W15: LIVE WEBINAR: ICS Institute Anorectal Dysfunction: Multidisciplinary Team (MDT) Approach to Pelvic Floor Disorders

Workshop Chair: Linda Ferrari, United Kingdom

Topic	Speakers
Introduction to the workshop	Linda Ferrari
Different specialties are necessary to treat a variety of pelvic floor symptoms	Linda Ferrari
Patients' pathway in a pelvic floor unit from referrals until treatment	Alison Hainsworth
Physiotherapists, nurses and clinical scientists: pilasters in clinical management of pelvic floor conditions	Paula Igualada-Martinez
The key role of multidisciplinary meeting	Liliana Bordeianou
The importance of multidisciplinary pelvic floor clinic	Arun Sahai
Combined surgical procedures to correct multicompartment prolapse	Liliana Bordeianou
Questions	All

Aims of Workshop

The aim of this course is to evaluate the importance of multidisciplinary approach for treatment of pelvic floor disorders and the importance of providing a complete service to patients affected by a variety of pelvic floor symptoms.

Principal aims are:

- Understanding the importance of different specialties involved in a pelvic floor unit
- Role of multidisciplinary pelvic floor clinic
- Multidisciplinary approach to the evaluation of concomitant multicompartment prolapse patients
- Role of combined surgical procedures
- Delineation of patients' pathway from referrals, to diagnostic tests to final management of patients with pelvic floor conditions

Learning Objectives

The importance of multidisciplinary pelvic floor meeting for discussion and management of patients with pelvic floor disorders

Target Audience

Bowel Dysfunction, Conservative Management

Advanced/Basic

Intermediate

Suggested Learning before Workshop Attendance

1. Bordeianou LG, Anger JT, Boutros M, Birnbaum E, Carmichael JC, Connell KA, De EJB, Mellgren A, Staller K, Vogler SA, Weinstein MM, Yafi FA, Hull TL; MEMBERS OF THE PELVIC FLOOR DISORDERS CONSORTIUM WORKING GROUPS ON PATIENT-REPORTED OUTCOMES. Measuring Pelvic Floor Disorder Symptoms Using Patient-Reported Instruments: Proceedings of the Consensus Meeting of the Pelvic Floor Consortium of the American Society of Colon and Rectal Surgeons, the International Continence Society, the American Urogynecologic Society, and the Society of Urodynamics, Female Pelvic Medicine and Urogenital Reconstruction. Dis Colon Rectum. 2020 Jan;63(1):6-23.
2. https://thepelvicfloorsociety.co.uk/
3. Pandeva I, Biers S, Pradhan A et al. The impact of pelvic floor multidisciplinary team on patient management: the experience of a tertiary unit. J Multidiscip Healthc. 2019 Mar 14;12:205-210.
4. Kapoor DS, Sultan AH, Thakar R, et al. Management of complex pelvic floor disorders in a multidisciplinary pelvic floor clinic. Colorectal Dis. 2008 Feb;10(2):118-23.

5. O'Leary BD, Agnew GJ, Fitzpatrick M, Hanly AM. Patient satisfaction with a multidisciplinary colorectal and urogynaecology service. Ir J Med Sci. 2019 Nov;188(4):1275-1278.
6. Brown HW, Barnes HC , Lim A. Better together: multidisciplinary approach improves adherence to pelvic floor physical therapy. Int Urogynecol J 2020 May;31(5):887-893.
7. Jalland K, Gurland B. Multidisciplinary Approach to the Treatment of Concomitant Rectal and Vaginal Prolapse. Clin Colon Rectal Surg, 2016 Jun;29(2):101-5.
8. Jallad K, Ridgeway B, Paraiso MFR, et al. Long-Term Outcomes After Ventral Rectopexy With Sacrocolpo- or Hysteropexy for the Treatment of Concurrent Rectal and Pelvic Organ Prolapse. Female Pelvic Med Reconstr Surg. 2018 Sep/Oct;24(5):336-340.
9. Wallace SL, Syan R, Enemchukwu EA, et al. Surgical approach, complications, and reoperation rates of combined rectal and pelvic organ prolapse surgery. Int Urogynecol J. 2020 Oct;31(10):2101-2108.
10. Wallace SL, Syan R, Enemchukwu EA, et al. Surgical approach, complications, and reoperation rates of combined rectal and pelvic organ prolapse surgery. Int Urogynecol J. 2020 Oct;31(10):2101-2108.

