FEMALE SEXUAL DYSFUNCTION AND PELVIC FLOOR DYSFUNCTION

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MIPS
Mediterranean Incontinence and Pelvic Floor Society

Plenary Session 8 - Female Sexual Dysfunction

Chair: A.Lukanovic

Female sexual Dysfunction and Pelvic floor disfunction	M. Espuña Pons
How to evaluate female sexual Dysfunction?	F. Dokmeci
Physiotherapy treatment of female Sexual Dysfunction	I. Ramírez
Er-Yag laser treatment implications in female sexual dysfunction	D. Lukanovic
Vaginal therapies in menopausal sexual and orgasmic dysfunction	O. Porta
Implications in the Mediterranean Setting & Discussion	A. Lukanovic

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FEMALE SEXUAL DYSFUNCTION AND PELVIC FLOOR DYSFUNCTION

- **Sexual health** is a right for the healthy or sick individual human being.

Important to the **practice of urogynaecology**:

- Assessment of **how pelvic floor dysfunction affects sexual health.**
- **Measure the changes after treatments.**

Use of validated questionaires (*generic and specific*).

How to ask, to evaluate and to measure

- **Female Sexual Function Index (FSFI)**
- Sexual dysfunction = FSFI scores ≤26

Good **generic instrument** for research purposes.

Assessment of SEXUAL OUTCOMES with SPECIFIC QUESTIONNAIRES

PISQ

A new instrument to measure sexual function in women with urinary incontinence or pelvic organ prolapse

Rebecca G. Rogers, MD, Dorothy Kammerer-Doak, MD, Analisa Villarreal, MD, Kimberly Coates, MD, and Clifford Qualls, PhD

Albuquerque, New Mexico, and Temple, Texas

(*Am J Obstet Gynecol 2001;184:552-8.*)

Int Urogynecol J (2003) 14: 164–168
DOI 10.1007/s00192-003-1063-2

ORIGINAL ARTICLE

Rebecca G. Rogers · Kimberly W. Coates · Dorothy Kammerer-Doak · Satkirin Khalsa · Clifford Qualls

A short form of the Pelvic Organ Prolapse/Urinary Incontinence Sexual Questionnaire (PISQ-12)

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Int Urogynecol J
DOI 10.1007/s00192-012-1952-3

EDITORIAL

The Pelvic Organ Prolapse Incontinence Sexual Questionnaire, IUGA-revised (PISQ-IR)

Rebecca G. Rogers · M. E. Espuña Pons

PISQ-IR

Int Urogynecol J
DOI 10.1007/s00192-012-2020-8

ORIGINAL ARTICLE

A new measure of sexual function in women with pelvic floor disorders (PFD): the Pelvic Organ Prolapse/Incontinence Sexual Questionnaire, IUGA-Revised (PISQ-IR)

R. G. Rogers · T. H. Rockwood · M. L. Constantine · R. Thakar · D. N. Kammerer-Doak · R. N. Pauls · M. Parekh · B. Ridgeway · S. Jha · J. Pitkin · F. Reid · S. E. Sutherland · E. S. Lukacz · C. Domoney · P. Sand · G. W. Davila · M. E. Espuna Pons

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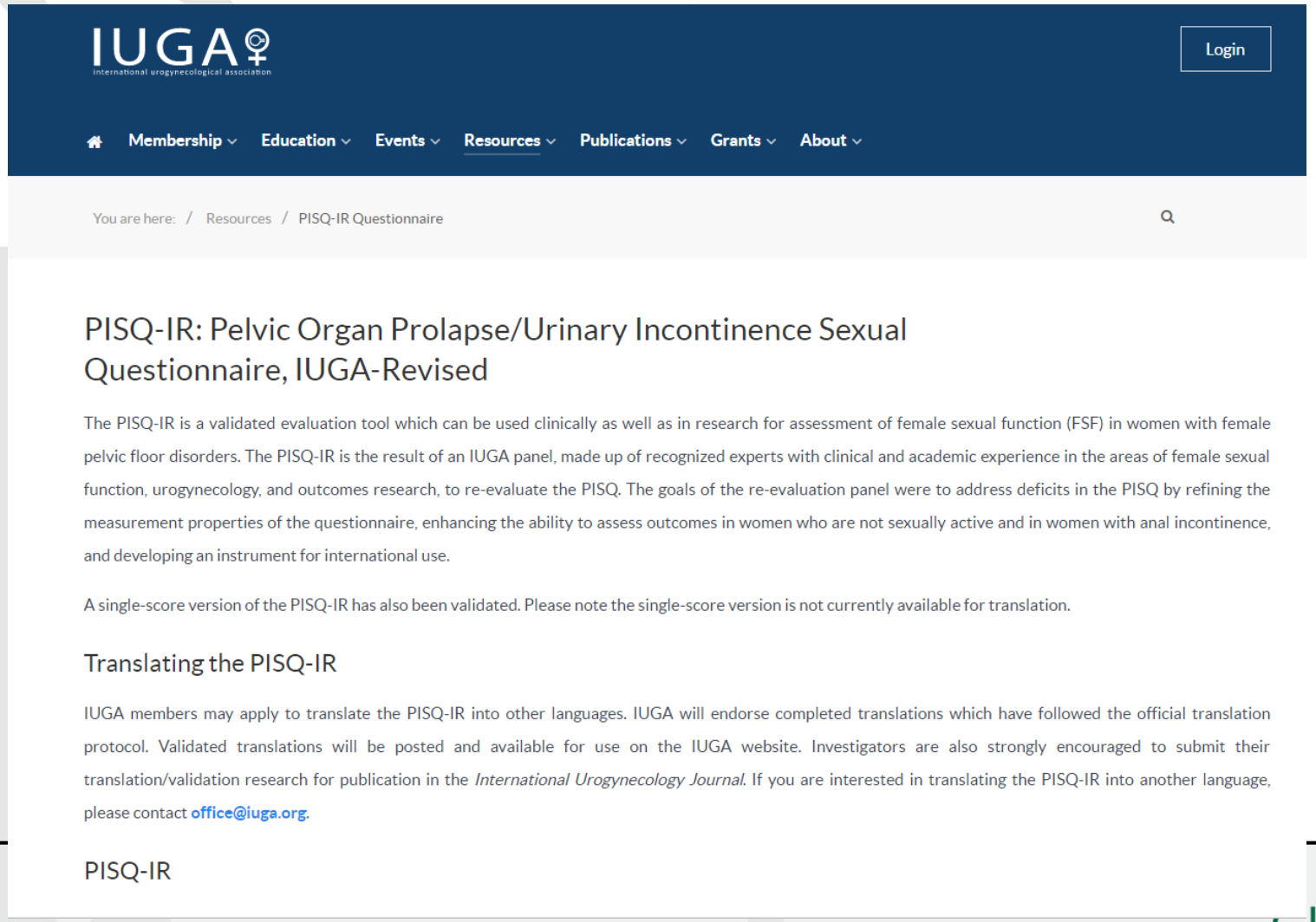
PISQ-IR

Arabian
Chinese mandarin
Czech
Dutch
French
German
Spanish
Hungarian
Japonese
Polish

PISQ-IR



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PISQ-IR: Pelvic Organ Prolapse/Urinary Incontinence Sexual Questionnaire, IUGA-Revised

The PISQ-IR is a validated evaluation tool which can be used clinically as well as in research for assessment of female sexual function (FSF) in women with female pelvic floor disorders. The PISQ-IR is the result of an IUGA panel, made up of recognized experts with clinical and academic experience in the areas of female sexual function, urogynecology, and outcomes research, to re-evaluate the PISQ. The goals of the re-evaluation panel were to address deficits in the PISQ by refining the measurement properties of the questionnaire, enhancing the ability to assess outcomes in women who are not sexually active and in women with anal incontinence, and developing an instrument for international use.

