



Common Female Pelvic Floor Disorders: Diagnosis, Treatment, and When to Refer

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FACOG, FPMRS

Welcome & Introduction

- Meet the Presenter



- Molly Dahl, MD
- Obstetrics & Gynecology
- Female Pelvic Medicine and Reconstructive Surgery

- Check out our Practice

- Providence Urogynecology & Surgical Gynecology
- Dr. Partoll (retired), Dr. Hammil
- Columbia Surgical Specialists
- 920 N Washington St, Spokane

Background

- OBGYN Residency 2014-2018
UC Davis, Sacramento CA
- Urogynecology Fellowship 2018-2021
LAC+USC, Los Angeles CA



Why Spokane?



Objectives

- Introduction to the FPMRS Subspecialty
 - What We Treat & Who We Work With
 - Pelvic Organ Prolapse
 - Urinary Incontinence
- } • Diagnosis
• Workup
• Treatment
- When To Refer And How We Can Help
 - Resources For Physicians And Patients
 - Questions and Answers

What is “FPMRS”?

- Female Pelvic Medicine and Reconstructive Surgery
 - “Urogynecology” or “Female Urology”
- Subspecialty of either OB/GYN or Urology
- Certified by the American Board of Medical Specialties
 - ACGME residency in OBGYN or Urology
 - ACGME fellowship in FPMRS
 - Pass a written/oral board examination

Areas of Expertise

- **Pelvic Organ Prolapse**
- **Bladder Issues**
 - Overactive Bladder
 - Urinary Incontinence
 - Urinary Retention
- **Bowel Issues**
 - Fecal Incontinence
 - Constipation
- **Obstetric Trauma**
 - Vesicovaginal and rectovaginal fistulas
- **Pelvic Pain & Sexual Dysfunction**

What we do

- Vaginal Surgery
- Laparoscopic Surgery
- Robotic Surgery
- Pessaries
- Slings and Urethral Bulking
- Botox and Sacroneuromodulation



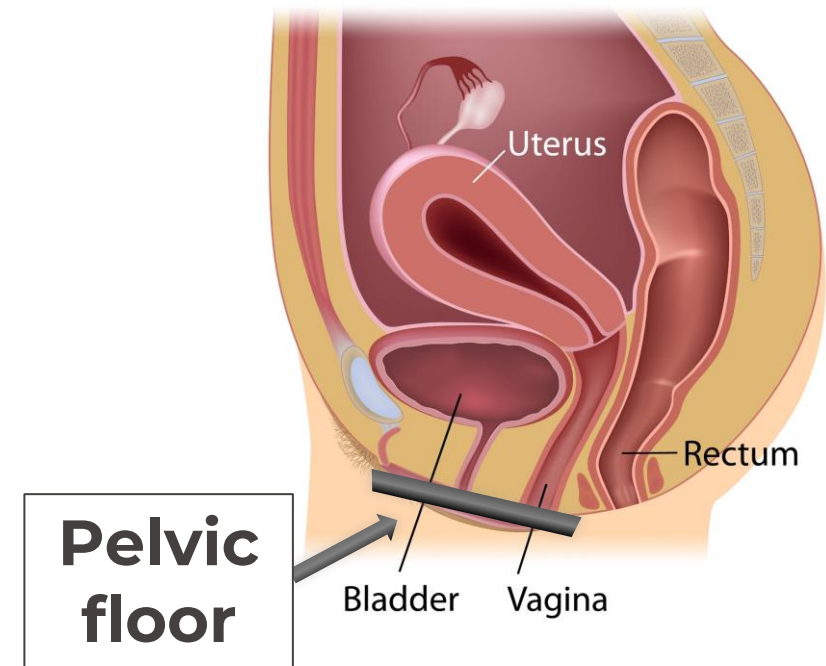
Who We Work With

- Gynecology
- Urology
- Gastroenterology and Colorectal Surgery
- Pelvic Floor Physical Therapy
- Multi-disciplinary group
(ambulatory or in-patient/surgical settings)



What is the “Pelvic Floor”?

- Set of muscles, ligaments and connective tissue
- Supports and controls function of the pelvic organs:
 - Bladder
 - Uterus
 - Rectum
 - Vagina



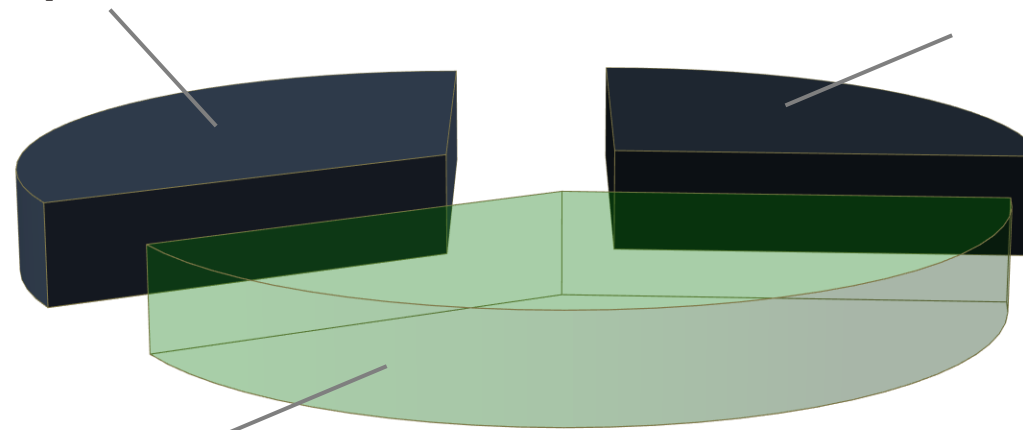
Pelvic Floor Disorders

About 1:3 women will experience a PFD in her lifetime and 1:9 will have surgery for a PFD

