The Impact of Pelvic Floor Dysfunction on Sexuality: How Should We Counsel Our Patients?

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Although the development of validated questionnaires[1,2] to measure sexual function among women with pelvic floor disorders clearly represents an advance in our field, we still don't fully understand how to interpret the scores derived from these validated tools. Two important articles in this month's Green Journal illustrate the challenges we face as we attempt to understand our patients' sexual function and sexual satisfaction.

In "Sexual Function 6 Months After First Delivery" (see p. 1040), Brubaker et al explore the association between obstetric anal sphincter disruption and sexual function.[3] Although their data fail to demonstrate an association between anal incontinence and decreased sexual satisfaction in these primiparous women, we must remember these are secondary endpoints of the CAPS study.[4] In other words, the CAPS study was not originally powered to detect these associations. Therefore, we must not diminish the potential effect of sphincter disruption on subsequent sexual satisfaction. Any experienced obstetrician knows that these injuries can be mentally devastating and extremely painful. Even when attempting to remove known risk factors,[5] we cannot always prevent or predict sphincter injuries. So how should we counsel these women after the fact? In my opinion, we should start by legitimizing the pain and suffering they may experience–instead of describing anal sphincter injuries as a "normal" occurrence. These new mothers should be informed of the special care required to keep their repair intact, and that they may experience a "slow road" to recovery compared with their friends and family who never had such an injury. We should also remember to specifically ask them about symptoms like fecal incontinence and sexual dysfunction during postpartum visits, as many women are reluctant to bring these things up. We should emphasize the importance of pelvic floor muscle strengthening, and possibly even refer them to a pelvic floor physical therapist to optimize this training. Finally, it may even be reasonable to at least consider delivery via cesarean for subsequent deliveries.[6] I often recommend the book *Ever Since I Had My Baby,* by Roger Goldberg, MD, MPH, to these women, because it allows them to learn about their injury and realize that they are "not the only one."

In "Female Sexual Function and Pelvic Floor Disorders" (see p. 1045) Handa et al investigate the association between pelvic floor disorders and sexual problems in a population of patients seeking gynecologic care.[7] Their findings are particularly timely due to the current rapidly evolving landscape within the world of pelvic organ prolapse surgery. I have come to realize that patients' expectations about their prolapse surgery are frequently unrealistic, but the patients themselves should not be faulted for having these expectations. They often assume that their prolapse operation will solve their urinary frequency, sexual dysfunction, or other such problems. These understand-

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able patient expectations must be addressed directly and managed appropriately–preoperatively. When it comes to sexual function after prolapse treatments, we have very little evidence with which to counsel patients. We often use synthetic or organic graft materials to augment our prolapse repairs, and we owe it to our patients to let them know that we cannot predict whether these materials will adversely affect their sex lives. Handa's study is an important first step toward better patient counseling. Hopefully we will soon see further studies comparing sexual satisfaction among groups of women undergoing various different prolapse treatments. Until such evidence is available, I will continue to tell my prolapse surgery patients that when it comes to their sex lives my realistic hope is to "do no harm" . . . and to warn them that their operation unfortunately might do just that.

REFERENCES

1. Rogers RG, Coates KW, Kammerer-Doak D, Khalsa S, Qualls C. A short form of the Pelvic Organ Prolapse/Urinary Incontinence Sexual Questionnaire (PISQ-12). Int Urogynecol J Pelvic Floor Dysfunct 2003;14:164–8.
2. Dennerstein L, Lehert P, Dudley E. Short scale to measure female sexuality: adapted from McCoy Female Sexuality Questionnaire. J Sex Marital Ther 2001;27:339–51.
3. Brubaker L, Handa VL, Bradley CS, Connolly A, Moalli P, Brown MB. et al. Sexual function 6 months after first delivery. Obstet Gynecol 2008;111:1040–4.
4. Borello-France D, Burgio K, Richter H, Zyczynski H, FitzGerald MP, Whitehead W, et al. Fecal and urinary incontinence in primiparous women. The childbirth and pelvic symptoms (CAPS) study. Obstet Gynecol 2006;108:863–72.
5. FitzGerald MP, Weber AM, Howden N, Cundiff GW, Brown MB, for the Pelvic Floor Disorders Network. Risk factors for anal sphincter tear during vaginal delivery. Obstet Gynecol 2007;109:29–34.
6. Culligan PJ, Myers JA, Goldberg RP, Blackwell L, Gohmann SF, Abell TD. Elective cesarean section to prevent anal incontinence and brachial plexus injuries associated with macrosomia–a decision analysis. Int Urogynecol J Pelvic Floor Dysfunct 2005 Jan–Feb;16:19–28.
7. Handa VL, Cundiff G, Chang HH, Helzlsouer KK, Female sexual function and pelvic floor disorders. Obstet Gynecol 2008;111:1045–52.