A single-score version of the PISQ-IR has also been validated. Please note the single-score version is not currently available for translation.

Translating the PISQ-IR

IUGA members may apply to translate the PISQ-IR into other languages. IUGA will endorse completed translations which have followed the official translation protocol. Validated translations will be posted and available for use on the IUGA website. Investigators are also strongly encouraged to submit their translation/validation research for publication in the *International Urogynecology Journal*. If you are interested in translating the PISQ-IR into another language, please contact office@iuga.org.

PISQ-IR

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The **effects of pelvic floor disorders (PFDs) on sexual health**.

- urinary incontinence (UI)
- pelvic organ prolapse (POP)
- anal incontinence (AI)

Remain **controversial** (**no impact / negative impact**) .

Fashokun TB, Harvie HS, Schimpf MO, et al. Sexual activity and function in women with and without pelvic floor disorders. Int Urogynecol J. 2013;24:91–7.
Handa VL, Cundiff G, Chang HH, Helzlsouer KJ. Female sexual function and pelvic floor disorders. Obstet Gynecol. 2008;111:1045–52.
Rogers RG. Sexual function in women with pelvic floor disorders. Can Urol Assoc J. 2013;7:S199–201.

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Pelvic floor symptoms have been shown to be **associated with : low sexual arousal, infrequent orgasm** and **dyspareunia***.

* **Handa VL, Cundiff G, Chang HH, Helzlsouer KJ**. Female sexual function and pelvic floor disorders. **Obstet Gynecol. 2008;111:1045–52.**

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Sexual dysfunction is common in women with LUTS and UI

- **FSFI:** Up to 45% of the women with **urinary incontinence (UI) and Lower urinary tract symptoms (LUTS)** complain of sexual dysfunction.
- 34% reporting **hypoactive sexual desire**, 23% **sexual arousal disorder**, 11% **orgasmic deficiency**, and 44% **sexual pain disorders** (*dyspareunia or non coital genital pain*)*

* **Salonia A**, Zanni G, Nappi RE, Briganti A, Dehò F, Fabbri F, et al. Sexual dysfunction is common in women with lower urinary tract symptoms and urinary incontinence: results of a cross-sectional study. **Eur Urol. 2004;45:642–8.**

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PISQ-IR:

Women with **anal incontinence** (AI) have similar rates of sexual activity but **poorer sexual function** than women without*.

* Cichowski SB, Komesu YM, Dunivan GC, Rogers RG. The association between fecal incontinence and sexual activity and function in women attending a tertiary referral center. Int Urogynecol J. 2013;24:1489–94.

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FEMALE SEXUAL DYSFUNCTION AND PELVIC FLOOR DYSFUNCTION

Pelvic floor dysfunctions (UI, OAB, AI, POP)

are independent risk factors for sexual disorders?

THE JOURNAL OF
SEXUAL MEDICINE **2017**

Is Pelvic Floor Dysfunction an Independent Threat to Sexual Function? A Cross-Sectional Study in Women With Pelvic Floor Dysfunction

Ryan J. Li-Yun-Fong, MD,[1] Maryse Larouche, MD,[2] Momoe Hyakutake, MD,[3] Nicole Koenig, BS,[2] Catherine Lovatt, MD,[4] Roxana Geoffrion, MD,[2] Lori A. Brotto, PhD,[2] Terry Lee, PhD,[5] and Geoffrey W. Cundiff, MD[2,5]

- Overall, there are a **higher rates of sexual dysfunctions,** related to desire, arousal, and orgasm **in women with PFD** however, this relation **might be explained by factors unrelated to the pelvic floor (*aging, dyspareunia, atrophy, and partner issues*).**

Li-Yun-Fong R et al . **Is Pelvic Floor Dysfunction an Independent Threat to Sexual Function**? A Cross-Sectional Study in Women With Pelvic Floor Dysfunction. J Sex Med. 2017 Feb;14(2):226-237

FEMALE SEXUAL DYSFUNCTION AND PELVIC FLOOR DYSFUNCTION

urinary leakage during sexual activity

Coital urinary incontinence

- **COITAL URINARY INCONTINENCE (CI) is a complain of involuntary loss of urine during coitus, occurring during penetration or at orgasm .**

Prevalence of urinary leakage during sexual activity

Author	Method	N	patients	Coital UI	What stage
Hilton 1988	questionnaire Case-control	324	urogynecologic clinic	24%	75% penetration 25% orgasm
Lam 1992	Population Random sample	441	with SUI	12 %	
Vierhout 1993	questionnaire	196	gynecologic clinic	34%	77% penetration 74% orgasm
Nygaard 1995	Mailed questionnaire	224	annual gynecologic examination	*77% had UI* 36% coital	
Moran 1999*	Retrospective	2153	urogynecologic clinic	10,6%	80 %penetration 20% orgasm
Burrows 2004	Retrospective	330	urogynecologic clinic	20%	
Lambrechtsen 2006	prospective	90 Consec.	urogynecologic clinic	32%	

* **Only** 22 **(10%)** of 228 women with coital UI **complained without direct question**