Care Seeking in Urinary Incontinence

26% of women wait over 5 years to seek help

33% wait 1 to 5 years



41% seek help within 1 year

Norton, P A et al. BMJ, 1988

Pelvic Organ Prolapse (POP)

Prevalence of POP



POP on Physical Exam
41-50%

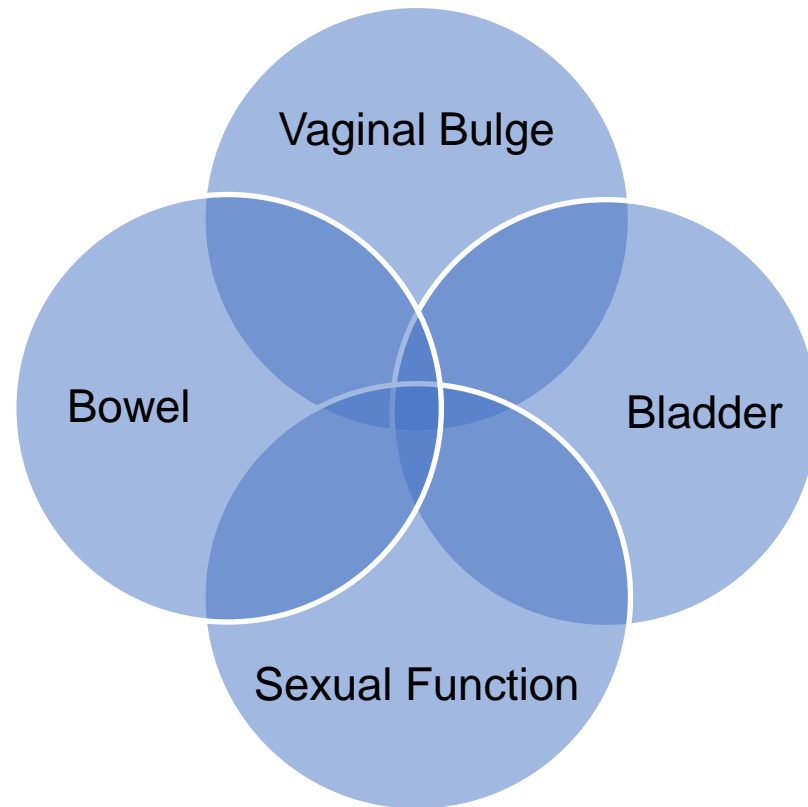


POP Symptoms
3-6%



Surgery for POP
6-18%

What patients might tell you...



Panel 2: Typical symptoms in women with pelvic organ prolapse

Vaginal

- Sensation of a bulge or protrusion
- Seeing or feeling a bulge or protrusion
- Pressure
- Heaviness

Urinary

- Incontinence
- Frequency
- Urgency
- Weak or prolonged urinary stream
- Hesitancy
- Feeling of incomplete emptying
- Manual reduction of prolapse to start or complete voiding
- Position change to start or complete voiding

Bowel

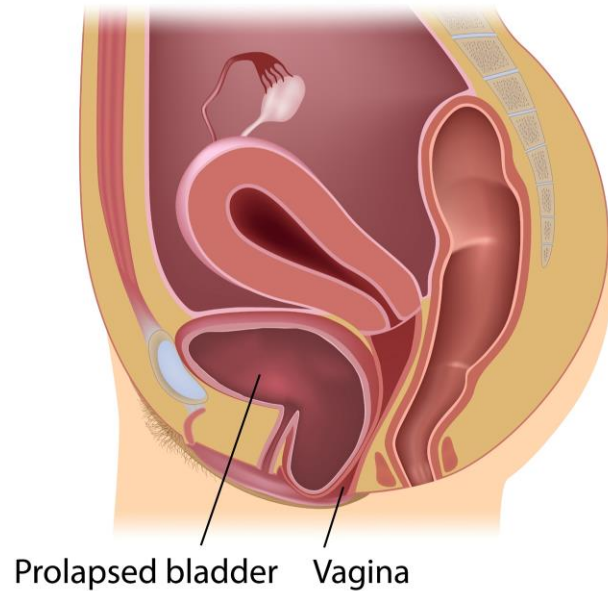
- Incontinence of flatus, or liquid or solid stool
- Feeling of incomplete emptying
- Straining during defecation
- Urgency to defecate
- Digital evacuation to complete defecation
- Splinting, or pushing on or around the vagina or perineum, to start or complete defecation
- Feeling of blockage or obstruction during defecation

