

Caring for women with pelvic floor disorders during pregnancy and postpartum: Expert guidance

How to evaluate and manage your patients with the 3 Ps—pregnancy, postpartum, and pelvic floor disorders

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IN THIS ARTICLE

SUI management in pregnancy

page 27

Postpartum fecal incontinence

page 28

Peripartum prolapse

page 30

Pelvic floor disorders (PFDs) affect many pregnant and newly postpartum women. These conditions, including urinary incontinence, anal incontinence, and pelvic organ prolapse (POP), can be overshadowed by common pregnancy and postpartum concerns (TABLE 1).¹ With the use of a few quick screening questions, however, PFDs easily can be identified in this at-risk population. Active management need not be delayed until after delivery for women experiencing bother, as options exist for women with PFDs during pregnancy as well as postpartum.

In this article, we discuss the common PFDs that obstetric clinicians face in the

context of case scenarios and review how you can be better equipped to care for affected individuals.

CASE 1 Screening

A 30-year-old woman (G1P1) presents for her routine postpartum visit after an operative vaginal delivery with a second-degree laceration.

How would you screen this patient for PFDs?

Why screening for PFDs matters

While there are no validated PFD screening tools for this patient population, clinicians can ask a series of brief open-ended questions as part of the review of systems to efficiently evaluate for the common PFDs in peripartum patients (see “Screening questions to evaluate patients for peripartum pelvic floor disorders” on page 27).

Pelvic floor disorders in the peripartum period can have a significant negative impact. In pregnancy, nearly half of women report psychological strain due to the presence of bowel, bladder, prolapse, or sexual dysfunction symptoms.² Postpartum, PFDs have negative effects on overall health, well-being, and self-esteem, with significantly increased rates of postpartum depression in women who experience urinary incontinence.^{3,4} Proactively inquiring about PFD symptoms, providing anticipatory guidance, and recommending treatment options can positively impact a patient in multiple domains.



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CASE 2 Stress urinary incontinence

A 27-year-old woman (G1P1) presents 2 months following spontaneous vaginal delivery with symptoms of urine leakage with laughing and running. Her urinary incontinence has been improving since delivery, but it continues to be bothersome.

What would you recommend for this patient?

Conservative SUI management strategies in pregnancy

Urinary tract symptoms are common in pregnancy, with up to 41.8% of women reporting urinary symptom distress in the third trimester.⁵ During pregnancy, estrogen and progesterone decrease urethral pressure that, together with increased intra-abdominal pressure from the gravid uterus, can cause or worsen stress urinary incontinence (SUI).⁶

During pregnancy, women should be offered conservative therapies for SUI. For women who can perform a pelvic floor contraction (a Kegel exercise), self-guided pelvic floor muscle exercises (PFMEs) may be helpful (see “Pelvic floor muscle exercises” on page 28). We recommend that women start with 1 to 2 sets of 10 Kegel exercises per day and that they hold the squeeze for 2 to 3 seconds, working up to holding for 10 seconds. The goal is to strengthen and improve muscle control so that the Kegel squeeze can be paired with activities that cause SUI.

For women who are unable to perform a Kegel exercise or are not improving with a home PFME regimen, referral to pelvic floor physical therapy (PFPT) can be considered. While data support the efficacy of PFPT for SUI treatment in nonpregnant women,⁷ data are lacking on PFME in pregnancy.

In women without urinary incontinence, PFME in early pregnancy can prevent the onset of incontinence in late pregnancy and the postpartum period.⁸ By contrast, the same 2020 Cochrane Review found no evidence that antenatal pelvic floor muscle therapy in incontinent women decreases incontinence in mid- or late-pregnancy or in the postpartum period.⁸ As the quality of this evidence is very low and there is no evidence of harm with PFME, we continue to recommend it for women with bothersome SUI.

TABLE 1 Incidence of pelvic floor disorders in the postpartum period¹

Pelvic floor disorder	Incidence at 6 weeks postpartum	Incidence at 6 months postpartum
Urinary incontinence		
Vaginal delivery	35%	31%
With OASI	35%	34%
Cesarean delivery	25%	23%
Fecal incontinence		
Vaginal delivery	11%	8%
With OASI	27%	17%
Cesarean delivery	10%	8%
Pelvic organ prolapse		
Vaginal delivery		29%
With OASI		38%
Cesarean delivery		21%

Abbreviation: OASI, obstetric anal sphincter injury.