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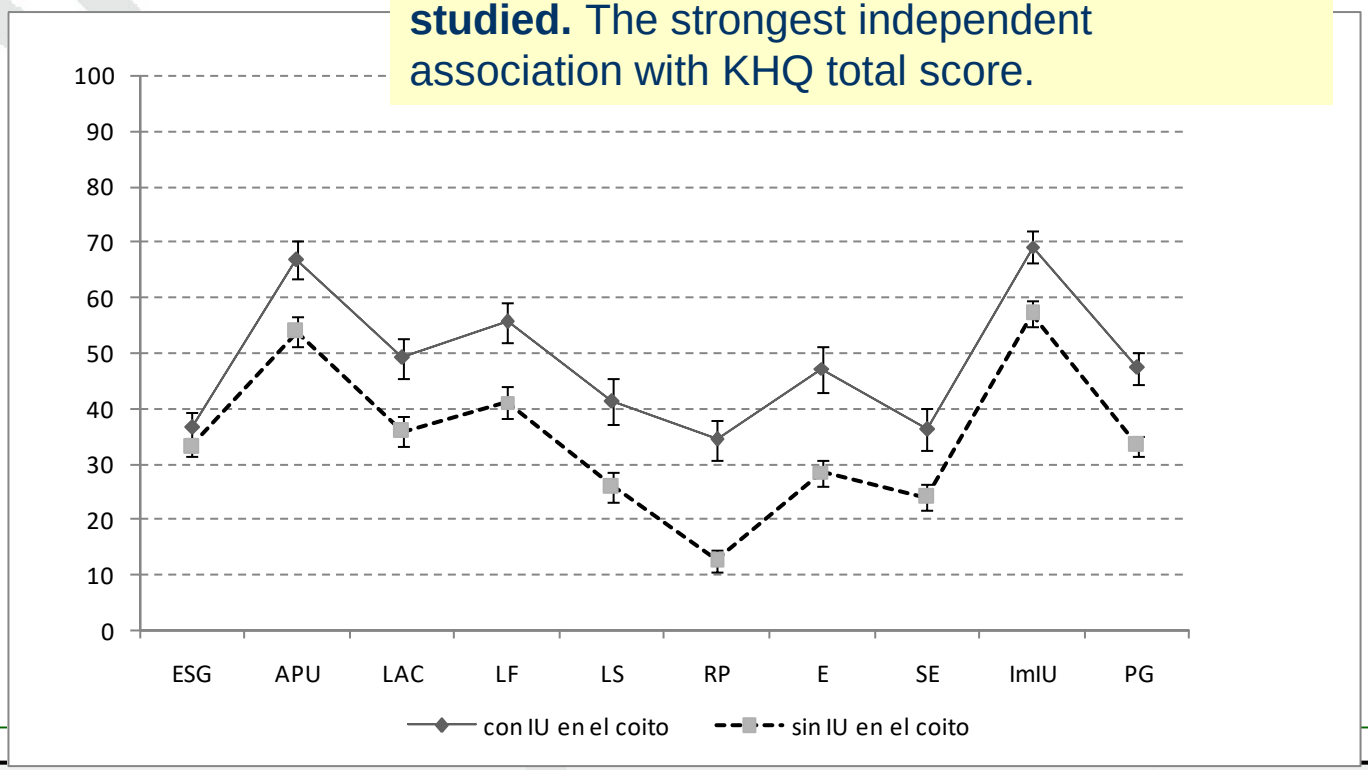
Impact on QoL of coital incontinence

- **Women with coital urinary incontinence had a higher scores (worse QoL) in all dimensions of KHQ**

N= 633 women seeking treatment for UI. (36,2%) *

*** positive answer in KHQ**

In a multiple regression model **adjusted with age, BMI and all other urinary symptoms studied.** The strongest independent association with KHQ total score.



•Espuna Pons M et al. Int Urogynecol Journal 2008

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EUROPEAN UROLOGY 54 (2008) 911–917

available at www.sciencedirect.com
journal homepage: www.europeanurology.com

European Association of Urology

Female Urology – Incontinence

Urinary Incontinence at Orgasm: Relation to Detrusor Overactivity and Treatment Efficacy

Maurizio Serati[a,*], *Stefano Salvatore*[a], *Stefano Uccella*[a], *Antonella Cromi*[a], *Vik Khullar*[b], *Linda Cardozo*[c], *Pierfrancesco Bolis*[a]

Urodynamic finding	Coital incontinence at orgasm ($n = 49$)	Coital incontinence during penetration ($n = 83$)
Detrusor overactivity	34 (69.4%)	13 (15.7%)
Urodynamic stress incontinence	5 (10.2%)	40 (48.2%)
Urodynamic mixed incontinence	0	11 (13.2%)
Inconclusive urodynamics	10 (20.4%)	19 (22.9%)

THE JOURNAL OF
SEXUAL MEDICINE 2018

Multicenter international study
1.041 women with UI

ORIGINAL RESEARCH

Coital Incontinence in Women With Urinary Incontinence: An International Study

Ester Illiano, MD,[1] Wally Mahfouz, MD,[2] Konstantinos Giannitsas, MD,[3] Ervin Kocjancic, MD,[4] Bini Vittorio,[5] Anastasios Athanasopoulos, MD,[3] Raffaele Balsamo, MD, PhD,[6] Franca Natale, MD, PhD,[7] Antonio Carbone, MD,[8] Donata Villari, MD,[9] Maria Teresa Filocamo, MD,[10] Enrico Finazzi Agrò, MD,[11] and Elisabetta Costantini, MD[1]

53,8%
Coital UI

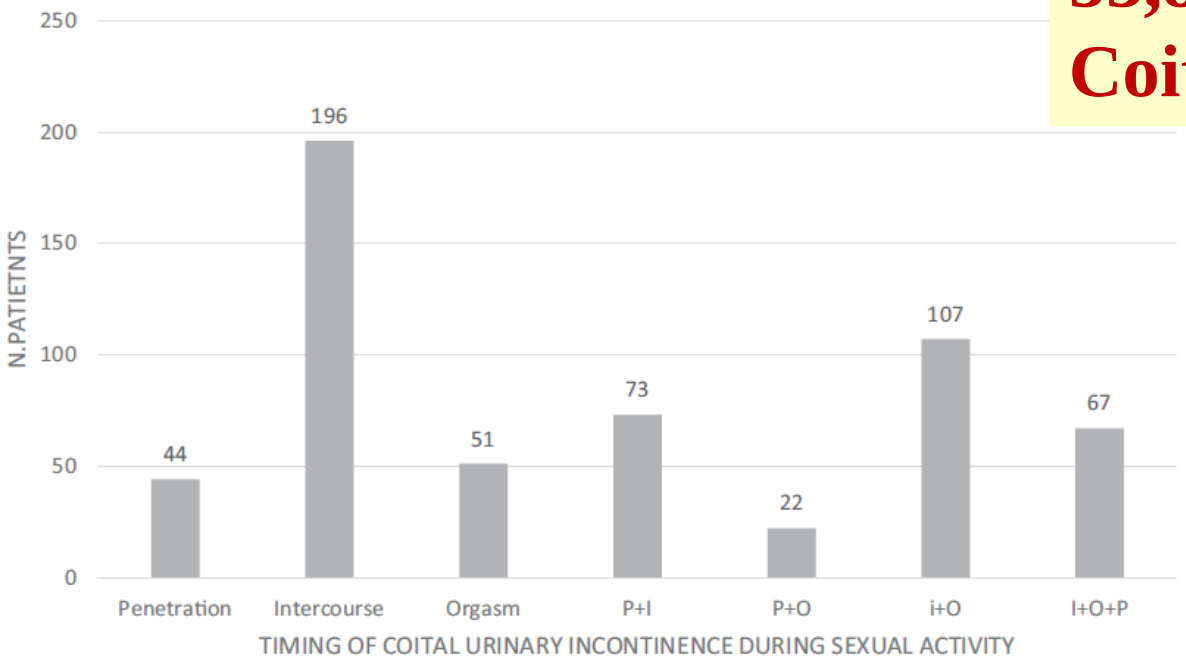

Figure 1. Patients with coital urinary incontinence according to the timing of occurrence during coitus. I = intercourse; O = orgasm; P = penetration.

