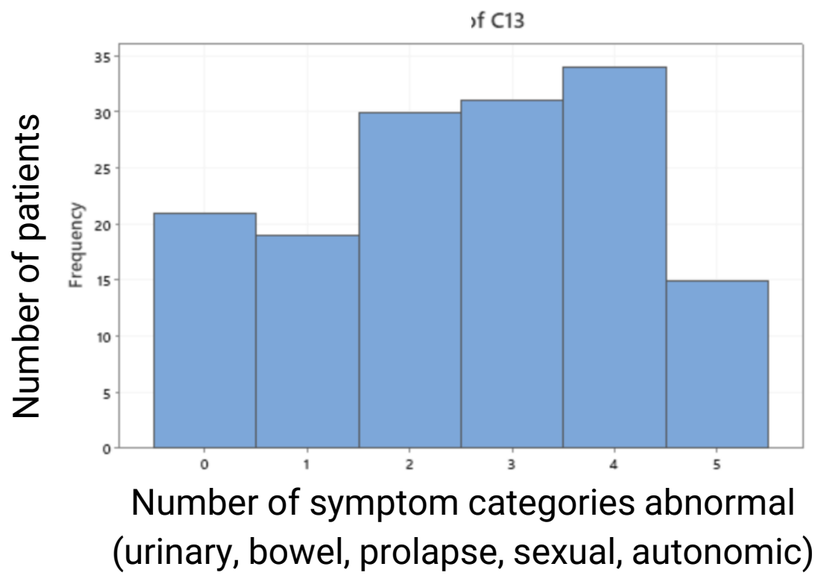

Figure 1: Histogram showing distribution of number of symptom types (urinary, bowel, prolapse, sexual, autonomic) versus number of patients. The average patient reported 2.55 ± 1.6 symptom categories.

	Pelvic Symptoms	Urinary Symptoms	Bowel Symptoms	Sexual Symptoms	Autonomic Symptoms
Urinary symptoms	5.6 (CI 3.0 - 10.3)	-	-	-	-
Bowel Symptoms	3.3 (CI 1.9-5.7)	5.3 (CI 2.7-10.3)	-	-	-
Sexual Symptoms	0.95 (CI 0.5-1.7)	1.36 (CI 0.7-2.6)	1.2 (CI 0.67-2.16)	-	-
Autonomic Symptoms	2.42 (CI 1.3 to 4.4)	2.6 (CI 1.3-5.0)	3.7 (CI 1.9-7.1)	0.9 (CI 0.45-1.8)	-
Prolapse Symptoms	6.7 (CI 3.6-12.2)	12.4 (CI 5.9-25.9)	15.2 (CI 7.4-31.3)	1.03 (0.55-1.92)	3.44 (CI 1.7-6.6)

Table 3: Binary logistic regression: significant correlation among pelvic pain, bowel symptoms, prolapse symptoms, urinary symptoms, autonomic symptoms, sexual symptoms.

CONCLUSIONS

- Patients presenting for evaluation of LUTS, incontinence and pelvic pain are likely to have co-existing pelvic symptomatology
- These associations were more pronounced in those with pelvic pain
- We recommend screening for multidisciplinary symptomatology at intake to optimize potential for improving quality of life
- Further support for a multidisciplinary clinical approach to pelvic floor disorders is needed

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