Incontinence pessaries or vaginal inserts (such as Poise Impressa bladder supports) can be helpful for SUI treatment. An incontinence pessary can be fitted in the office, and fitting kits are available for both. Pessaries can safely be used in pregnancy, but there are no data on the efficacy of pessaries for treating SUI in pregnancy. In nonpregnant women, evidence demonstrates 63% satisfaction 3 months post-pessary placement for SUI.⁷

We do not recommend invasive procedures for the treatment of SUI during pregnancy or in the first 6 months following delivery. There is no evidence that elective cesarean delivery prevents persistent SUI postpartum.⁹

Managing SUI in the postpartum period

After the first 6 months postpartum and exhaustion of conservative measures, we offer

Screening questions to evaluate patients for peripartum pelvic floor disorders

Sometimes during pregnancy or after having a baby, a woman experiences pelvic floor symptoms. Do you have any of the following?

- leakage with coughing, laughing, sneezing, or physical activity
- urgency to urinate or leakage due to urgency
- bulging or pressure within the vagina
- pain with intercourse
- accidental bowel leakage of stool or flatus

Pelvic floor muscle exercises¹

To identify and engage the proper pelvic floor muscles:

- Insert a finger in the vagina and squeeze the vaginal muscles around your finger.
- Imagine you are sitting on a marble and have to pick it up with the vaginal muscles.
- Squeeze the muscles you would use to stop the flow of urine or hold back flatulence.

Perform sets of 10, 2 to 3 times per day as follows:

- Squeeze: Engage the pelvic floor muscles as described above; avoid performing Kegels while voiding.
- Hold: For 2 to 10 seconds; increase the duration to 10 seconds as able.
- Relax: Completely relax muscles before initiating the next squeeze.

Reference

1. UpToDate. Patient education: pelvic muscle (Kegel) exercises (the basics). 2018. <https://uptodate-free.ir/topic.htm?path=pelvic-muscle-kegel-exercises-the-basics>. Accessed February 24, 2021.

surgical interventions for women with persistent, bothersome incontinence. Surgery for SUI typically is not recommended until child-bearing is complete, but it can be considered if the patient's bother is significant.

For women with bothersome SUI who still desire future pregnancy, management options include periurethral bulking, a retropubic urethropexy (Burch procedure), or a midurethral sling procedure. Women who undergo an anti-incontinence procedure have an increased risk for urinary retention during a subsequent pregnancy.¹⁰ Most women with a midurethral sling will continue to be continent following an obstetric delivery.

Anticipatory guidance

At 3 months postpartum, the incidence of urinary incontinence is 6% to 40%, depending

on parity and delivery type. Postpartum urinary incontinence is most common after instrumented vaginal delivery (32%) followed by spontaneous vaginal delivery (28%) and cesarean delivery (15%). The mean prevalence of any type of urinary incontinence is 33% at 3 months postpartum, and only small changes in the rate of urinary incontinence occur over the first postpartum year.¹¹ While urinary incontinence is common postpartum, it should not be considered normal. We counsel that symptoms may improve spontaneously, but treatment can be initiated if the patient experiences significant bother.

A longitudinal cohort study that followed women from 3 months to 12 years postpartum found that, of women with urinary incontinence at 3 months postpartum, 76% continued to report incontinence at 12 years postpartum.¹² We recommend that women be counseled that, even when symptoms resolve, they remain at increased risk for urinary incontinence in the future. Invasive therapies should be used to treat bothersome urinary incontinence, not to prevent future incontinence.

CASE 3 Fecal incontinence

A 24-year-old woman (G1P1) presents 3 weeks postpartum following a forceps-assisted vaginal delivery complicated by a 3c laceration. She reports fecal urgency, inability to control flatus, and once-daily fecal incontinence.

How would you evaluate these symptoms?