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Multicenter international study 1.041 women with UI

Table 3. Univariate analysis and multivariate logistic regression final model for coital incontinence during penetration, intercourse, and orgasm vs clinical data

	Univariate analysis		Logistic regression	
Clinical data	*P* value	OR (95% CI)	*P* value	OR (95% CI)
Coital incontinence during penetration				
SUI	<.0001	51 (29.8–90)	<.0001	56.6 (32.12–100.0)
Cesarean delivery	.0045	0.7 (0.52–0.99)	.062	0.6 (0.43–1.02)
Previous hysterectomy	.001	1.8 (1.27–2.50)	<.0001	2.7 (1.66–4.44)
Previous failed anti-incontinence surgery	.0032	1.5 (1.03–2.19)	.035	1.7 (1.04–2.94)
BMI >25 kg/m^2	.748	1.0 (0.77–1.43)		
Coital incontinence during intercourse				
Mixed urinary incontinence >SUI	<.0001	2.3 (1.77–2.98)	<.0001	2.5 (1.91–3.31)
Cesarean delivery	<.0001	0.8 (0.62–1.03)	.001	0.6 (0.47–0.82)
Previous hysterectomy	<.0001	2.1 (1.62–2.90)	<.0001	2.9 (2.09–4.03)
Previous failed anti-incontinence surgery	<.0001	2.3 (1.68–3.21)	<.0001	2.6 (1.87–3.72)
BMI >25 kg/m^2	<.0001	1.8 (1.42–2.34)	<.0001	1.9 (1.50–2.56)
Coital incontinence during orgasm				
Mixed urinary incontinence >UUI	<.0001	2.3 (1.63–3.23)	<.0001	3.6 (2.51–5.39)
UUI	<.0001	4.1 (2.88–6.02)	<.0001	8.2 (5.35–12.54)
Cesarean delivery	.005	0.6 (0.48–0.87)	<.0001	0.3 (0.27–0.54)
Previous hysterectomy	<.0001	2.4 (1.80–3.30)	<.0001	4.04 (2.79–5.87)
Previous failed anti-incontinence surgery	.005	1.6 (1.15–2.32)	.08	1.41 (0.95–2.09)
BMI >25 kg/m^2	.264	1.1 (0.88–1.56)		

BMI = body mass index; OR = odds ratio; SUI = stress urinary incontinence; UUI = urgency urinary incontinence.

Iliano et al 2018

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IUGA-ICS Join report on the terminology for assessment of sexual function (2018)

International Urogynecology Journal (2018) 29:647–666
https://doi.org/10.1007/s00192-018-3603-9

SPECIAL CONTRIBUTION

An international Urogynecological association (IUGA)/international continence society (ICS) joint report on the terminology for the assessment of sexual health of women with pelvic floor dysfunction

Rebecca G. Rogers[1] · Rachel N. Pauls[2] · Ranee Thakar[3] · Melanie Morin[4] · Annette Kuhn[5] · Eckhard Petri[6] · Brigitte Fatton[7] · Kristene Whitmore[8] · Sheryl A. Kingsberg[9] · Joseph Lee[10]

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ICS-IUGA Terminology : Haylen et al Int Urogynecol J (2018) 29:647-666.

1. Coital urinary incontinence: urinary incontinence occurring during or after vaginal intercourse[1]

2. Orgasmic urinary incontinence (NEW): urinary incontinence at orgasm
3. Penetration urinary incontinence (NEW): urinary incontinence at penetration (penile, manual, or sexual device)
4. Coital urinary urgency (NEW): Feeling of urgency to void during vaginal intercourse.
5. Post coital LUT symptoms (NEW): Such as worsened urinary frequency or urgency, dysuria, suprapubic tenderness.

FEMALE SEXUAL DYSFUNCTION AND PELVIC FLOOR DYSFUNCTION

Impact of SUI surgery

FEMALE SEXUAL DYSFUNCTION AND PELVIC FLOOR DYSFUNCTION

Impact of SUI surgery

Impact of incontinence surgery on sexual function

Systematic review and Meta-Analysis Jha et . J Sex Med 2012 ; 9:34-43

Table 2 Change in sexual function following all incontinence surgery

S No	Study	Procedure (total cases)	Improvement % (N)	No change % (N)	Deterioration % (N)
1	El Enen et al. [23]	TOT (62)	11 (7)	86 (53)	3 (2)
2	Sentilhes et al. [24]	TVT/TOT (145)	31.2 (45)	53.9 (78)	14.9 (22)
3	Jha et al. [3]	TVT (62)	50 (31)	42 (26)	8 (5)
4	Murphy et al. [26]	TVT (36)	38.9 (14)	52.8 (19)	8.3 (3)
		TVT-O (103)	37.1 (38)	61 (63)	1.9 (2)
5	Elzevier et al. [27]	TOT (44)	18.2 (8)	68.2 (30)	13.6 (6)
				73.5 (25)	5.9 (2)
6				—	9.9 (10)
7				28.3 (15)	47.2 (25)
				24.4 (10)	63.4 (26)
8				53.7 (29)	9.3 (5)
9	Ghezzi et al. [14]	TVT (53)	34 (18)	62.2 (33)	3.8 (2)
10	Elzevier et al. [15]	TVT (65)	26.1 (17)	72.3 (47)	1.6 (1)
11	Glavind et al. [17]	TVT/IVS (48)	25 (12)	60.4 (29)	6.6 (7)
12	Mazouni et al. [10]	TVT (55)	1.8 (1)	74.4 (41)	23.8 (13)
13	Maaita et al. [18]	TVT (43)	5 (6)	71 (31)	14 (6)
14	Byung [29]	TVT (94)	21.3 (20)	64.9 (61)	13.8 (13)
		TOT (57)	15.8 (9)	66.7 (38)	17.5 (10)
15	Hasse [30]	Burch (14)	7 (1)	93 (13)	—
16	Abdel-Fattah et al. [31]	TOT/ TVT-O (199)	94 (188)	1.4 (3)	4.3 (8)
17	Ward and Hilton [32]	Burch (79)	47 (37)	—	—
		TVT (98)	54 (53)	—	—
18	Marszalek et al. [34]	TVT (52)	33.3 (17)	52.4 (28)	14.3 (7)

TOT = transobturator tape; TVT = tension-free vaginal tape.

Women with surgery for SUI without POP

REVIEWS J Sex Med 2012;9:34–43

Impact of Incontinence Surgery on Sexual Function: A Systematic Review and Meta-Analysis

Swati Jha, MD, MRCOG,* Manjunath Ammenbal, MRCOG,† and Mostafa Metwally, MD, MRCOG‡

*Department of Urogynaecology, Sheffield Teaching Hospitals NHS Foundation Trust, Jessop Wing, Tree Root Walk, UK;
†Obstetrics and Gynaecology, Sheffield Teaching Hospitals NHS Foundation Trust, Jessop Wing, Tree Root Walk, UK;
‡Reproductive Medicine, Sheffield Teaching Hospitals NHS Foundation Trust, Jessop Wing, Tree Root Walk, UK

