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Multidisciplinary team (MDT) approach to pelvic floor disorders

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ABSTRACT

Pelvic floor disorders encompass a spectrum of different functional and anatomical disorders, which often require input from different disciplines. Usually, patients are referred with one main complaint, but often other symptoms are associated. For example, a patient referred with rectal prolapse may also suffer with urinary incontinence and associated anterior and middle compartment prolapse.

Multidisciplinary assessment and treatment should be conducted from initial assessment to best understand which specialties should be involved in symptom management. Conservative and surgical interventions both play an important role for these pathologies and are often used in combination.

The aim of this manuscript is to present the importance of the multidisciplinary approach to pelvic floor disorders and the value of different healthcare professionals and specialties. Consideration about future expansions of pelvic floor services will be presented as well, with special attention to the role of dietician, pain team and psychologist.

1. Introduction

Pelvic floor disorders (PFD) include a spectrum of different conditions such as faecal incontinence (FI), obstructive defecation syndrome (ODS), urinary symptoms, vaginal symptoms and pelvic organ prolapse (POP) [1]. PFD have a complex pathophysiology and different manifestations, making their treatment complex. The majority of patients are women, and it has been estimated that approximately 24% of adult women have at least one symptom of PFD [2]. Male PFDs are less prevalent than in women, which is the main reason why the literature is less exhaustive. In the past, the standard was a single-specialty approach to PFD, with urogynaecologists, urologists and colorectal surgeons with special interest in pelvic floor disorders assessing patients separately. As a result, most patients felt incomplete resolutions of symptoms and limited satisfaction after surgical procedure, due to presence of residual symptoms [3]. For this reason, The National Institute for Health, and Clinical Excellence (NICE) recommended multidisciplinary team (MDT) management of patients with PFD with the aim to improve patients' outcome and standardize treatment [4].

A multidisciplinary approach to patients with PFD may be introduced with an initial evaluation using a structured interview, which can be conducted over the phone. Telephone triage assessment clinic (TTAC) is a process whereby specialized pelvic floor nurses call patients with specific health problems based on their referrals, assess and direct them to appropriate diagnostic tests or specific consultations (Fig. 1) [5–10]. TTAC for patients with PFD has the potential to assess these complex patients through structured questionnaires [11] and direct them to the most appropriate investigations and treatments.

The pelvic floor MDT should include core members, essential to run a multidisciplinary pelvic floor service. To guarantee a multidisciplinary approach, these core members should include a colorectal surgeon with an interest in pelvic floor disorders, a urogynaecologist specialized in the treatment of middle compartment prolapse and female urinary disorders, a urologist to treat female and male patients with urinary symptoms, pelvic floor physiotherapists and specialist nurses, responsible for conservative management and in some countries a clinical scientist, to conduct pelvic floor investigations [12].

Regular multidisciplinary meetings, which occur in most institutions on weekly basis, are fundamental to discuss treatment options for these complex patients. A recent retrospective analysis of prospectively collected data of women referred and discussed at a pelvic floor MDT over a year in a tertiary referral centre has been published [13]. In total, 152 patients were discussed; the MDT recommended a change in the initial management plan in 20% (31/152) of cases, of whom 80% (25/31) were patients with complex urinary incontinence. Furthermore, combined multidisciplinary pelvic floor clinics have been demonstrated to improve patients' satisfaction [14–16] and increase adherence to treatment.

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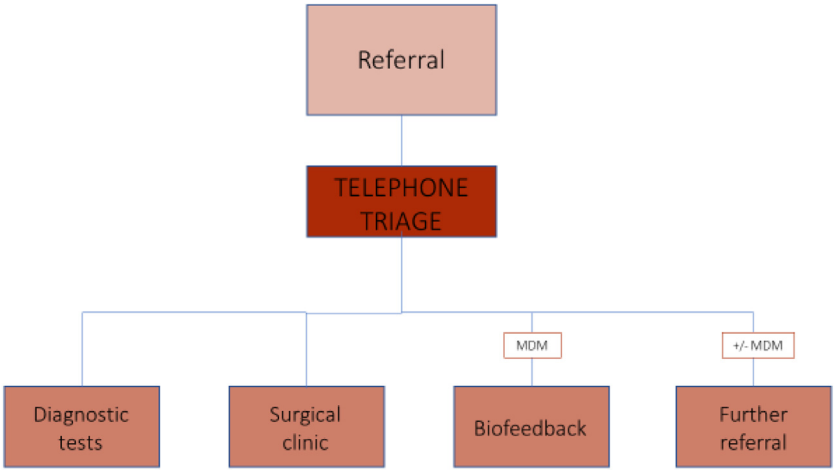