Steps in evaluation

The initial evaluation should include an inquiry regarding the patient's stool consistency and bowel regimen. The Bristol stool form scale can be used to help patients describe their typical bowel movements (TABLE 2).¹³ During healing, the goal is to achieve a Bristol type 4 stool, both to avoid straining and to improve continence, as loose stool is the most difficult to control.

A physical examination can evaluate healing and sphincter integrity; it should include inspection of the distal vagina and perineal body and a digital rectal exam. Anal canal resting tone and squeeze strength should be evaluated, and the digital rectal

TABLE 2 Bristol stool form scale¹³

Type	Description
1	Separate hard lumps, like nuts (hard to pass)
2	Sausage-shaped but lumpy
3	Like a sausage but with cracks on its surface
4	Like a sausage or snake, smooth and soft
5	Soft blobs with clear-cut edges (passed easily)
6	Fluffy pieces with ragged edges, a mushy stool
7	Watery, no solid pieces, entirely liquid

examination scoring system (DRESS) can be useful for quantification (TABLE 3).¹⁴ Lack of tone at rest in the anterolateral portion of the sphincter complex can indicate an internal anal sphincter defect, as 80% of the resting tone comes from this muscle (FIGURE).¹⁵

The rectovaginal septum should be assessed given the increased risk of rectovaginal fistula in women with obstetric anal sphincter injury (OASI). The patient should be instructed to contract the anal sphincter, allowing evaluation of muscular contraction. Lack of contraction anteriolaterally may indicate external anal sphincter separation.

Conservative options for improving fecal incontinence symptoms

The patient can be counseled regarding stool bulking, first with insoluble fiber supplementation and cessation of stool softeners if she is incontinent of liquid stool. If these measures are not effective, use of a constipating agent, such as loperamide, can improve stool consistency and thereby decrease incontinence episodes. PFPT with biofeedback can be offered as well. While typically we do not recommend initiating PFPT before 6 weeks postpartum, so the initial phases of healing can occur, early referral enables the patient to avoid a delay in access to care.

The patient also can be counseled about a referral to a pelvic floor specialist for further evaluation. A variety of peripartum pelvic floor disorder clinics are being established by Female Pelvic Medicine and Reconstructive Surgery (FPMRS) physicians. These clinics provide the benefit of comprehensive care for pelvic floor disorders in this unique population.

When conservative measures fail. If a patient has persistent bowel control issues despite conservative measures, a referral to an FPMRS physician should be initiated.

Delivery route in future pregnancies

The risk of a subsequent OASI is low. While this means that many women can safely pursue a future vaginal delivery, a scheduled cesarean delivery is indicated for women with persistent bowel control issues, wound healing complications, and those who

TABLE 3 Digital rectal examination scoring system (DRESS)¹⁴

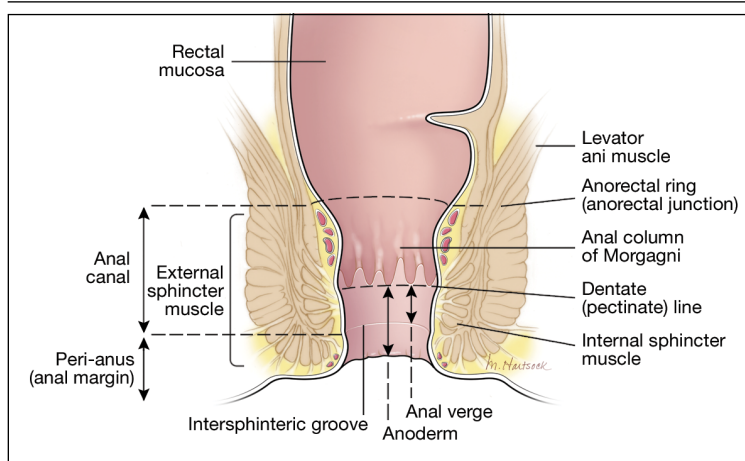
Resting score		Squeeze score	
0	No discernible tone at rest, an open or patulous anal canal	0	No discernible increase in tone with squeezing effort
1	Very low tone	1	Slight increase
2	Mildly decreased tone	2	Fair increase but below normal
3	Normal	3	Normal
4	Elevated tone, snug	4	Strong squeeze
5	Very high tone, a tight anal canal, difficult to insert a finger	5	Very strong squeeze, to the point of being painful to the examiner

experienced psychological trauma from their delivery.¹⁶ We recommend a shared-decision making approach, reviewing modifiable and nonmodifiable risk factors to help determine whether or not a future vaginal birth is appropriate. It is important to highlight that a cesarean delivery does not protect against fecal incontinence in women with a history of OASI; however, there is benefit in preventing worsening of anal incontinence, if present.¹⁷