DOI: 10.1111/j.1743-6109.2011.02366.x

Women with surgery for SUI without POP

No diferences with TVT vs TOT/ TVT-O

	TVT		TOT/TVT-O			Odds ratio
Study or subgroup	Events	Total	Events	Total	Weight	M-H, Random, 95% CI
Byung et al	20	94	9	57	24.5%	1.44 [0.61, 3.43]
Murphy et al	14	36	39	103	30.3%	1.04 [0.48, 2.28]
Pace et al	31	35	62	66	8.7%	0.50 [0.12, 2.13]
Sentilhes et al	23	81	21	64	36.4%	0.81 [0.40, 1.65]
Total (95% CI)		**246**		**290**	**100.0%**	**0.97 [0.63, 1.49]**
Total events	88		131			

Heterogeneity: Tau² = 0.00; Chi² = 1.88, df = 3 (P = 0.60); I² = 0%
Test for overall effect: Z = 0.15 (P = 0.88)

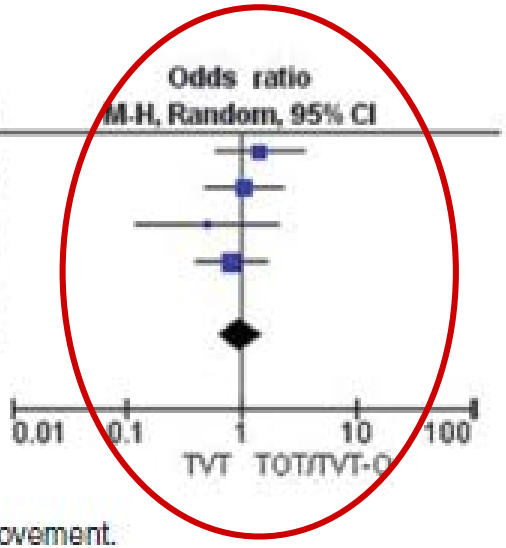
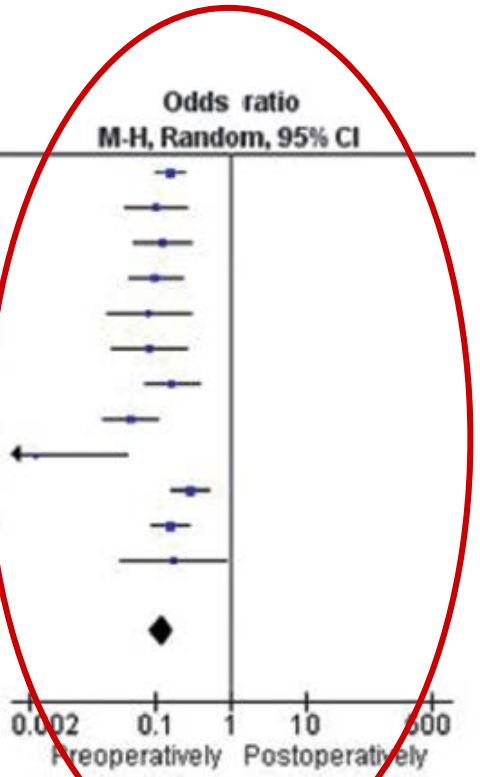


Figure 3 Comparison of TVT vs. TOT/TVT-O for improvement.

Systematic review and Meta-Analysis Jha et . J Sex Med 2012 ; 9:34-43

Study or subgroup	Postoperative Events	Total	Preoperative Events	Total	Weight	Odds ratio M-H, Random, 95% CI
Abdel Fatah et al	83	199	164	199	13.7%	0.15 [0.10, 0.24]
Byung et al	5	151	39	151	8.0%	0.10 [0.04, 0.26]
Elzevier et al 2004	8	65	35	65	8.7%	0.12 [0.05, 0.29]
Elzevier et al 2008	9	78	45	78	9.3%	0.10 [0.04, 0.22]
Ghezzi et al	3	53	23	53	5.6%	0.08 [0.02, 0.28]
Glavind et al	4	50	26	50	6.4%	0.08 [0.03, 0.26]
Jha et al 2007	15	54	38	54	9.2%	0.16 [0.07, 0.37]
Jha et al 2009	15	82	60	72	9.2%	0.04 [0.02, 0.10]
Moran et al	10	52	52	52	1.5%	0.00 [0.00, 0.04]
Sentilhes et al	19	142	50	142	12.0%	0.28 [0.16, 0.51]
Ward et al	15	177	122	323	12.3%	0.15 [0.09, 0.27]
Yeni et al	2	32	9	32	4.0%	0.17 [0.03, 0.87]
Total (95% CI)		**1135**		**1271**	**100.0%**	**0.12 [0.08, 0.17]**
Total events	188		663			

Heterogeneity: Tau² = 0.21; Chi² = 24.05, df = 11 (P = 0.01); I² = 54%
Test for overall effect: Z = 11.37 (P < 0.00001)



- **Coital urinary incontinence decreases significatlly after SUI surgery (OR 0.11; 95% CI 0.07,0.17).**

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Impact of incontinence surgery on sexual function

2018

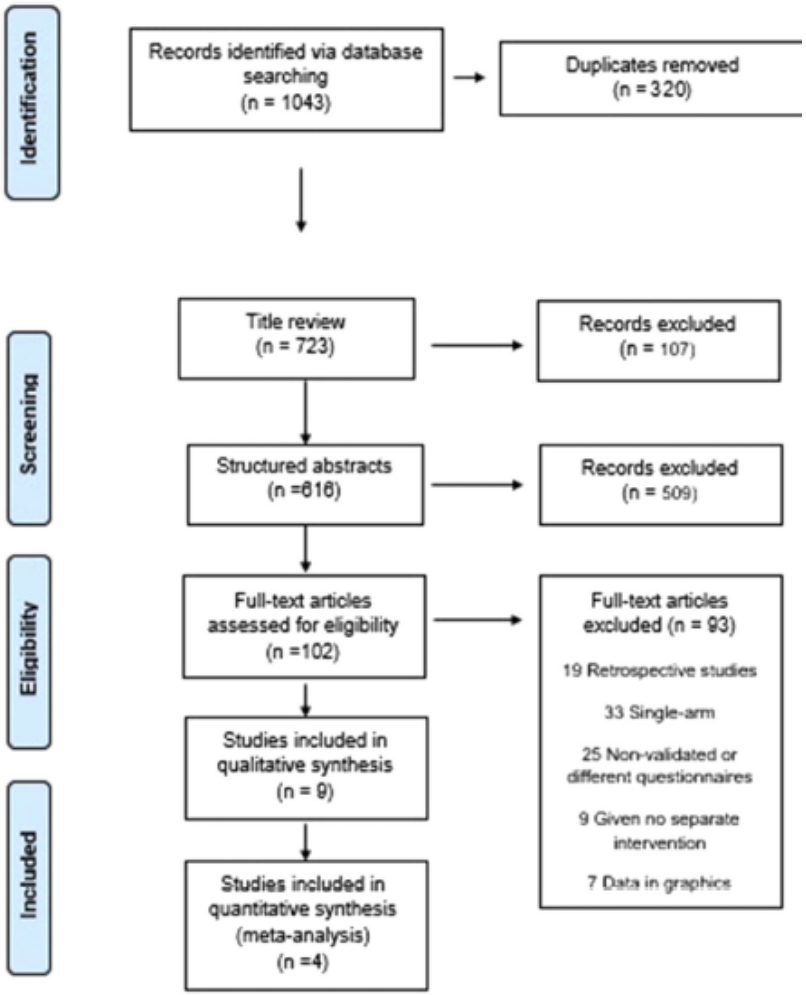

Figure 1. Flow diagram of selected studies. Figure 1 is available in color online at www.smr.jsexmed.org.