Sexual

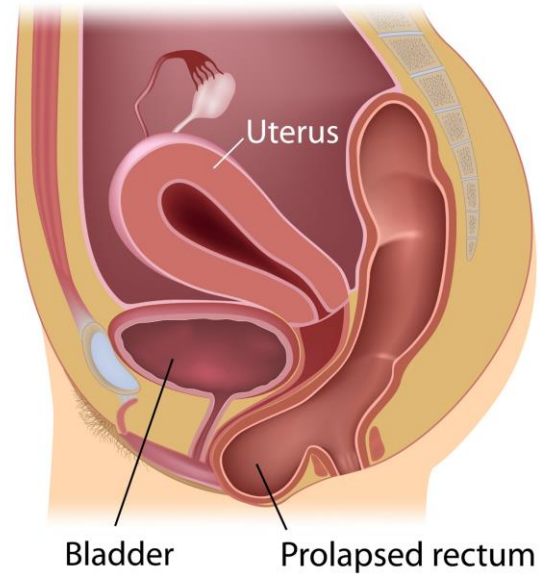
- Dyspareunia

POP—Anatomy Basics

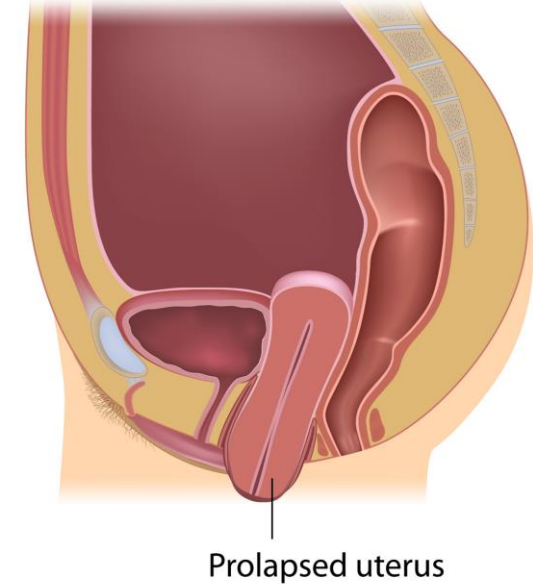
Cystocele



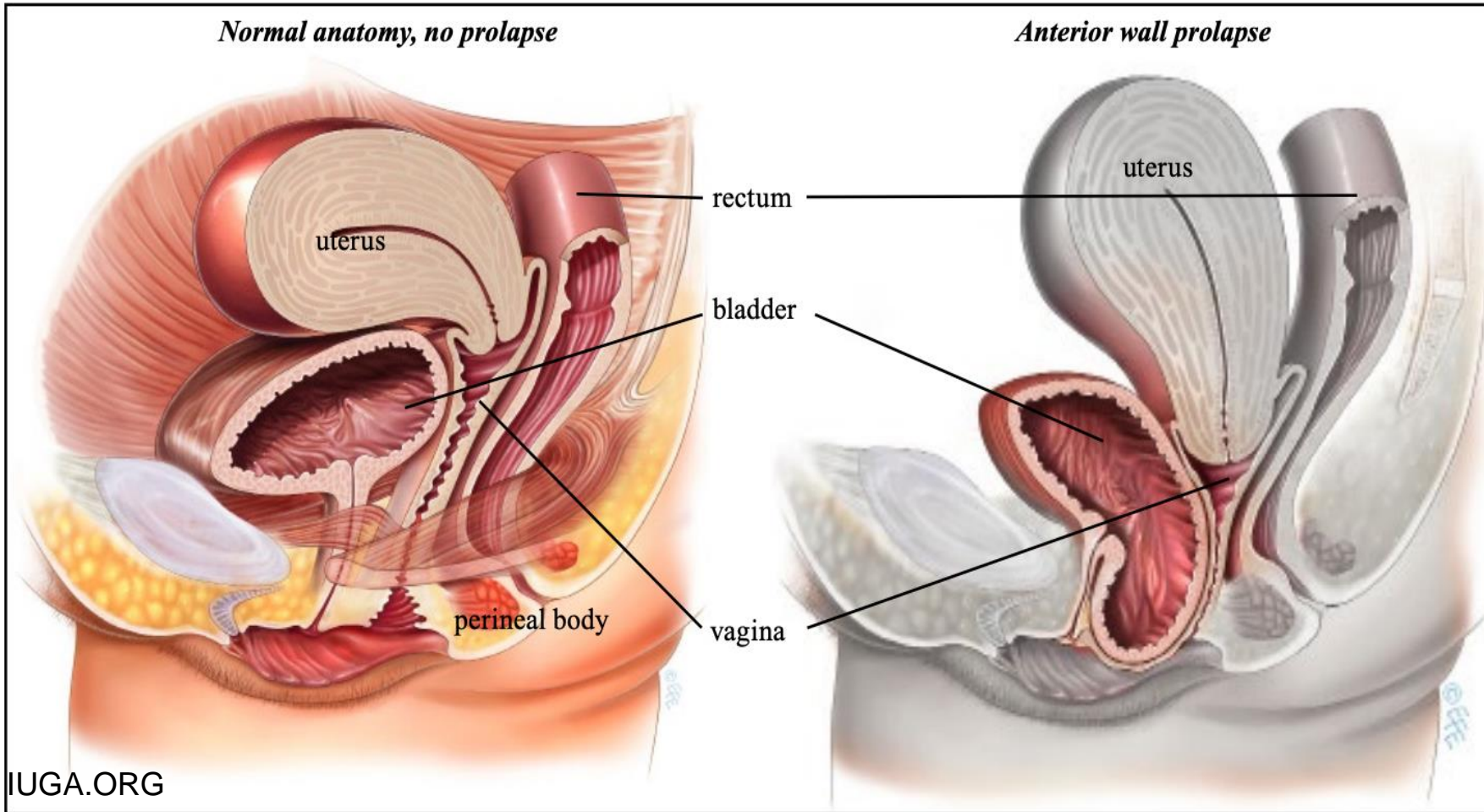
Rectocele



Uterine Prolapse



Urethral hypermobility and kinking



1. Loss of anterior vaginal wall support leads to hypermobility-> SUI

2. Prolapse beyond the hymen can lead to urethral kinking -> less SUI

3. Advanced POP is associated with slow stream and incomplete emptying

Risk Factors

- Age
- BMI
- Parity
- Large Babies
- Prolonged Labor
- Operative Delivery