Fig. 1. Structure of Telephone triage clinic.

First line treatment for PFD is conservative management [17–19]. Conservative treatment consists of a variety of strategies, for instance the improvement of pelvic floor muscle function and the improvement of aspects such as stool consistency and rectal emptying [20]. These strategies are tailored for patient's specific symptoms, and consist of 'combination therapy' including lifestyle modifications, education and counselling, habit training, medications, dietary modification, toilet positioning and biofeedback training [20]. If necessary, patients might learn how to use suppositories and/or transanal irrigation to optimize rectal emptying. When conservative measures fail, surgery should be considered after discussion in a multidisciplinary meeting. Surgery might aim to repair POP or treat anal or urinary incontinence. Moreover, combined procedures to treat differing POPs and urinary incontinence can be performed simultaneously if appropriate [14,21–24].

The aim of this manuscript is to present the importance of multidisciplinary approach to PFD and the value of different healthcare professionals and medical specialties. The future of pelvic floor services will be discussed as well, with special attention to the role of dietician, pain team and psychologist.

2. Different specialties are necessary to treat a variety of pelvic floor symptoms

Pelvic organ prolapse (POP) are common disorders referred to pelvic floor units. IUGA (International Urogynaecological Association) and the ICS (International Continence Society) divide vaginal prolapse into anterior vaginal wall prolapse (cystocoele/urethrocoele/uterus/vaginal vault/enterocoele), posterior vaginal wall prolapse (rectocoele/vaginal vault/enterocoele) and uterine/cervical or vaginal vault prolapse [1,25]. The main common symptom for all prolapse is vaginal heaviness, which can be combined with other specific complaints. The reported prevalence of POP varies widely (1%–65%) depending on whether it is ascertained by symptoms, pelvic examination or both [26]. Patients with symptomatic anorectal or rectal prolapse are referred to pelvic floor units with symptoms such as pain, incomplete evacuation, bloody and/or mucous rectal discharge, and faecal incontinence or constipation [27].

Constipation, (complaint of infrequent and/or incomplete bowel motions and/or the need for frequent straining or manual assistance as defined by the ICS and the Rome IV criteria), is another common reason for referral [26,28–30]. Depending on the definition, 20% of the population report symptoms (2%–28% adults). After exclusion of secondary causes (obstructing colonic lesions, neurological, metabolic and endocrine disorders), constipation can be divided into problems of stool transit (slow transit) and problems related to rectal emptying (evacuation disorder). This latest group of patients present with, symptoms of obstructed defaecation syndrome (ODS) might be further divided into those with a structurally significant pelvic floor abnormality (e.g. rectocoele or internal rectal prolapse, namely intussusception), and those characterized by functional defaecation disorder [28–30].

Faecal incontinence (FI) is "the involuntary loss of faeces [29]. Prevalence varies based on definition; several large, population-based studies of community dwelling women estimate prevalence ranges between 9% and 19%, with an increase with age [31]. Even in patients with mild or infrequent symptoms, FI negatively affects quality of life and is associated with increased risks of depression and social isolation [31,32]. In 40% of patients, FI and functional constipation coexist; this overlap should be carefully considered during assessment [33].

Urinary incontinence is another common reason for referral to the pelvic floor unit and include stress urinary incontinence (SUI) and urge urinary incontinence (UUI), which can coexist in patients with mixed urinary incontinence (MUI)[1,34].