CASE 4 Uterovaginal prolapse

A 36-year-old woman (G3P3) presents for her routine postpartum visit at 6 weeks after a spontaneous vaginal delivery without lacerations. She reports a persistent feeling of vaginal pressure and fullness. She thinks she felt a

FIGURE Anatomy of the anorectum¹⁵



bulge with wiping after a bowel movement.

What options are available for this patient?

Prolapse in the peripartum population

Previous studies have revealed an increased prevalence of POP in pregnant women on examination compared with their nulligravid counterparts (47.6% vs 0%).¹⁸ With the changes in the hormonal milieu in pregnancy, as well as the weight of the gravid uterus on the pelvic floor, it is not surprising that pregnancy may be the inciting event to expose even transient defects in pelvic organ support.¹⁹

It is well established that increasing parity and, to a lesser extent, larger babies are associated with increased risk for future POP and surgery for prolapse. In the first year postpartum, nearly one-third of women have stage 2 or greater prolapse on exam, with studies demonstrating an increased prevalence of postpartum POP in women who delivered vaginally compared with those who delivered by cesarean.^{20,21}

Initial evaluation

Diagnosis can be made during a routine pelvic exam by having the patient perform a Valsalva maneuver while in the lithotomy position. Using half of a speculum permits evaluation of the anterior and posterior vaginal walls separately, and Valsalva during a bimanual exam can aid in evaluating descent of the uterus and cervix.

Excellent free patient education resources available online through the American Urogynecologic Society and the International Urogynecological Association can be used to direct counseling.

Treatments you can offer for POP

For pregnant or postpartum patients with bothersome prolapse, initial management options include pessary fitting and/or PFPT referral. In pregnancy, women often can be successfully fitted with a pessary for POP; however, as expulsion is a common issue, selection of a stiffer or space-occupying device may be more efficacious.

Often, early onset POP in pregnancy resolves as the gravid uterus lifts out of the pelvis in the second trimester, at which time the pessary can be discontinued. In the postpartum period, a pessary fitting can be undertaken similarly to that in nonpregnant patients. While data are lacking in the peripartum population, evidence supports the positive impact of PFPT on improving POP symptom bother.²² Additionally, for postpartum women who experience OASI, PFPT can produce significant improvement in subjective POP and associated bother.²³

Impact of future childbearing wishes on treatment

The desire for future childbearing does not preclude treatment of patients experiencing bother from POP after conservative management options have failed. Both vaginal native tissue and mesh-augmented uterine-sparing repairs are performed by many FPMRS specialists and are associated with good outcomes. As with SUJ, we do not recommend invasive treatment for POP during pregnancy or before 6 months postpartum.

In conclusion

Obstetric specialists play an essential role in caring for women with PFDs in the peripartum period. Basic evaluation, counseling, and management can be initiated using many of the resources already available in an obstetric ambulatory practice. Important adjunctive resources include those available for both providers and patients through the American Urogynecologic Society and the International Urogynecological Association. In addition, clinicians can partner with pelvic floor specialists through the growing number of FPMRS-run peripartum pelvic floor disorder clinics across the country and pelvic floor physical therapists.

If these specialty clinics and therapists are not available in your area, FPMRS specialists, urologists, gastroenterologists, and/or colorectal surgeons can aid in patient diagnosis and management to reach the ultimate goal of improving PFDs in this at-risk population. ●

FAST TRACK

In caring for women with PFDs, clinicians can partner with pelvic floor specialists through the growing number of FPMRS-run clinics across the country and pelvic floor physical therapists

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