- Genetics
- Connective Tissue Disease
- Pelvic Surgery
- Menopause/Hormonal Status

Evaluation: History

- “Do you feel or see a bulge coming out of the vagina?”
- History:
 - Medical
 - Surgical
 - Obstetric
 - Sexual
 - Social -**How this affects their daily life**

Evaluation: History

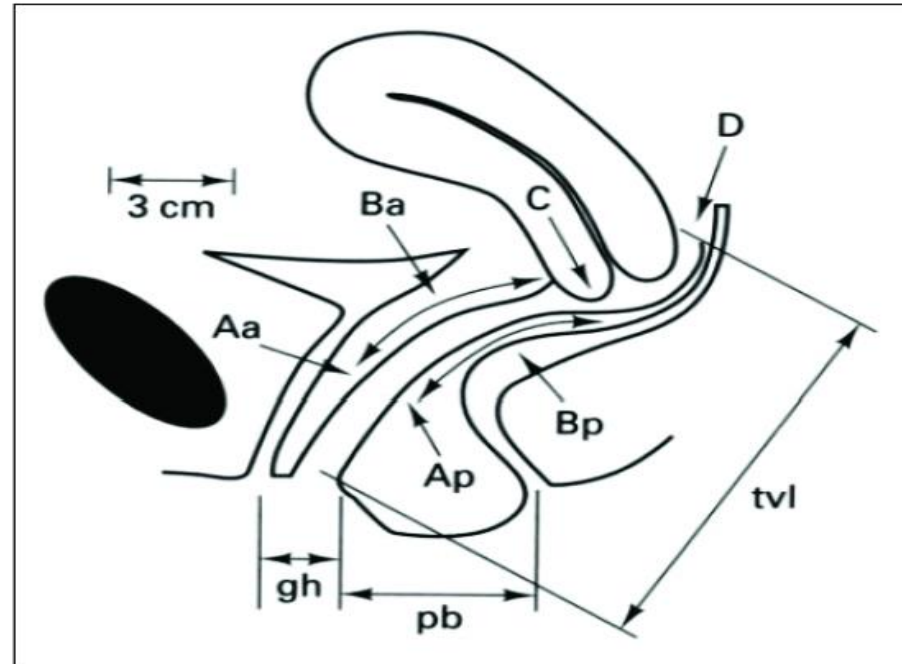
Symptomatic? Bothersome?

- Pelvic pressure and bulge
- Urinary: Difficulty emptying
- Defecatory: Pushing, straining, splinting or manually evacuating
- Sexual Dysfunction: **Active?** Pain, embarrassment

