CORRESPONDENCE

The Investigation and Treatment of Female Pelvic Floor Dysfunction

by PD Dr. med. Katharina Jundt, Prof. Dr. med. Ursula Peschers and Prof. Dr. med. Heribert Kentenich in issue 33–34/2015

Proctologists Omitted

As colorectal surgeons, we are regularly concerned with pathomorphological disorders of the female pelvic organs, the pelvic floor and its sphincter systems; therefore, we consider it important to highlight aspects of the topic which were only mentioned in passing in the article, if at all. Unfortunately, the article's title is somewhat misleading (1). We have the impression that the article only deals with the investigation and treatment of urinary incontinence and pelvic organ prolapse. However, many patients experience not only urinary incontinence but a combination of urinary and fecal incontinence, with some suffering only from fecal incontinence. Many epidemiological studies are available on this topic, but these are not mentioned in the article.

With regard to the evaluation of pelvic floor dysfunction *(Box 2)*, the basic evaluation is carried out by a "general practitioner, gynecologist, or urologist", according to the article. For the extended basic evaluation, it suffices if it is carried out by a "gynecologist or urologist (with the aid of a psychiatrist and/ or specialist in psychosomatic medicine, if indicated)". Only at the level of special tests, the article requires a "specialist (perhaps at a specialized continence and pelvic floor center". At the end of the list, we find "endoanal intrasonography, if indicated, and dynamic magnetic resonance defecography, if indicated".

A more differentiated approach to pelvic and pelvic floor dysfunctions has long been followed in many offices and hospitals (gynecology, urology and proctology) all over Germany—not only in specialized continence and pelvic floor centers. Interdisciplinary collaboration between the specialties, including colorectal surgery, is the only way to ensure that all aspects of the investigation and treatment of female pelvic floor dysfunction are covered in a way that fulfils today's quality requirements.

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Broadened View

Unfortunately, it is necessary to broaden the view on the surgical treatment of vaginal vault prolapse (1) and also include long-term data from the CARE study conducted in the United States (2) and data from a Czech multicenter study (3). In the CARE study, in which only continent women with vaginal vault prolapse underwent surgery, 81% of all women were incontinent 7 years after sacrocolpopexy. By means of abdominal Burch colposuspension, incontinence could be prevented in only 6% of these women. During the same period, 34%–48% experienced "anatomical" recurrences. Mesh erosions occurred in 10% of these patients. The authors were "[…] surprised by the high failure rate as this procedure has been regarded as the gold standard in pelvic floor repair surgery".

The Czech multicenter study showed as early as one year after sacrospinous ligament fixation (Amreich-Richter) that 40% of all women had become incontinent (25% de-novo stress urinary incontinence, 15% de-novo urge urinary incontinence). 39% of all patients experienced anatomical recurrences and 20% mesh erosions (Prolift). The authors regarded these outcomes as "unexpected and unexplainable". These results should lead to greater reflection on this approach.

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Vaginal Delivery as Leading Risk Factor

The article reports pelvic floor exercise treatment success rates of 56% in patients with stress urinary incontinence (1) based on the result of a meta-analysis of four studies including a total of 165 women. Furthermore, the authors state that mental disorders are more common among patients with bladder dysfunction than among other women. However, the question is how often these abnormalities result from the feeling of insecurity these patients develop in response to their incontinence problem. The patient population referred to in the article were Swedish women aged 20 to 59. Prolapse of the reproductive organs was found in 31% of the women of this patient population, typically after childbirth. However, the article reports the following figures: Two pregnancies with vaginal delivery result in an eightfold increase in the odds of developing incontinence (2). Symptomatic prolapse is twice as common after vaginal delivery compared with cesarean section in every stage of birth (14.6% vs. 6.3%). To complement this, here are the data of the German Federal Statistical Office (Destatis: Statistics of hospital diagnosis, 077): In 35% of vaginal deliveries, tears require surgical treatment. This corresponds to

295 000 women versus 225 000 with cesarean section. Damaged connective tissue structures after childbirth can only partly be detected by examination of the perineal region (2). As pelvic floor exercises are primarily aimed at muscle strengthening, they have little effect on these injuries. The editors of the textbook state in their editorial that "surgical techniques can only repair a small proportion of these anatomical changes". It has to be asked whether conservative incontinence treatment can achieve better results.