SEXUAL MEDICINE REVIEWS REVIEW

Female Sexual Function Following Surgical Treatment of Stress Urinary Incontinence: Systematic Review and Meta-Analysis

Maria Cláudia Bicudo-Fürst, MD,[1] Pedro Henrique Borba Leite, MD,[1] Felipe Placco Araújo Glina, MD,[2] Willy Baccaglini, MD,[1] Rafael Vilhena de Carvalho Fürst, MD,[1] Carlos Alberto Bezerra, MD,[1] and Sidney Glina, MD[1]

The impact of SUI surgery on sexual function is uncertain because of the imprecision of the effect and inconsistency among studies.

Most questionnaires utilized were not validated

FEMALE SEXUAL DYSFUNCTION AND PELVIC FLOOR DYSFUNCTION

Impact of POP surgery

FEMALE SEXUAL DYSFUNCTION AND PELVIC FLOOR DYSFUNCTION

Impact of POP surgery
Native tissue surgery

Int Urogynecol J (2015) 26:321–327
DOI 10.1007/s00192-014-2518-3

REVIEW ARTICLE

A systematic review and meta-analysis of the impact of native tissue repair for pelvic organ prolapse on sexual function

Int Urogynecol J (2015) 26:321–327

Study or Subgroup	Preoperative Mean	SD	Total	Postoperative Mean	SD	Total	Weight	Mean Difference IV, Fixed, 95% CI
Altman et al 2011	33.1	6.7	73	35.1	0.7	73	42.3%	-2.00 [-3.55, -0.45]
Azar et al 2008	15.9	10	60	21.9	11.1	60	7.1%	-6.00 [-9.78, -2.22]
Dua et al 2012	59.88	28.1	123	82.28	26	123	2.2%	-22.40 [-29.17, -15.63]
Fayyad et al 2008	59.5	45.9	101	71	43.7	101	0.7%	-11.50 [-23.86, 0.86]
Milani et al 2011	31.5	7.2	28	34.7	5.7	28	8.7%	-3.20 [-6.60, 0.20]
Novi et al 2006	83.6	8.2	50	89.1	7.1	50	11.2%	-5.50 [-8.51, -2.49]
Paraiso et al 2006	29	8	42	36	5	42	12.4%	-7.00 [-9.85, -4.15]
Pauls et al 2007	25.16	6.67	26	24.63	6.58	26	7.8%	0.53 [-3.07, 4.13]
Sokol et al 2012	32	6.5	17	35	4	16	7.6%	-3.00 [-6.66, 0.66]
Total (95% CI)			**520**			**519**	**100.0%**	**-3.79 [-4.80, -2.79]**

Heterogeneity: Chi² = 48.95, df = 8 (P < 0.00001); I² = 84%
Test for overall effect: Z = 7.39 (P < 0.00001)

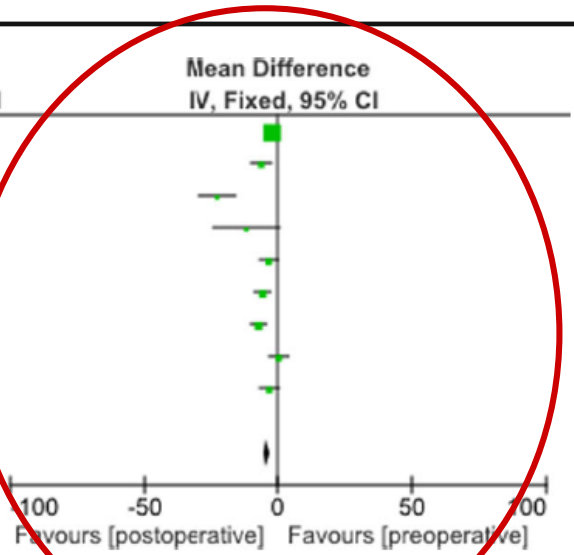

Fig. 2 Sexual function before and after surgery

The study concluded that **sexual function is significantly improved after POP vaginal surgery with native tissue**

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PELVIC ORGAN PROLAPSE SURGERY AND SEXUAL FUNCTION

VAGINAL POP SURGERY USING

DISPAREUNIA before and after **native tissue repair**

47 % of women showed improvement

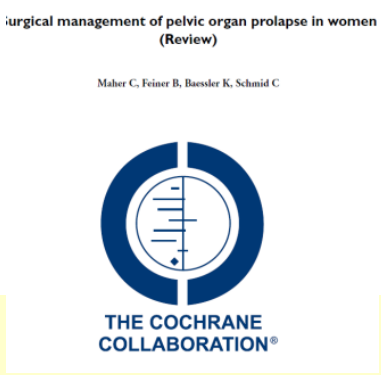
39 % no change

18 % deterioration

4 % had new-onset dyspareunia.

Jha S, Gray T. A systematic review and meta-analysis of the impact of native tissue repair for pelvic organ prolapse on sexual function. Int Urogynecol J. 2015 ;26:321-7.

PELVIC ORGAN PROLAPSE SURGERY AND SEXUAL FUNCTION



VAGINAL POP SURGERY WITH / WITHOUT MESH

- After **anterior polypropylene mesh repair**, **no significant differences** in sexual function or ***de novo*** **dyspareunia** were identified when **compared with anterior colporraphy**

Maher C, Feiner B, Baessler K, Christmann-Schmid C, Haya N, Marjoribanks J. Transvaginal mesh or grafts compared with native tissue repair for vaginal prolapse. The Cochrane data base of systematic reviews. 2016;2:CD012079.
Maher C, Feiner B, et al. Surgical management of pelvic òrgan prolapse in women. Update in: Cochrane Database Syst Rev. 2016 Nov 30;11:CD004014.

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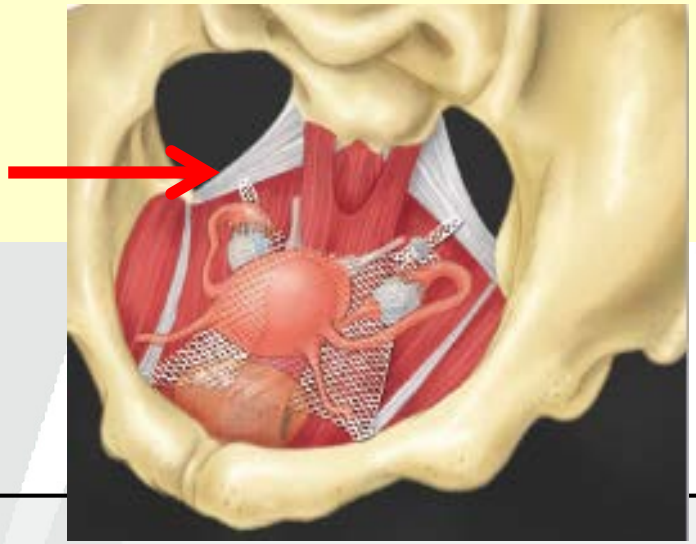
Table 4. Summary of Findings Tables comparing Anterior Colporrhaphy and Polypropylene Mesh for Anterior Compartment Prolapse. Reproduced from the 2016 Cochrane review on anterior compartment prolapse.