Prolapse Stage: POP-Q Exam



Stage 2

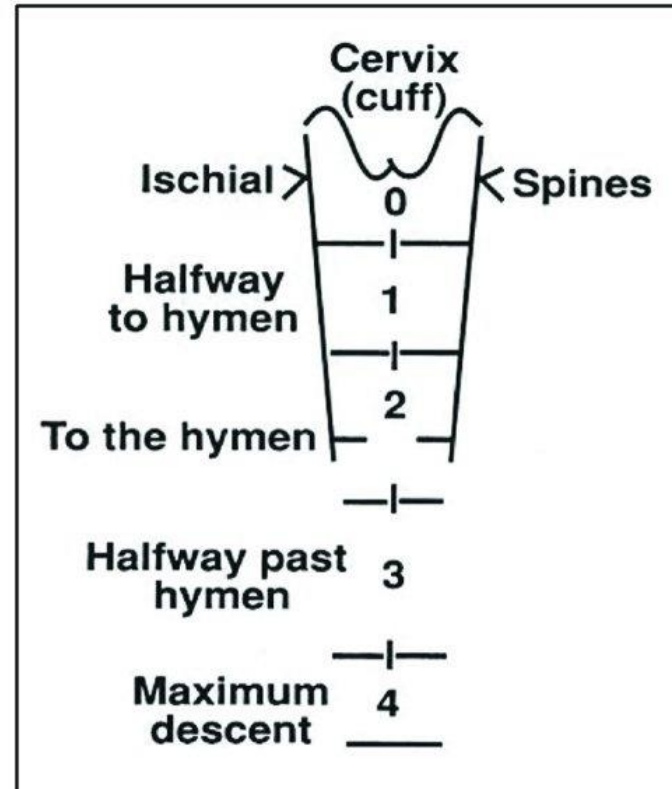


Stage 3

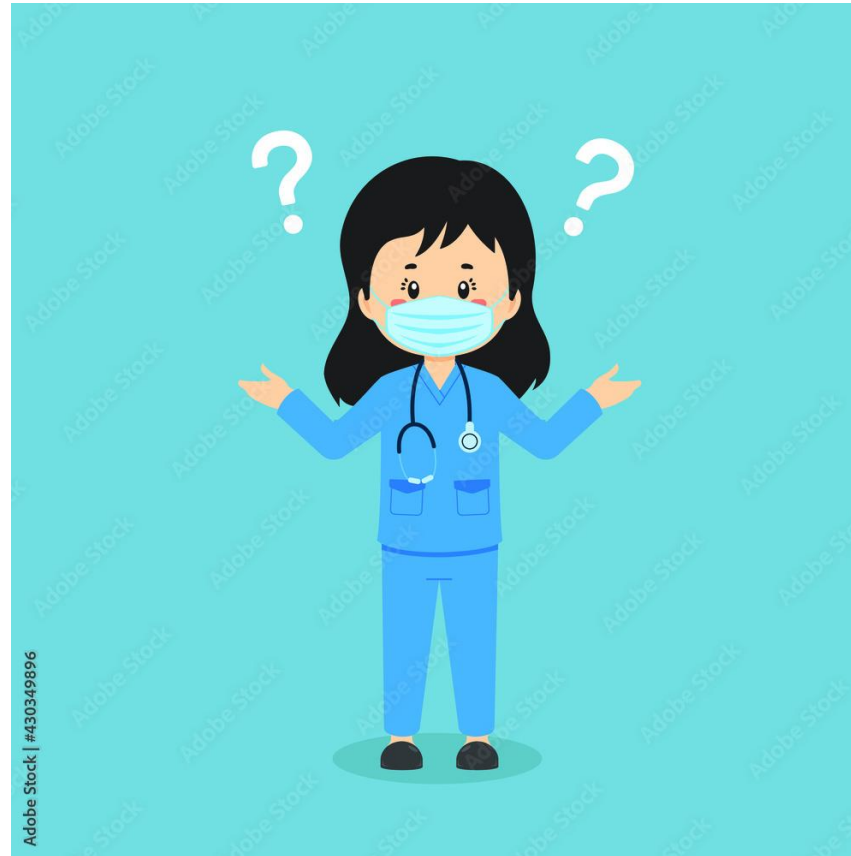


Stage 4

Prolapse Grade



Is there a bulge?



POP Treatment Options

- Conservative - Physical Therapy
- Non-surgical - Pessaries
- Surgical

Conservative Management

- Pelvic Floor Physical Therapy vs. Control
 - Improvement in symptoms
 - 17% had improvement by 1 stage in anatomy
 - 6 months of supervised PT best results



Hagen et al . [Cochrane Database Syst Rev. 2011](#)

Non-surgical Management: Pessaries

- 81% successfully fitted, 86% continued use, 12% minor complications (7% pain, 3% erosion 2 % constipation)
- Risk Factors for unsuccessful placement:
 - Short vaginal length (<6cm)
 - Wide introitus (>4 fingerbreadths)
 - Genital hiatus: total vaginal length ratio >0.8
 - Age <65
 - Lower POP-Q stage

Lone et al. *Int J Gynaecol Obstet.* 2011

Clemons et al. *Am J Obstet Gynecol.* 2004

Geoffrion et al. *Female Pelvic Med Reconstr Surg.* 2013



coopersurgical.com

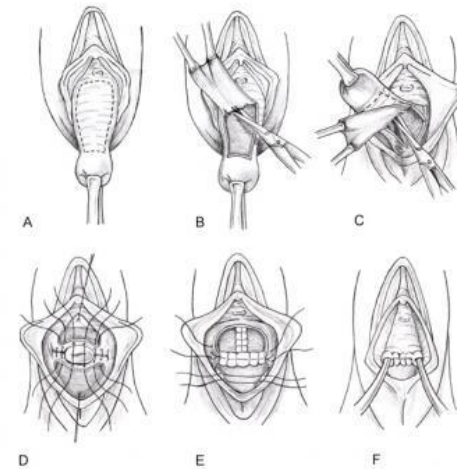
POP Treatment: Surgical

- Obliterative (Colpocleisis)
- Native Tissue Repair (Uterosacral Suspension)
- Sacrocolpopexy (Robotic or Laparoscopic)



Obliterative Prolapse Repair

- Frail, Elderly, Medically Complex, Advanced Prolapse, Does not desire future vaginal intercourse
- High Satisfaction >90%
- Low complication Rate
- Improved body Image, low regret