An Australian/New Zealand study (3) collected data on this question at 3 months, 6 years and 12 years after index birth. At 12 years, 53% still reported urinary incontinence. In 38%, urinary incontinence was persistent, i.e. it had been previously reported.

Three out of four patients with incontinence at 3 months after index birth still reported incontinence at 12 years. According to a US study (4), the risk of pelvic organ prolapse doubles after the second vaginal delivery.

Conclusion: The therapeutic options available to treat pelvic floor dysfunction are limited.

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NPH Among the Potential Causes

One differential diagnosis that I miss in this otherwise very well researched article (1) is normal pressure hydrocephalus (NPH). This condition is neither mentioned under risk factors nor in history-taking as a potential cause of urinary or fecal incontinence, even though both types of incontinence are main symptoms of this disorder, besides abnormal gait.

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In Reply:

Dr. Jongen and colleagues rightly point out that the article paid too little attention to the aspect of coloproctology (1). Unfortunately, a comprehensive discussion of anal incontinence and anal evacuation disorders would have exceeded the scope of this article. However, there is no doubt that the evaluation of colorectal function is an integral part of any comprehensive pelvic floor assessment and that treatment planning should take into account all aspects of pelvic floor function. According to both the criteria of the German Continence Society and the certification criteria of ClarZert, every accredited pelvic floor center must have gynecology, urology and coloproctology services available. As highlighted by the colleagues, fortunately this interdisciplinary collaboration is flourishing in many practice and hospitals, not only in certified centers.

Professor Jäger cites two studies with disappointing results with regard to anatomic repair and the development of de novo incontinence for sacrocolpopexy, sacrospinous fixation and vaginal mesh implantation. Nygaard et al. report long-term outcomes at 7 years after abdominal sacrocolpopexy. However, only 126 of the initial 233 participants (59%) were available for evaluation after seven years. In 31 of 126 (24%) patients, a recurrence of pelvic organ prolapse according to the study criteria was found, but half of these had complaints. While 49 of 126 patients (39%) experienced symptoms of prolapse, 27 of these patients had no anatomical recurrence. When evaluating these findings, it is also important to keep in mind that prolapses can develop in other vaginal compartments over the years. Abdominal sacrocolpopexy primarily treats vaginal vault prolapse and only 11 of 126 patients (9%) had a recurrence at this compartment. Following abdominal sacrocolpopexy, a new prolapse often develops in the posterior vaginal compartment as this is not satisfactorily accessible during the abdominal procedure.

Recurrences after vaginal sacrospinous fixation commonly involve the anterior vaginal wall as with this technique the vagina is pulled in a posterior, inferior direction with some force. This type of prolapse often remains asymptomatic.

To respond to these suboptimal results with greater reflection alone is not enough. Required are well-designed, randomized long-term studies not sponsored by the industry.

Professor Wenderlein's comments refer to the clinical history (delivery type) and the limited success of surgical treatment. Hence, a psychosomatic perspective is required. Fundamentally, one can agree with this.

Dr Materna points out that the main symptoms of normal pressure hydrocephalus are abnormal gait and incontinence. When taking the history of a patient, exploratory questions regarding neurological symptoms should always be asked. Abnormal gait in combination with incontinence should always trigger further neurological investigations to exclude any potential neurological causes of incontinence.

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Prof. Peschers has served as a paid consultant for Astellas and Allergan and has received reimbursement of medical meeting participation fees from Pfizer. She has received lecture honoraria and reimbursement of travel and accommodation expenses from Coloplast, Allergan, AMS, and Astellas and has been paid for carrying out clinical trials on behalf of Coloplast and Allergan.