SUMMARY AND REFERENCES FOR TALKS

Ms Linda Ferrari, Pelvic floor clinical fellow, Guy's and St Thomas' NHS Foundation Trust, London UK
Different specialties are necessary to treat a variety of pelvic floor symptoms

Pelvic floor disorders (PFD) are common and heterogeneous conditions which include a spectrum of different conditions such as anal incontinence (AI), obstructive defaecation syndrome (ODS), stress urinary incontinence (SUI), pelvic organ prolapse and chronic pelvic pain[1]. PFD have a complex pathophysiology and different surgical manifestations, making their treatment complex[2]. Majority of patients are women and it has been estimated that approximately 24% of adult women have at least one symptom of PFD. In the past, the standard was a single-specialty approach to PFD, with urogynaecologists, urologists and colorectal pelvic floor specialists assessing patients separately[3]. As a result, most patients felt incomplete resolutions of symptoms and increase failure rate after surgery. For this reason, The National Institute for Health and Clinical Excellence (NICE) recommended multidisciplinary team (MDT) management of patients with PFD with the aim to improve patients' outcome and standardize treatment[4].

References:

1. Billecocq S, Bo K, Dumoulin C, et al. An International Urogynecological Association (IUGA)/International Continence Society (ICS) joint report on the terminology for the conservative and non-pharmacological management of female pelvic floor dysfunction. Prog Urol. 2019 Mar;29(4):183-208.
2. Nygaard I, Barber MD, Burgio KL. Prevalence of symptomatic pelvic floor disorders in US women. JAMA 2008 Sep 17;300(11):1311-6.
3. Mowat A, Maher D, Baessler K, et al. Surgery for women with posterior compartment prolapse. Cochrane Database Syst Rev. 2018 Mar 5;3(3):CD012975.
4. NICE Guidance - Urinary incontinence and pelvic organ prolapse in women: management: © NICE (2019) Urinary incontinence and pelvic organ prolapse in women: management. BJU Int. 2019 May;123(5):777-803.

Ms Alison Hainsworth, consultant Colorectal surgeon, Guy's and St Thomas' NHS Foundation Trust, London UK
Patients' pathway in a pelvic floor unit from referrals until treatment

A multidisciplinary approach to patients' with pelvic floor disorders might be introduced since the initial evaluation through the use of a structured interview, which can be conducted over the phone. Telephone triage assessment clinic (TTAC) is a process where specialized nurses call patients with specific health problems based on their referrals, assess and direct them to appropriate diagnostic tests or specific consultations[5-10]. TTAC for patients with pelvic flor disorders has the potential to assess these complex patients through structured questionnaires[11] and direct them to the most appropriate investigations and treatments. This structured approach allows patients to be assessed in a private environment without the embarrassment of a face to face consultation and has the advantage to avoid a long journey to tertiary referral centres, which have been centralized. Finally, there has been an increase demand for continence services, which is due not only to population aging but also to the increase awareness to treat them to preserve quality of life. In this scenario, TTAC has the potential advantage to reduce the length of time between the referral and the initial assessment and the consequent evaluation and treatment.

References:

5. Bunn F, Byrne G, Kendall S. The effects of telephone consultation and triage on healthcare use and patient satisfaction: a systematic review. Br J Gen Pract. 2005 Dec;55(521):956-61.
6. Holt TA, Fletcher E, Warren F, Telephone triage systems in UK general practice: analysis of consultation duration during the index day in a pragmatic randomised controlled trial. Br J Gen Pract. 2016 Mar;66(644):e214-8.
7. Bunn F, Byrne G, Kendall S. Telephone consultation and triage: effects on health care use and patient satisfaction. Cochrane Database Syst Rev. 2004 Oct 18;(4):CD004180. Review.
8. Berghmans B, Nieman F, Leue C,et al. Prevalence and triage of first-contact complaints on pelvic floor dysfunctions in female patients at a Pelvic Care Centre. Neurourol Urodyn. 2016 Apr;35(4):503-8.
9. Berghmans B, Nieman F, Leue C, et al. Prevalence and triage of first contact pelvic floor dysfunction complaints in male patients referred to a Pelvic Care Centre. Neurourol Urodyn. 2016 Apr;35(4):487-91.
10. Igbedioh C, Williams AB, Schizas A. Introducing a pelvic floor telephone assessment service. Journal of Community Nursing, 2014, 28(4):59-65
11. Bordeianou LG, Anger JT, Boutros M, Birnbaum E, Carmichael JC, Connell KA, De EJB, Mellgren A, Staller K, Vogler SA, Weinstein MM, Yafi FA, Hull TL; MEMBERS OF THE PELVIC FLOOR DISORDERS CONSORTIUM WORKING GROUPS ON PATIENT-REPORTED OUTCOMES. Measuring Pelvic Floor Disorder Symptoms Using Patient-Reported Instruments: Proceedings of the Consensus Meeting of the Pelvic Floor Consortium of the American Society of Colon and Rectal Surgeons, the International Continence Society, the American Urogynecologic Society, and the Society of Urodynamics, Female Pelvic Medicine and Urogenital Reconstruction. Dis Colon Rectum. 2020 Jan;63(1):6-23.

Paula Igualada-Martinez, Lead for the women's health physiotherapy service, Guy's and St Thomas' NHS Foundation Trust, London UK

Physiotherapists, nurses and clinical scientists: pilasters in clinical management of pelvic floor conditions

Multidisciplinary teamwork is recognised as a core component, even cornerstone, of contemporary management of pelvic floor dysfunction, and it seems that collaborative teamwork is an expected and essential part of the current drive to patient-centred care. Pelvic floor disorders are common and its assessment and management by nurses, physiotherapists and clinical scientists is supported by significant, high-quality evidence.
Overlap exists between the care physiotherapists and nurses provide for pelvic floor patients however their collaboration it's a wonderful opportunity to enhance the pelvic floor service provision by streamlining access to treatment, identification of people at high risk of pelvic floor dysfunction and translating pelvic floor dysfunction self-management principles into treatment. Clinical scientists carry out urodynamic studies and/or anorectal investigations to assist in the diagnosis and treatment planning of patients with pelvic floor related conditions. In such an environment, one cli-nician can identify and assess pelvic floor dysfunction while another supports multimodal non-surgical management and communication within the patient's circle of care.
This presentation will review the most up-to-date evidence regarding collaborative team working in the non-surgical assessment and management of pelvic floor dysfunction and a ´proposed model of collaborative teamwork' will be presented.

References:
Bakker E, Shelly B, Esch FH, Frawley H, McClurg D, Meyers P. International Continence Society supported pelvic physiotherapy education guideline. Neurourol Urodyn. 2018 Feb;37(2):869-876.

An International Urogynecological Association (IUGA)/Interna-tional Continence Society (ICS) joint report on the terminology forthe conservative and nonpharmacological management of female pelvic floor dysfunction(2016) https://doi.org/10.1002/nau.23107.

Ms Liliana Bordeianou, Chief of the Colorectal Surgery Program at Massachusetts General Hospital, Boston, USA
The key role of multidisciplinary meeting
Pelvic floor multidisciplinary team should include core members, essential to run a multidisciplinary pelvic floor service. In the view to guarantee a multidisciplinary approach, these core members should include[12]:

- A colorectal surgeon with specific interest in pelvic floor disorders, specialised in performing a wide spectrum of operations needed for posterior pelvic organ prolapse and procedures related to improve fecal incontinence (FI);
- A urogynaecology to treat patients with middle compartment prolapse, as well as women with SUI and urge urinary incontinence;
- A urologist to treat female and male patients with urinary symptoms';

- A pelvic floor physiotherapist and specialist nurse dedicated to optimise conservative management;
- Clinical Scientist to delivery pelvic floor investigations;

Additional members might provide a valid contribution but might be considered not essential. Examples are Gastroenterologists with a specific interest in dysmotility disorders, Pain management specialist interested in chronic pelvic pain, a psychologist and psychiatrist to help patients with associated depression/anxiety disorders. A recent retrospective analysis of prospectively collected data of women referred and discussed at joint Pelvic floor MDT over a year in a tertiary referral centre has been published13. In total, 152 patients have been discussed; the MDT recommended a change in the initial management plan in 20% (31/152) of cases, of whom 80% (25/31) were patients with complex urinary incontinence.