The above-mentioned symptoms might coexist and there is good evidence in the literature regarding this. A recent study investigated the presence of urinary symptoms in patients with FI [35]. Ortega et al. found that patients with FI are more likely to have UUI, mixed urinary incontinence and leakage of urine during sexual intercourse [35]. Similarly, patients with constipation seem to experience urogenital symptoms, such as dyspareunia, urinary hesitancy, and sensation of incomplete bladder emptying [36]. Considering the coexistence of different PFD, patients referred to pelvic floor units should be assessed for symptoms attributable to all pelvic floor compartments. This can be achieved through standardized questionnaires for different complaints, including screening questions for those aspects which do not form a part of the patients initial presenting complaint. Pelvic floor units should provide comprehensive, multifaceted care.

3. Patients' pathway in pelvic floor unit from referral until treatment

Multicompartmental PFD often co-exists and the complex interplay between functional, anatomical and psychological factors must be addressed to plan treatment. In recent years the use of the telephone triage assessment clinic (TTAC) has increased, particularly in the era of the Covid-19 pandemic and with the centralization of services [6,37]. Specialized nurses call patients with specific health problems based on their referrals to assess them and refer them for appropriate diagnostic tests or to specific healthcare professionals. TTAC provides the advantages of decreased hospital visits, which may be particularly helpful for those with incontinence or in whom taking time away from work or family commitments is difficult. However, it may not be appropriate in the context of communication or language barriers.

Moreover, building up a rapport with the patient to enable discussion of sensitive information over the telephone may be difficult and takes training and expertise. TTAC must be complemented with a face to face appointment early on in the patient pathway to allow for essential physical examination.

The TTAC has been designed so that anyone presenting to the pelvic floor unit can be assessed, whether they have primarily bowel, urinary or sexual dysfunction or symptoms of vaginal or bowel prolapse. This enables the true integration of colorectal, urological and urogynaecological departments and then subsequent referral to the appropriate MDT member. Furthermore, the use of standardized questionnaires at presentation also enable to re-assess patients after treatment, be conservative or surgical, to determine their efficacy. Three recent studies have demonstrated that patients assessed with TTAC for pelvic floor and colorectal symptoms are highly satisfied [37–39] about the modality and they hope that TTAC is maintained as an option beyond the pandemic [39].

This structured approach allows patients to be assessed in a private environment has the advantage of avoiding a long journey to tertiary referral centres. TTAC allows the multidisciplinary structured approach to pelvic floor dysfunction, which is fundamental to understand the complexity of pelvic floor disorders. The use of standardized questionnaires helps to understand the complexity of these multifactorial symptoms and the number of specialists needed to address them [11]. These patients have different problems characterized by faecal and/or urinary incontinence, ODS and POP.

4. The key role of multidisciplinary meeting

The pelvic floor multidisciplinary meeting has a central role for patients with PFD [13]. In our institutions, for instance, the MDT is composed by specialized colorectal and continence nurses, clinical scientists, physiotherapists, research fellows, consultant colorectal surgeons with specialist interest in pelvic floor disorders, urologists, urogynaecologists, obstetricians, midwifes, radiologists and administrative support. It is conducted on weekly basis for patients with the main complaint of bowels symptoms and twice a month for patients with associated urinary symptoms, anterior and middle compartmental prolapse.

Our multidisciplinary meeting has different aims. First it provides support to colorectal nurses and physiotherapists for conservative treatment and allow them to discuss patients who fail to improve. Furthermore, it allows to review results of pelvic floor investigations and in selected cases images related to POP. Finally, decisions about the surgical approach for POP needs to be made during these meetings with a shared decision approach; this may include differing surgical options, which should then be discussed with the patient. An open discussion including all members is encouraged, with the view to obtain mutual support in management of patients with complex disorders.

The multidisciplinary meeting is also the setting where we make plans for patients who might benefit for combined surgical procedures (mainly for multicompartment prolapse) or might benefit from review in a combined clinic, with representation from more than one specialty. It is particularly important to make shared decisions and communicate this to patients before clinic appointments, to allow time for reflexion and preparation.