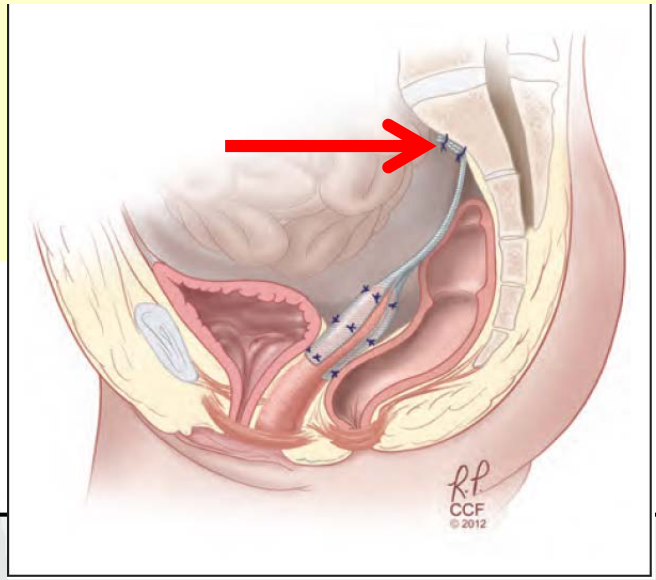
Outcomes	Anterior Repair (Colporrhaphy)	Polypropylene Mesh	Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
Awareness of prolapse	256 per 1000	143 per 1000 (110 to 187)	RR 0.56 (0.43 to 0.73)	974 (7 studies)	⊕⊕⊕⊖ moderate[1]
Repeat surgery – Prolapse	16 per 1000	7 per 1000 (4 to 13)	RR 0.44 (0.24 to 0.81)	1619 (12 studies)	⊕⊕⊕⊖ moderate[1]
Repeat surgery - Surgery for prolapse, SUI or mesh exposure	56 per 1000	91 per 1000 (64 to 128)	RR 1.62 (1.15 to 2.28)	1518 (12 studies)	⊕⊕⊖⊖ low[2,3]
Recurrent anterior compartment prolapse	406 per 1000	138 per 1000 (101 to 187)	RR 0.34 (0.25 to 0.46)	1481 (11 studies)	⊕⊕⊕⊖ moderate[1]
Apical or posterior compartment prolapse	93 per 1000	172 per 1000 (94 to 313)	RR 1.85 (1.01 to 3.37)	300 (2 studies)	⊕⊕⊖⊖ low[4,5]
Stress urinary incontinence (de novo)	86 per 1000	133 per 1000 (88 to 202)	RR 1.55 (1.02 to 2.35)	939 (6 studies)	⊕⊕⊖⊖ low[5,6]
De novo dyspareunia	36 per 1000	67 per 1000 (34 to 132)	RR 1.86 (0.94 to 3.66)	583 (8 studies)	⊕⊕⊕⊖ moderate[7]

PELVIC ORGAN PROLAPSE SURGERY AND SEXUAL FUNCTION

EFECTS OF VAGINAL vs ABDOMINAL POP SURGERY

- Some anatomic aspects of the POP repair : **vaginal depth, axis, and depth of mesh placement,** are different **in vaginal and abdominal approach.**





International Urogynecology Journal (2019) 30:545–555
https://doi.org/10.1007/s00192-018-3702-7

ORIGINAL ARTICLE

Anatomical outcomes 1 year after pelvic organ prolapse surgery in patients with and without a uterus at a high risk of recurrence: a randomised controlled trial comparing laparoscopic sacrocolpopexy/cervicopexy and anterior vaginal mesh

Eduardo Bataller[1] · Cristina Ros[1,2] · Sonia Anglès[1] · Miriam Gallego[1] · Montserrat Espuña-Pons[1] · Francisco Carmona[1]

The inclusion criteria were:

- women requiring POP surgery (30-75 years of age)
- **primary or recurrent symptomatic POP**
- **severe POP (stage 3 or greater anterior POP with a stage 2 or greater apical POP**).
- **no previous mesh surgery**

Randomization

60 anterior vaginal mesh

60 laparoscopic cervico/colposacropexy

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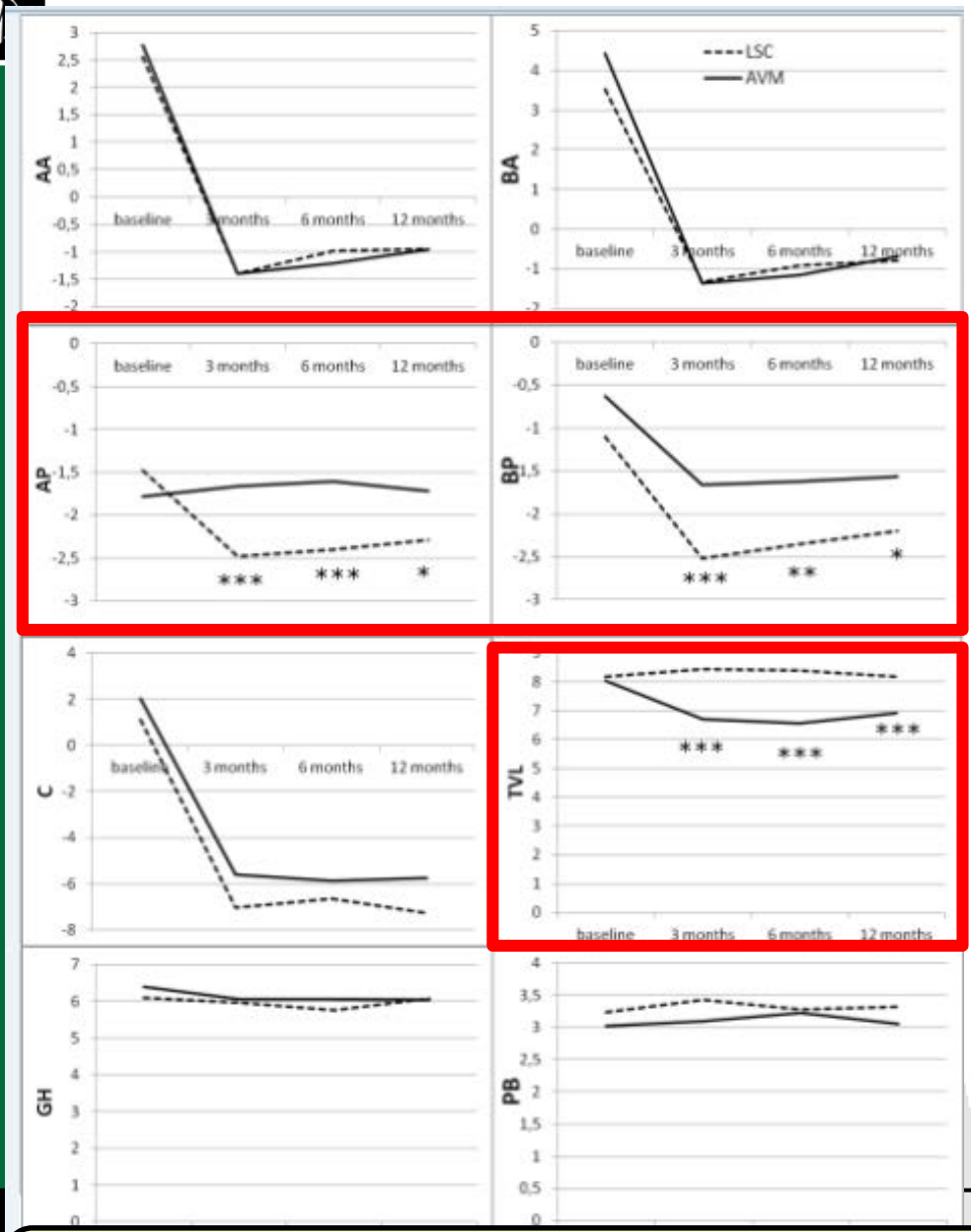