References:
12. https://thepelvicfloorsociety.co.uk/
13. Pandeva I, Biers S, Pradhan A et al. The impact of pelvic floor multidisciplinary team on patient management: the experience of a tertiary unit. J Multidiscip Healthc. 2019 Mar 14;12:205-210.

Mr Arun Sahai, Consultant Urology, Guy's and St Thomas' NHS Foundation Trust, London UK
The importance of multidisciplinary pelvic floor clinic

Combined multidisciplinary pelvic floor clinics have been demonstrated to improve patients' satisfaction[14,15] and increase adherence to treatment. Kapoor et al[14] retrospectively analysed a cohort of 113 patients referred to a tertiary referral center over 3 years. A total of 113 patients have been assessed in a multidisciplinary clinic led by an Urogynaecologist and Colorectal Surgeon physicians over a 3-year period. Patient satisfaction audit found that 73% of care were excellent/good. Similar results have been found by O'Leary et al[15], who conducted a survey among 136 women who attended a combined clinic between colorectal and urogynaecology physician a pelvic floor tertiary referral centre in in 2015. In total, 87 patients responded to questionnaires, 97% found beneficial seeing multiple specialists during the same appointment and 94% would recommend the pelvic floor centre. Furthermore, adherence to conservative management seems to improve when patients attend a combined clinic with physician and physiotherapist[16]. Patients who saw physiotherapist the same day as their first urogynaecology visit were more likely to attend further physiotherapy sessions compared to those who did not (91% vs 61%, $p<0.001$).

References:
14. Kapoor DS, Sultan AH, Thakar R, et al. Management of complex pelvic floor disorders in a multidisciplinary pelvic floor clinic. Colorectal Dis. 2008 Feb;10(2):118-23.
15. O'Leary BD, Agnew GJ, Fitzpatrick M, Hanly AM. Patient satisfaction with a multidisciplinary colorectal and urogynaecology service. Ir J Med Sci. 2019 Nov;188(4):1275-1278.
16. Brown HW, Barnes HC , Lim A. Better together: multidisciplinary approach improves adherence to pelvic floor physical therapy. Int Urogynecol J 2020 May;31(5):887-893.

Ms Liliana Bordeianou, Chief of the Colorectal Surgery Program at Massachusetts General Hospital, Boston, USA
Combined surgical procedures to correct multicompartment prolapse

First line treatment for pelvic floor disorders is conservative management, when this fails, surgery should be considered after discussion in multidisciplinary meeting. Combined procedures for middle and posterior compartment prolapse as well as urinary incontinence procedures combined with pelvic organ prolapse ones might be done together if appropriate[14,17-20]. Jalland K et al[18] retrospectively 59 patients, who underwent ventral rectopexy with either concurrent sacrocolpo or hysteropexy at a tertiary care centre between 2009 and 2015. After a median follow-up of 17 months, they found that combined procedures were associated with significant improvement in anatomic and subjective outcomes. Similar results have been found by Kapoor et al in their rectrospective review, with the conclusion that joint surgical procedures might accelerate patients' treatment and improve satisfaction.

References:
17. Jalland K, Gurland B. Multidisciplinary Approach to the Treatment of Concomitant Rectal and Vaginal Prolapse. Clin Colon Rectal Surg, 2016 Jun;29(2):101-5.
18. Jallad K, Ridgeway B, Paraiso MFR, et al. Long-Term Outcomes After Ventral Rectopexy With Sacrocolpo- or Hysteropexy for the Treatment of Concurrent Rectal and Pelvic Organ Prolapse. Female Pelvic Med Reconstr Surg. 2018 Sep/Oct;24(5):336-340.
19. Wallace SL, Syan R, Enemchukwu EA, et al. Surgical approach, complications, and reoperation rates of combined rectal and pelvic organ prolapse surgery. Int Urogynecol J. 2020 Oct;31(10):2101-2108.

20. Wallace SL, Syan R, Enemchukwu EA, et al. Surgical approach, complications, and reoperation rates of combined rectal and pelvic organ prolapse surgery. Int Urogynecol J. 2020 Oct;31(10):2101-2108.