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Fritel X[1], Ravit M[2], Fauconnier A[2], Cosson M[3], Campagne-Loiseau S[4], Capmas P[5], Debodinance P[6], Deffieux X[7], Ferry P[8], Saussine C[9], Wagner L[10], Lucot J[11]

1. *Université de Poitiers, Faculté de Médecine et Pharmacie, CIC 1402, CHU de Poitiers, France,* ***2.*** *Université Paris-Saclay, Risques Cliniques en Santé des Femmes et en Santé Périnatale, France,* ***3.*** *Université de Lille, CHU de Lille, France,* ***4.*** *Université d'Auvergne, CHU Estaing, Clermont-Ferrand, France,* ***5.*** *Université Paris-Saclay, Hôpital Bicêtre APHP, France,* ***6.*** *CH de Dunkerque, France,* ***7.*** *Université Paris-Saclay, CHU Antoine-Béclère APHP, Clamart, France,* ***8.*** *CH de La Rochelle, France,* ***9.*** *Hôpitaux Universitaires de Strasbourg, France,* ***10.*** *CHU Carémeau, Nîmes, France,* ***11.*** *CH de Béthune, France*

DO SURGEONS PRESUME WOMEN'S HOPES AND FEARS ASSOCIATED WITH PROLAPSE REPAIR? A SECONDARY ANALYSIS IN PROSPERE TRIAL.

Hypothesis / aims of study

Pelvic organ prolapse (POP) is a frequent but not life-threatening trouble. Some women affected by this condition are going to choose a surgical repair, while some not. Little is known about why women seek treatment, why they choose a surgical treatment, and their expectations in surgical repair [1,2]. We don't know if surgeons anticipate or presume women's expectations.

Our aim was to analyse expectations (hopes and fear) reported by women before surgery scheduled for POP and to compare hopes and fears reported by women to hopes and fears anticipated by surgeons.

Study design, materials and methods

The PROSPERE randomized trial was designed to analyse complications associated to POP repair with mesh by comparing laparoscopic sacropexy (LSC) and vaginal repair with mesh (VRM). Before randomization, we solicited each woman included to report 5 hopes and 5 fears (ordering the main in first) with regard to the operation scheduled. We also asked surgeons involved in the RCT to anticipate what would be the fears and hope of a typical patient. The categorization of women's hopes and fears was based on the women's answers received. Similar answers with a similar wording were brought together in the same dimension. In the other hand, we took care to respect, as possible, the distinction made by each woman between different hopes and fears. When a woman repeated similar expectations, the dimension was counted only one time for the overall summary. To compare women's and surgeon's expectations we considered the overall rank of each dimension for hopes and fears: The most frequently chosen dimension received the first rank, the second one the second rank, and so on. That method permitted to establish and compare the order of expectations for women and surgeons.

Results

Among 265 women included in PROSPERE RCT, 261 (98%) reported at least one hope (mean 2.28). Most of them reported one to 3 hopes (respectively 72, 79 and 70), and 35 and 5 women reported four and five hopes. 229 women (86%) reported at least one fear (mean 1.53). Most of them reported one (114) or two fears (77) and the others reported from three to five fears (respectively 20, 12, and 6 women). Among the 39 surgeons who participate to PROSPERE RCT, 16 (41%) responded to the expectations questionnaire as they were a patient scheduled for prolapse repair.

Table 1: Hopes reported by women and surgeons (* redundant answers were ignored)

	Women						Surgeons
	1st	2nd	3rd	4th	5th	overall*	overall*
	N= 261	N= 189	N= 110	N= 40	N= 5	N= 261	N= 16
Hopes	n	n	n	n	n	n (%)	n (%)
Prolapse repair	132	20	9	1	.	156 (60)	13 (81)
Urinary improvement	37	58	20	6	.	103 (39)	15 (94)
Physical abilities	21	36	20	11	3	74 (28)	11 (69)
Intercourse improvement	13	30	28	4	1	70 (27)	9 (56)
Well-being	36	18	14	7	2	66 (25)	10 (63)
Pain or heaviness	17	19	7	7	.	49 (19)	5 (31)
Bowel improvement	3	7	4	3	.	16 (6)	7(44)
Hygienic expectation	1	1	5	1	.	8 (3)	0
No perioperative complication	1	.	2	.	.	3 (1)	0
Other hopes	.	.	1	.	.	1 (0)	1 (6)