5. Physiotherapists, nurses and clinical scientists: pilasters in clinical management of pelvic floor conditions

Significant, high-quality evidence supports the assessment and conservative management of PFD by both continence nurses and pelvic health physiotherapists [4,40–45].

Conservative management includes patient education, lifestyle modification, supervised pelvic floor muscle training (PFMT), manual therapy, bladder, and bowel retraining, electromyographic biofeedback (EMG BFB), neuromuscular electrical stimulation (NMES), intravaginal devices and pessaries, medication, and advice on hygiene and physical activity [4,40–45].

Table 1
Competencies required to manage pelvic floor disorders (PFD) in the community care setting.

Competencies required to assess and manage PFD in the community care setting.
• Carrying out initial assessments.
• Awareness of the psychosocial implications of PFD.
• Identifying risk factors.
• Interpreting urinalysis.
• Conducting and interpreting bladder scans to measure post-void residual volume.
• Conducting routine digital assessments of the pelvic floor and pelvic floor muscle contractions and relaxation.
• Training women and their families and carers in behavioural interventions for pelvic floor dysfunction (such as bladder and bowel retraining).
• Prescribing and reviewing medications, and knowledge of interactions related to PFD.
• Supervising a PFMT programme.
• Managing the use of pessaries and intravaginal devices.
• Training other care providers to assess and manage pelvic floor dysfunction.
• Assessments of mobility and personal care issues related to pelvic floor dysfunction.
• Identifying which women need referral to specialist care.

Conservative management is often delivered depending on local expertise and availability of the different continence health care professionals. Occasionally, this creates uncertainty to the medical practitioners as to where to refer the patient for continence assessment and management. This is because the scope of practice and continence care provision often overlaps between physiotherapists and nurses, as both types of providers engage in collecting a detailed patient history, using bladder and bowel diaries and assessing pelvic floor muscle function [46].

To facilitate interprofessional and multidisciplinary collaboration, NICE [44] recommended that health care professionals delivering continence care should have a standard set of acquired competencies to assess and manage PFD in the community care setting (Table 1).

Furthermore, the UK Pelvic Floor Society recommended in 2021 that PFD can be managed efficiently in the community without requiring the resources associated with hospital visits and that trained nurses, physiotherapists and other allied health professionals can conduct some protocol driven procedures to free up specialists for other work [47].

Clinical scientists are amongst other allied health care professionals that support the patient's continence journey. Clinical Scientists play a key role in the PFD diagnostic process as they provide scientific advice and guidance to clinicians on the clinical utility, appropriateness and results of urodynamics studies and anorectal manometry where inaccurate or unreliable results would adversely affect patient care [48]. Depending on local expertise and postgraduate training, they may also provide pelvic floor care.

Considering the vast evidence behind the assessment and management of PFD by nurses, physiotherapists, and clinical scientists there are still several barriers that preclude first-line continence care provision by these professionals. For example, despite the proliferation of clinical guidelines, there is increasing evidence that practicing clinicians and nurses (in the community, acute care, and in long term care) are not consistently following them or the model of care is mostly physician led. Implementation models should be developed on how to translate guidelines into clinical practice and emphasis on non-physician interdisciplinary continence models of care is required [49,50]. Despite increased awareness amongst healthcare providers and consumers of healthcare over the last decade, combined with the high level of efficacy of conservative care strategies, health seeking behaviour for PFD remains low [49]. Interdisciplinary and MDT working and

communication, improves collaboration between specialties, is crucial for healthcare delivery across clinical settings and provides excellent learning and teaching opportunities [51].

Where local expertise is available and the competencies are established, a physio-nurse led clinic should be considered to triage and manage patients with PFD and expedite those at risk to the consultant led clinic [10,44,46,47]. This model of care creates streamlined cost-effective pathways, ensures optimal care to patients where the full range of therapeutic options are considered, improves patients experience and outcomes and increases clinicians' job satisfaction [50,52].