No statistically significant differences were found among POP-Q **anterior vaginal wall points** between groups.

Better results were obtained with **LSC-CS** in **posterior** vaginal wall points and total **vaginal length**

Three patients **(7%)** with **dyspareunia de novo** in the LSC-CS group, while 7 women **(19%)** in the **AVM** group (NS).

PELVIC ORGAN PROLAPSE SURGERY AND SEXUAL FUNCTION VAGINAL vs ABDOMINAL POP SURGERY

EUROPEAN UROLOGY 74 (2018) 167–176

available at www.sciencedirect.com
journal homepage: www.europeanurology.com

European Association of Urology

Platinum Priority – Female Urology – Incontinence

Editorial by Frank Van der Aa and Dirk De Ridder on pp. 177–178 of this issue

Safety of Vaginal Mesh Surgery Versus Laparoscopic Mesh Sacropexy for Cystocele Repair: Results of the Prosthetic Pelvic Floor Repair Randomized Controlled Trial

Jean-Philippe Lucot[a,], Michel Cosson[a], Georges Bader[b], Philippe Debodinance[c], Cherif Akladios[d], Delphine Salet-Lizée[e], Patrick Delporte[c], Denis Savary[f], Philippe Ferry[g], Xavier Deffieux[h], Sandrine Campagne-Loiseau[f], Renaud de Tayrac[i], Sébastien Blanc[j], Sandrine Fournet[k], Arnaud Wattiez[d], Richard Villet[e], Marion Ravit[l], Bernard Jacquetin[f], Xavier Fritel[m], Arnaud Fauconnier[b,l]*

There was no difference in symptoms, quality of life, improvement, composite definition of success, anatomical results rates between groups **except for the vaginal apex and length, and dyspareunia , in favour of abdominal (LS).**

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Conclusions: LS is a valuable option for primary repair of cystocele in sexually active patients. LS is safer than TVM, but may not be feasible in all cases. Both techniques offer same functional outcomes, success rates, and anatomical outcomes, but sexual function is better preserved by LS.

Patient summary: Our study demonstrates that laparoscopic sacropexy (LS) is a valuable option for primary repair of cystocele. LS offers equivalent success rates to vaginal mesh procedures, but is safer with a lower rate of complications and reoperations, and sexual function is better preserved.

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FEMALE SEXUAL DYSFUNCTION AND PELVIC FLOOR DYSFUNCTION

Conclusions

- Sexual dysfunctions are prevalent in women with pelvic floor disorders
- **Assessment and management** of this problem is necessary **when it causes distress.**
- **Validated questionnaires (FSFI, PISQ)**

FEMALE SEXUAL DYSFUNCTION AND PELVIC FLOOR DYSFUNCTION

Conclusions

- **Coital incontinence** common in women with LUTS.
- When counseling women undergoing s**urgery for stress incontinence** and coital incontinence, they may be told that **coital incontinence is likely to improve.**

FEMALE SEXUAL DYSFUNCTION AND PELVIC FLOOR DYSFUNCTION

Conclusions:

- With the surgical reconstructive **treatment of the prolapse**, in most cases, **activity and sexual function improves** or **stays the same.**

- **Insufficient information are available to provide evidence-based recommendations** for POP repair.
Continued longitudinal investigation will be important to better understand female sexual function after POP repair

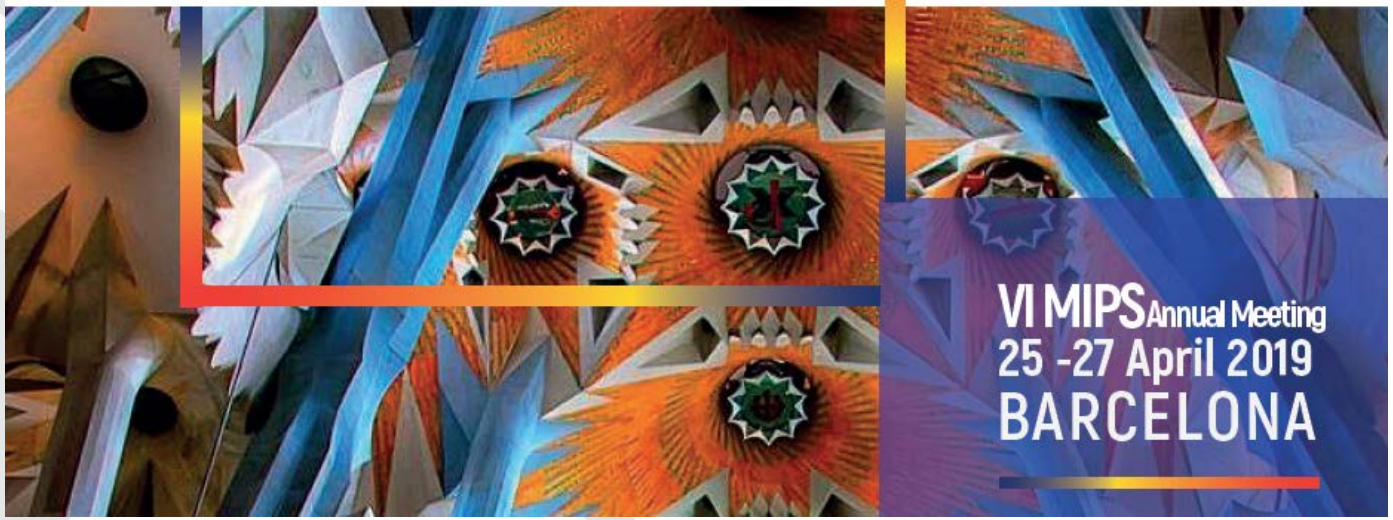
FEMALE SEXUAL DYSFUNCTION AND PELVIC FLOOR DYSFUNCTION

Conclusions

- The **most common factor negatively influencing** the evaluation of sex life after surgery is **dyspareunia.**

- Further investigation into this group of patients may allow us to **understand factors contributing to patients' dyspareunia**, which may improve our treatment approach

MIPS
Mediterranean Incontinence and Pelvic Floor Society



THANK YOU

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