Hopes were categorized in 10 domains (Table 1): Prolapse repair (for example: "no longer bulge out of the vagina"); Urinary symptoms improvement ("no more leakage"); Physical abilities ("return to normal physical activity"); Intercourse improvement ("resume my sex life"); Well-being or comfort ("feel better"); No more pain or heaviness ("no longer that feeling of heaviness"), Bowel symptoms improvement ("move my bowel correctly"); Hygienic expectation ("not wearing protections"); No perioperative complication ("that operation happens well"); and other expectations.

Fears were categorized in 11 domains (Table 2): Failure or prolapse recurrence ("fear of relapse"); Perioperative complication ("anaesthesia fear"); Urinary symptoms ("be incontinent"); Pain ("fear of pain"); Sexual matter ("decreased sexual desire"); Disability or physical troubles ("Fear of not being able to resume my physical activities"); Mesh complications ("mesh exposure"); Fatigue ("have to pay attention to everything"); Bowel problems ("constipation"); Other fears ("infection"); and Absence of any fear ("I have no fear, he knows what to do").

Table 2: Fears reported by women and surgeons (* redundant answers were ignored)

	Women						Surgeons
	1st	2nd	3rd	4th	5th	overall*	overall*
	N= 229	N= 115	N= 38	N= 18	N= 6	N= 229	N= 16
Fears	n	n	n	n	n	n (%)	n (%)
Failure or POP recurrence	63	27	4	.	2	87 (38)	15 (94)
Perioperative complication	49	20	7	3	1	64 (28)	13 (81)
Urinary symptoms	40	14	7	.	.	60 (26)	14 (88)
Pain	16	20	5	4	.	44 (19)	11 (69)
Sexual matter	7	10	2	2	1	22 (10)	7 (44)
Disability or physical troubles	2	7	4	.	.	13 (6)	2 (13)
Mesh complication	5	4	1	1	.	11 (5)	2 (13)
Fatigue	4	2	1	1	.	7 (3)	1 (6)
Bowel problems	1	3	.	1	.	5 (2)	2 (13)
Other fears	2	7	7	6	2	17 (7)	4 (25)
Absence of any fear	40	1	.	.	.	40 (17)	0

For surgeons, expectations were similar than for women (Tables 1 and 2). We found an excellent correlation between women's and surgeon's hopes (Spearman correlation coefficient: 0.93, p= 0.001) and between women's and surgeon's fears (0.95, p= 0.000).

Interpretation of results

Women had reasonable expectations about prolapse surgery, only 60% expected a disappearance of the prolapse, and in the other hand, one third (38%) were frighten by the risk of failure. These result are congruent with the high risk failure rate related to prolapse surgery. That may reflect that surgeons take time to explain the risk of failure.

Alongside of surgical results on prolapse, a large part of women's expectations concerned functional results, a quarter, or more, expected an improvement about urinary symptoms, physical abilities, intercourse, and also comfort. Even if the women included were aware of mesh related complications (that issue was clearly mentioned in the RCT information sheet), less than 5%, listed this fear.

French women included in our study reported similar expectations than Dutch women with some differences in expectations order [3]. While prolapse repair was the main hope (60%) in our study, it was urinary symptoms improvement the main hope (70%) in the Dutch study. The main fear in our study was failure or relapse (38%), while become incontinent was the main fear (52%) for Dutch women. That may reflect some differences in surgery indications, patient information, or social and cultural environment between French and Dutch practices.

Surgeons who participated to the study were able to anticipate most women's expectations, probably because they practice this type of surgery on a regular basis. However, our study showed also that women scheduled for POP surgery may expect a large variety of hopes and fears that need an individual assessment.

Concluding message

Our study may help surgeons to take into account women's expectations before pelvic floor reconstructive surgery.

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