



Editorial

Complete and thorough evaluation is critical for the initiation of surgery in the management of women with pelvic floor disorders



Female pelvic floor disorders, a broad range of clinical scenarios, including lower urinary tract excretory and defecation disorders, such as urinary incontinence (stress urinary incontinence: SUI), anal incontinence, overactive bladder (OAB), and pelvic organ prolapse (POP), as well as sexual disorders have a significant impact on women's quality of life (QoL) and also present a financial burden on the health care systems.^{1–3} Treatment includes non-surgical and surgical approach, and the latter is often used in the severe form of anatomic defect, including POP.⁴ The importance of surgical role in the management of severe form of anatomic defect is also supported by recent publication,^{5,6} because surgical trend is clear and evidence is relatively strong, contributing to fewer publications of “POP” topics in the recent two years.⁴ Therefore, it is welcome to learn Dr. Chin's publication to explore the relationship between OAB symptoms and paravaginal defects and further to identify the effect of repairing paravaginal defect on OAB symptom control.⁷ The authors retrospectively enrolled 30 women with advanced cystocele and limited apical and posterior vaginal wall prolapse who received a single Perigee procedure to study the difference between pre- and post-operation on OAB symptoms.⁷ Results showed there was no statistically significant difference of symptoms of OAB before and after surgery.⁷ Therefore, the authors concluded that repairing paravaginal defect could restore the anatomic defect but did not improve the severity of OAB.⁷ The current study is interesting and worthy of further discussion.

First, the relevance of the assessment of health-related QoL (HR-QoL) and functional status are important adjuncts to standard clinical outcomes.^{4,8} Therefore, this should be further emphasized in the management of age-related diseases, such as functional disturbance or non-lethal diseases. Symptom improvement should be always considered as major component of success in the treatment for women with pelvic floor disorders by any invasive procedure. As shown by authors themselves,⁷ OAB symptoms are common among women with vaginal anterior wall prolapse. This can be clearly explained by close anatomical and functional relationship of the lower

urinary tract, lower genital tract and anorectum in these patients.⁴ However, urinary symptoms in these patients with pelvic floor disorders might be much more complicated. For example, OAB might contain at least two distinct entities, including bladder oversensitivity and detrusor overactivity.^{9,10} Without accurate diagnosis, therapeutic effect might not be satisfied. Therefore, thorough and complete evaluation before surgery might satisfy the patients' expectancy.

Second, it is interesting to find the different types of POP might be correlated with different risk for OAB, although the authors did not mention this part. Women with existence of paravaginal defect and central defect had the higher capacity to present their desire to void but women with single central defect had the much lower capacity to show desire to void (260 ml versus 187 ml).⁷ That suggested that women with single central defect might have a higher risk of OAB, since the key symptom of OAB is urgency (lower compliance of urinary bladder capacity).^{11,12}

Third, it is possible that surgical intervention for POP might further deteriorate the “objective parameters” by urodynamic and/or ultrasound evaluation in the Dr. Chin's study,⁷ because these women had 240 ml for normal desire to void before operation but the volume for first desire to void dropped 196 ml after operation.⁷ Furthermore, in consistent with the above-mentioned data, cystometric capacity was 445 ml preoperatively but also dropped 398 ml post-operatively.⁷ Moreover, this deterioration effect is much more apparent in women with coexistence of central defect and paravaginal defect. Although the authors concluded that repairing paravaginal defect did not show significantly improve the severity of OAB symptoms in objective urodynamic data or subjective questionnaire data, there is no doubt to find that women with coexistence of central defect and paravaginal defect might get the benefits by repairing paravaginal defect. Based on the authors' data, we found that women treated with repairing paravaginal defect had less difference of normal desire to void and cystometric capacity between pre- and post-operation than women treated with repairing single central defect did (260 ml/214 ml versus

260 ml/137 ml with difference of 46 ml versus 123 ml, and 455 ml/418 ml versus 455 ml/332 ml with difference of 37 ml versus 123 ml, respectively).⁷ These findings are worthy of our attention.

In conclusion, with an increasing elderly population, there is greater demand on the healthcare providers with more complicated patients due to the different etiologies, different modulating factors, and the accompanied co-morbidities. The current study by Chin hints us that preoperative thorough and detailed evaluation might be critical step in the management of complicated diseases, such as POP.

Conflicts of interest

The authors declare that they have no conflicts of interest related to the subject matter or materials discussed in this article.

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