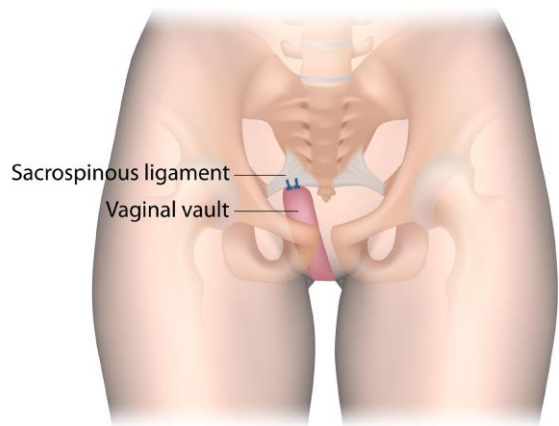


Hill et al *Am J Obstet Gynecol* 2016
Crisp et al. *Am J Obstet Gynecol* 2013
Crisp et al. *Female Pelvic Med Reconstr Surg.* 2016
Abbasy and Kenton *Clin. Obstet Gynecol* 2010

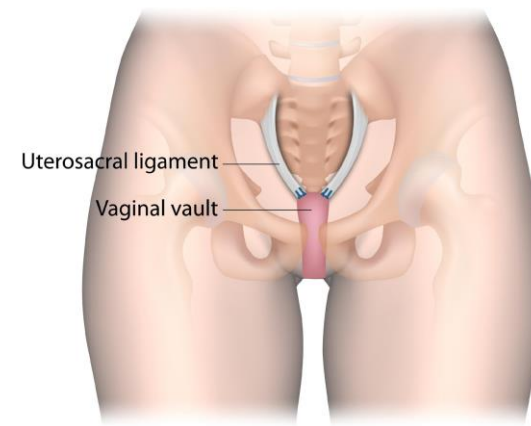
Adam et al <http://emedicine.medscape.com/article/268258>

Native Tissue Reconstruction

- Uterosacral /Sacrospinous Ligament Suspension
- Anterior and Posterior Colporrhaphies



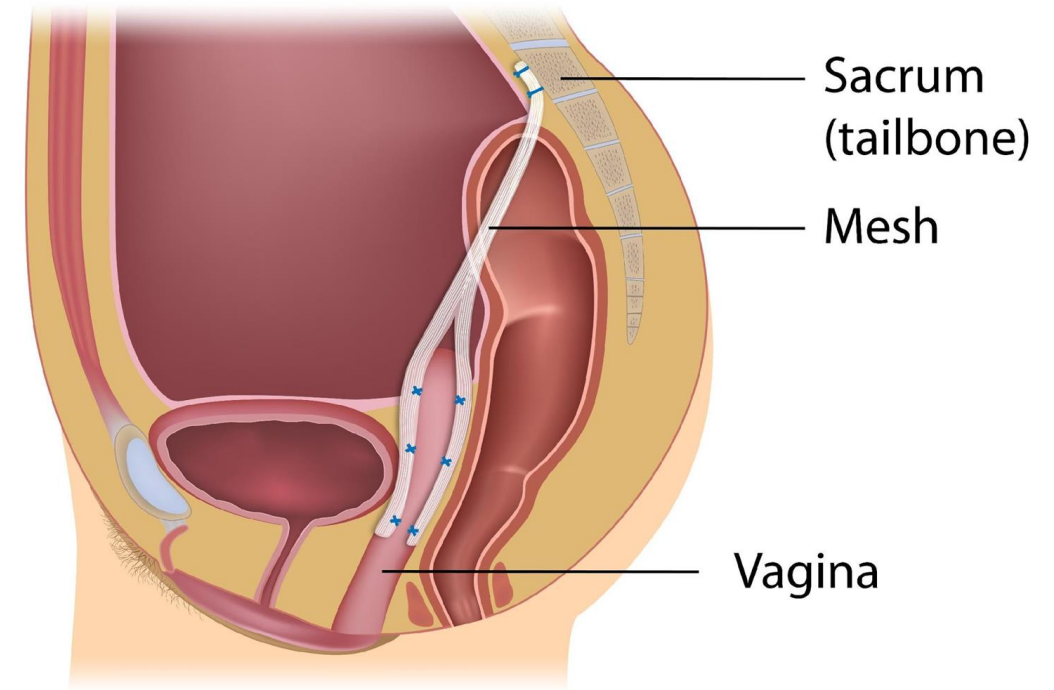
**Sacrospinous Ligament
Fixation**



**Uterosacral Ligament
Suspension**

Sacrocolpopexy

- Abdominal, Laparoscopic, Robotic Routes
- ECARE: 7 year outcomes, symptom success 70-75%, anatomic success 75%, Composite failure 34-48%, mesh erosion 10%



Nygaard et al. JAMA 2013

Urinary Incontinence

Urinary Incontinence

- 50% of women over age 60



COUGH

STRESS INCONTINENCE



URGENCY INCONTINENCE

Other causes of urinary incontinence



FUNCTIONAL



OVERFLOW

Evaluation

- UTI?
- Retention?
- Medications? (Diuretics)
- Diabetes?
- Sleep apnea?
- Obesity?
- Smoking?

