2020 Third Annual National Conference

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Red Rock Hotel – Las Vegas, NV
Urogynecologic/Pelvic Floor Dysfunction

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Disclosures

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Disclosures

Nicole Martinez de Andino, NP-C
Steering Committee: Salix, Clinical Area- IBS
Objectives

• Review basic anatomy of pelvic floor
• Discuss prevalence of pelvic floor disorders
• Identify issues in screening for pelvic floor disorders and barriers in seeking care
• Define main types of pelvic floor disorders, risk factors, management options for each
• Discuss functional anorectal pain
Pelvic Floor Anatomy

Female

Male

Main Types of Pelvic Floor Dysfunction

• Urinary incontinence
• Fecal incontinence
• Pelvic organ prolapse
Prevalence of Pelvic Floor Dysfunction

• By 2050: Estimated 43.8 million women with at least 1 pelvic floor disorder\textsuperscript{1}

• 25% of women based on NHANES\textsuperscript{2}
  – #1 urinary incontinence 17%
  – #2 fecal incontinence 9%
  – #3 pelvic organ prolapse 3%

PFD Prevalence

- **Urinary Incontinence**\(^1\)
  - More common in women than men
  - Approximately 10% of all adult women affected
  - More than 40% of women 70 years of age and older affected

- **Fecal Incontinence**\(^2\)
  - 1 in 7 in large population-based study
  - Higher prevalence in IBD, celiac, IBS, diabetes

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Development of Pelvic Floor Disorders

Predispose
- Gender
- Race
- Anatomic
- Neurologic
- Collagen

Incite
- Pregnancy
- Radiation
- Nerve damage
- Surgery

Decompensate
- Aging
- Dementia
- Decreased mobility

Promote
- Constipation
- Smoking
- COPD
- Obesity
- Occupation
- Medications

Screening

• Survey of 154 PCPs
  – Screening rates UI vs. FI: 75% vs 35%
  – Those screening for UI and feeling informed to treat FI were more likely to screen for FI

• UI is included in Merit-based Incentive Payment System

Screening Tips

Use preferred terms:

- “Accidental bowel leakage” (73%)
- “Bowel incontinence” (23%)
- “Fecal incontinence” (6%)

Bring it up:

- Majority of patients want providers to mention the topic

Use multiple phrases:

- “Any bowel control issues? Accidental bowel leakage? Incontinence of stool? Not making it to the toilet when you need to?”

Seeking Care

• Most people do not seek care
  – Less than 50% of women with UI seek care
  – Only 10-30% with FI seek care
    • 2 years after symptom onset for women
    • 3 years after symptom onset for men

Barriers to Seeking Care

- Lack of knowledge
- Fear about treatment
- Normative thinking
- Avoidance/Denial
- Life Impact
- Embarrassment/Shame
- Provider barriers
- Access limitations

Urinary Incontinence & Impact on Health

- Involuntary leakage of urine
- Not associated with increased mortality
- Impacts
  - Quality of life
  - Sexual dysfunction
  - Morbidity
  - Increased caregiver burden
Types of Urinary Incontinence

• Stress
  – Most common type for women
• Urge and Overactive Bladder
  – More common in older women
• Overflow
• Functional

Many have features of more than one type
Stress Urinary Incontinence Management Options

- Weight loss interventions
- Topical estrogen
- Pelvic floor muscle training
- Anti-incontinence surgery

Stress Urinary Incontinence Cure Rates

SUI Cure Rates

- INJECTIBLE BULKING AGENTS: 30.90%
- PFMT MEN: 78%
- PFMT WOMEN: 58.80%
- MALE SLINGS: 53%
- SURGICAL INTERVENTION WOMEN: 82.30%

Urge Incontinence Management

- Urinary diary
- Modifying contributing factors
- Topical estrogen
- Kegel’s
- Bladder training

Pharmacologic therapy
- Anti-muscarinic
- Beta 3 agonist

Invasive treatments

Hong MK, Ding DC. *Gynecol Minim Invasive Therap*. 2019; 8:143-8.
Urge Urinary Incontinence Cure Rates

UUI Cure Rates

- PFMT MEN: 30%
- SACRAL NEUROMODULATION: 15%
- ANTIMUSCARINICS: 49%
- MIRABEGRON: 46%

Fecal Incontinence and Impact on Health

• Inability to control bowel movements
• Stool leaking unexpectedly from rectum
• Results from many different causes
• Impacts:
  – Self-esteem
  – Quality of life
  – Morbidity, disability, cost
Risk Factors for Fecal Incontinence

#1 Diarrhea

#2 Strong urge before bowel movements

#3 Chronic illness, especially if associated with diarrhea
Best Practice Advice for Fecal Incontinence

