Analysis of a specialist pelvic floor service within a district general hospital

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Aims of study

Pelvic floor dysfunction has a high prevalence and has a significant impact on quality of life. Despite this there is no overarching approach to the provision of pelvic floor services in the United Kingdom. The investigation and treatment of patients presenting with pelvic floor symptoms are delivered via a mixture of non-specialists and specialist local or regional services.

We aimed to analyse the case mix and management of patients presenting to a local district hospital colorectal pelvic floor service, comprising of 2 colorectal surgeons with a sub specialty interest, a specialist nurse and physiotherapist.

Study design

All patients who attended the colorectal pelvic floor clinic between October 2011 and July 2019 were retrospectively identified from clinic records. Their case files were reviewed in order to determine patient demographics, investigations performed, diagnosis and management.

Results

In total 342 records were analysed. The majority of patients were female (94.7%) with a mean age of 56.2 years. Lower gastrointestinal endoscopy was the commonest investigation (96.5%), followed by proctography (40.6%) and manometry (27.5%).

Symptoms and signs included obstructive defecation (28.4%), passive faecal incontinence (28.4%), urge faecal incontinence (18.9%), constipation (9.5%), rectal prolapse (6.8%), rectocele (5.8%) and mucosal prolapse (1.1%)(Table 1).

Symptoms and signs	Percentage of patients
Obstructive defecation	28.4%
Passive faecal incontinence	28.4%
Urge faecal incontinence	18.9%
Constipation	9.5%
Rectal prolapse	6.8%
Rectocele	5.8%
Mucosal prolapse	1.1%

Table 1: Symptoms and signs of patients presenting to the colorectal pelvic floor clinic

A small number (4.5%) of patients were referred to a tertiary MDT but the majority were managed locally. A significant number (32.6%) underwent nurse led management. Interventions included physiotherapy (36.6%), irrigation (27.9%), laxatives (12.9%), percutaneous tibial nerve stimulation (1.6%) and sacral nerve stimulation (0.5%) (Table 2).

Surgery occurred in 12.2% of patients, with laparoscopic ventral mesh rectopexy being the most frequently (5.8%) performed. Other procedures included transanal haemorrhoidal artery devascularisation (3.7%), ileostomy (0.8%), rubber band ligation of haemorrhoids (0.8%), Delorme's (0.5%) and Altmeirs (0.3%).

Intervention	Percentage of patients
Physiotherapy	36.6%
Irrigation	27.9%
Laxatives	12.9%
Surgery	12.2%
Percutaneous nerve stimulation	1.6%
Sacral nerve stimulation	0.5%

Table 2: Interventions prescribed for patients presenting to the colorectal pelvic floor clinic

Interpretation of results

Patients presenting with pelvic floor dysfunction are overwhelmingly female and of increasing age which is in keeping with known risk factors. The signs and symptoms as well as the required investigations are varied. Patients attending a colorectal pelvic floor service undergo a wide range of interventions with the majority being able to be managed through physiotherapy or medically. A significant number are able to be managed exclusively by specialist nurses. Only a minority of the patients ultimately require surgical intervention.

Concluding message

With the right skill mix, ready access to investigations and supportive tertiary services the majority of patients presenting to a colorectal pelvic floor clinic can be managed in a district general hospital setting.

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