Treatment: SUI



COUGH

STRESS INCONTINENCE

- Conservative - Physical Therapy
- Non-surgical - Pessaries
- Surgical – Slings or Urethral Bulking

Treatment: Overactive Bladder

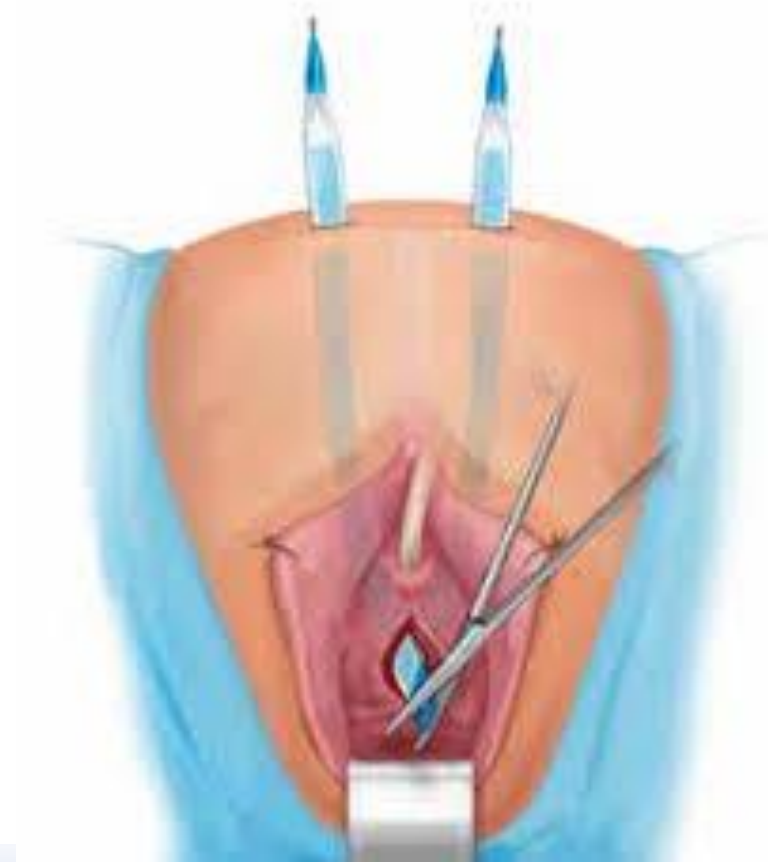


- First Line- Physical Therapy & Bladder Training
- Second Line- Medications (eg. Vesicare, Mirabegron)
- Third Line- Botox, Sacroneuromodulation, PTNS

What about women with POP & UI?



Mid-urethral sling



What's the deal with mesh?

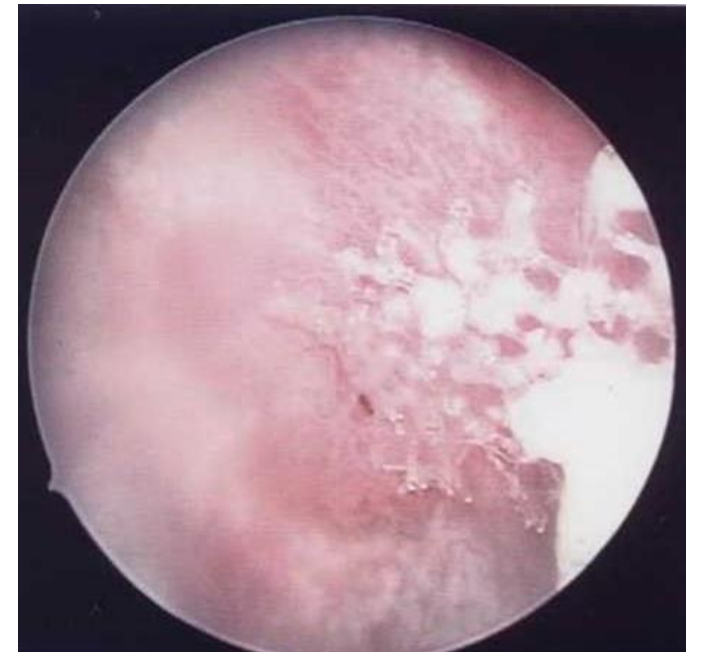
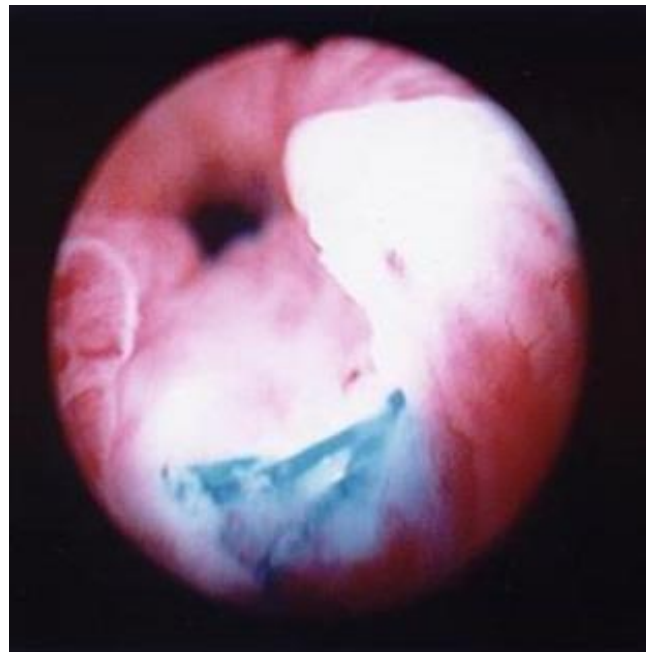
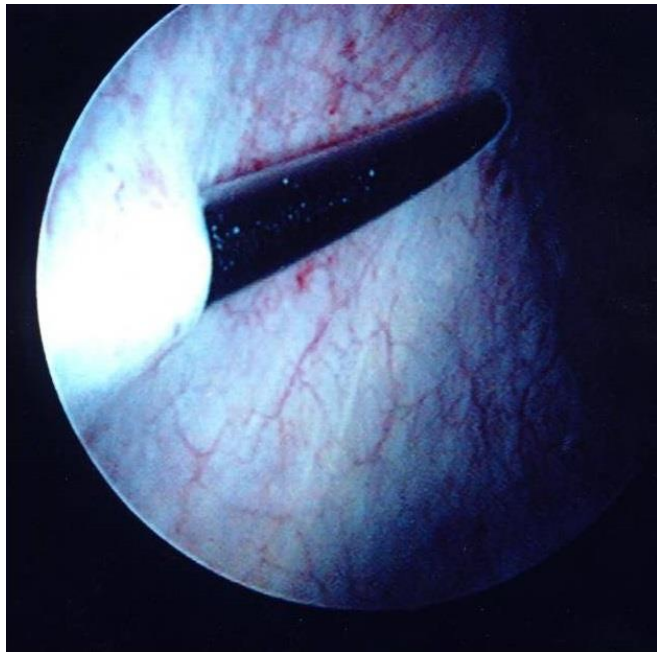
- Mesh for prolapse
 - Vaginal mesh kits
 - Sacrocolpopexy
- Mesh for incontinence
 - TOT
 - TVT