Conservative therapies

Pelvic floor retraining with biofeedback

Bulking agents

Sacral nerve stimulation

Barrier devices/ sphincteroplasty/ other surgery
Conservative Treatment

• Conservative treatment
  – Patient education
  – Normalizing stool consistency with diet and medications
  – Keep rectum empty
  – Pelvic floor exercises

• Improves fecal incontinence by about 60%

• Eliminates the problem 1 in 5

Biofeedback

**Goals of Biofeedback**
- Strengthen anal sphincter muscle
- Increase puborectalis tone
- Improve rectal sensation
- Eliminate sensory delay
- Improve recto-anal coordination

**Patient Selection**
- Those that have not responded to conservative treatment
  - eg, antidiarrheals, fiber supplements
- Patients with adequate motivation and cognitive ability
- Contraindicated in neurological disorders, <8 years of age, visual impairment

Injectable Bulking Agents

Dextranomer-hyaluronic acid

• Four 1mL injections into deep submucosa
• Approximately 5mm above dentate line
• May be repeated if inadequate response

Outcomes

• RCT 206 patients
• 52% of active treatment vs. 32% of sham reported improvement in incontinence episodes of >50%

Sacral Nerve Stimulation

• Mechanism of action is not known
• Particularly effective in neurological disorders
• Objective changes include:
  – Increase in resting and squeeze pressure
  – Increase in squeeze duration
  – Improved perception of rectal sensation

Other Options

Artificial anal sphincter

• Vaginal insert
• Anal plug

Barrier devices

• Significant improvement in symptoms
• Often need repeat operations

Sphincteroplasty

• For patients who do not respond to initial management and have evidence of sphincter injury
• Short term improvement, but deterioration in continence over time

Fecal Incontinence Cure Rates

- METHYLCELLULOSE+LOPERAMIDE: 46%
- BIOFEEDBACK MEN: 41%
- SACRAL NEUROMODULATION FEMALE: 41%

Rectal Prolapse

- “Full-thickness intussusception of the rectal wall, which protrudes externally through the anus”¹
- Not common – about 0.5% of population overall²
- Women 6x more likely than men to prolapse²
- Peak incidence²
  - 60’s for women
  - <40 years of age for men

Prolapse Is Associated With:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fecal Incontinence</td>
<td>• Mucus, blood, stool</td>
</tr>
<tr>
<td></td>
<td>• 50-75% of patients with prolapse</td>
</tr>
<tr>
<td>Constipation</td>
<td>• 25-50% of patients with prolapse</td>
</tr>
<tr>
<td></td>
<td>• Blockage worsened by straining</td>
</tr>
<tr>
<td>Discomfort</td>
<td>• May or may not be associated with bowel movements</td>
</tr>
</tbody>
</table>

Functional Anorectal Pain

- Levator ani syndrome
- Unspecified anorectal pain
- Proctalgia fugax
<table>
<thead>
<tr>
<th></th>
<th>Levator Ani Syndrome</th>
<th>Proctalgia Fugax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Age</td>
<td>30-60</td>
<td>Any age (rare before puberty)</td>
</tr>
<tr>
<td>Sex difference</td>
<td>M&lt;W</td>
<td>M=W</td>
</tr>
<tr>
<td>Pain quality</td>
<td>Vague, dull ache, or pressure</td>
<td>Cramping, gnawing, aching, or stabbing</td>
</tr>
<tr>
<td>Pain duration</td>
<td>&gt;30 minutes</td>
<td>Seconds to several minutes</td>
</tr>
<tr>
<td>Precipitating factors</td>
<td>Sitting for long periods, stress, sex, defecation, childbirth, surgery</td>
<td>Stress, anxiety</td>
</tr>
<tr>
<td>Associated symptoms</td>
<td>Possibly psychosocial</td>
<td>Possibly psychosocial</td>
</tr>
</tbody>
</table>
Algorithm for Managing Anorectal Pain

- Pain associated with constipation?
  - Yes
    - Pain brief/episodic with pain free periods?
      - Yes
        - Levator muscle tender to palpation?
          - Yes
            - Levator ani syndrome
          - No
            - Proctalgia fugax
        - No
          - Complete appropriate tests (i.e. imaging, endoscopy)
          - Defecatory disorder
    - No
      - Reassurance
      - Beta-2 adrenergic agonists

- Features suggest structural disease?
  - Yes
    - Complete appropriate tests (i.e. imaging, endoscopy)
  - No
    - Pelvic floor retraining

- Levator ani syndrome
  - Yes
    - Inadequate response
    - Multidisciplinary pain management
  - No

Questions