Mesh Benefits

- More durable surgery
- Lower recurrence rates for prolapse
- Minimally invasive surgery
- Still the standard of care for prolapse and incontinence

Complications



Position Statement

This Position Statement was developed by a joint task force between the American Urogynecologic Society (AUGS) and the Society for Urodynamics, Female Pelvic Medicine and Urogenital Reconstruction (SUFU). This document reflects clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Mesh Midurethral Slings for Stress Urinary Incontinence

Introduction

The purpose of this position statement by the American Urogynecologic Society (AUGS) and the Society of Urodynamics, Female Pelvic Medicine and Urogenital Reconstruction (SUFU) is to support the use of the midurethral sling in the surgical management of stress urinary incontinence, the type of urine leakage generally associated with coughing, laughing and sneezing.

Developed in the early 1990's, midurethral slings (MUS) treat stress urinary incontinence (SUI) in a minimally invasive, generally outpatient procedure. This technique utilizes a small mesh strip composed of monofilament polypropylene placed through the vagina under the mid-urethra exiting from 2 small sites in either the suprapubic or groin areas.



Who to refer?

- **Vaginal Prolapse**
- **Urinary Incontinence**

- Urinary urgency or frequency
- Recurrent bladder infections
- Urinary retention
- Microscopic hematuria
- Sexual dysfunction
- Pelvic Pain
- Surgical management of fibroids, ovarian cysts, urethral diverticulum, vaginal cysts

Who to refer?

MINIMALLY INVASIVE GYNECOLOGIC SURGERY

- Irregular bleeding
- Painful periods
- Endometriosis
- Fibroids
- Ovarian Masses
- Pelvic Pain
- Hysteroscopy



Dr. Kelli McEntee

When to Send...

- For a second set of **eyes**: (bumps, lumps, lesions)
- For a second set of **hands**: Surgery, procedural options, refractory or complicated patients...
- For diagnostic tools (urodynamics, cystoscopy, pessaries)
- For **questions**: any time you have a question or want to escalate care
- Molly.Dahl@Providence.org Cell: 925-330-3740

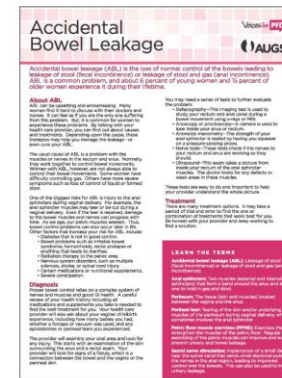
Resources for You and Your Patients

- AUGS.org
- [IUGA: YourPelvicFloor.org/leaflets](http://IUGA:YourPelvicFloor.org/leaflets)
- VoicesforPFD.org

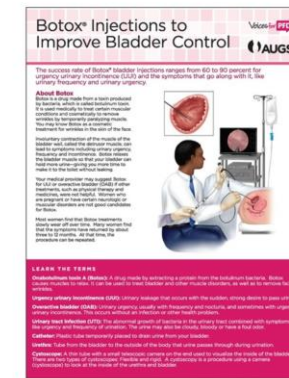


Fact Sheets

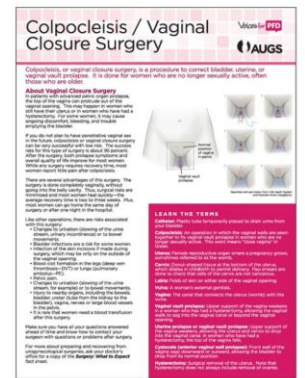
Click on the images below to download these resources designed to help you better understand your diagnoses and treatment options.



Accidental Bowel Leakage



Botox Injections to Improve



Colpocleisis/Vaginal Closure



Molly.Dahl@Providence.org

Providence.org/locations/wa/urogynecology



Questions?



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