6. The importance of multidisciplinary pelvic floor clinic

Combined multidisciplinary pelvic floor clinics have been demonstrated to improve patients' satisfaction [14,15] and increase adherence to treatment. Kapoor et al. [14] retrospectively analysed a cohort of 113 patients referred to a tertiary referral centre over 3 years. A total of 113 patients have been assessed in a multidisciplinary clinic led by a urogynaecologist and colorectal surgeon over a 3-year period. A patient satisfaction audit found that 73% of care were excellent/good. Similar results have been found by O'Leary et al. [15], who conducted a survey among 136 women who attended a combined clinic between colorectal and urogynaecology physician a pelvic floor tertiary referral centre in 2015. In total, 87 patients responded to questionnaires, 97% found beneficial seeing multiple specialists during the same appointment and 94% would recommend the pelvic floor centre. Furthermore, adherence to conservative management seems to improve when patients attend a combined clinic with physician and physiotherapist [16]. Patients who saw physiotherapist the same day as their first urogynaecology visit were more likely to attend further physiotherapy sessions compared to those who did not (91% vs 61%, $p<0.001$).

Multidisciplinary clinics offer several advantages. First, allow patients with more than one complaint to be assessed and examined, avoiding multiple hospital visits. Furthermore, if symptoms cannot be treated with same strategy (conservative or surgical approach), an open conversation with different specialists will allow patients to establish their own priorities. If surgery is indicated to treat a multicompartment pelvic organ prolapse, clinic will become the setting to explain risks and benefit from surgery and understand patients' expectations.

7. Combined surgical procedures to correct multicompartment prolapse

In the past, rectal prolapse and POP was treated as separate entities. Surgical treatment for combined prolapse can be performed via the perineal or abdominal route [53]. For rectal prolapse surgery, the abdominal approach includes posterior rectopexy and ventral mesh rectopexy (VMR), while the perineal approach involves Delormes' or Altemeier's procedures. Treatment for uterovaginal or vaginal vault prolapse can be made through abdominal approach and this seems to be superior to the transvaginal suspension procedures [54,55].

Combined surgical procedures have the advantage to correct multiple anatomical defects in a single procedure, avoiding a second operation. Jalland K et al. [22] retrospectively reviewed 59 patients, who underwent ventral rectopexy with either concurrent sacrocolpo or hysteropexy at a tertiary care centre between 2009 and 2015. After a median follow-up of 17 months, they found that combined procedures were associated with significant improvement in anatomic and subjective outcomes. Similar results have been found by Kapoor et al. in their retrospective review, with the conclusion that joint surgical procedures might accelerate patients' treatment and improve satisfaction [14].

A recent retrospective multicentric study evaluated the impact of middle compartment suspension on the durability of rectal prolapse repair [56]. Data were collected among 20 centres, abdominal rectopexy procedures with and without middle compartment suspension were compared. Of the 198 patients (98% female, age 60.2 ± 15.6 years) who underwent abdominal repairs (59% robotic), 138 patients (70%) underwent some concomitant middle compartment suspension. Patients who had an additional middle compartment suspension seemed to have lower early rectal prolapse recurrences (median follow-up 3 months) [56]. On multivariable regression, factors associated with decreased short-term recurrences are age, previous repairs, and the use of mesh, and the addition of some form of pouch of Douglas repair.

Although evidence from the literature is limited and more robust studies with extended follow-up are required to understand long term outcomes, existing evidence favours combined surgical procedures in the setting of patients with multicompartment prolapse.

8. Expanded MDT service: role of dietician, obstetrician, pain team, psychologist

Diet plays an important role in benign colorectal conditions, including constipation and FI. While first line dietary advice is considered standard for initial conservative treatment, a more systematic dietician input may be beneficial for many patients [57]. For patients with chronic constipation, first-line modification is increased dietary or supplemental fibre intake. In a systematic review of 4 trials that included 315 participants with chronic constipation, randomization to soluble fibre compared with placebo or no therapy led to improvement in global symptoms (87% vs 47%), straining (36% vs 79%), stool consistency, and mean number of stools per day (1.3 vs 0.9) [58]. Other evidences can be learned from individuals who consume vegetarian and vegan diets. These groups have more frequent bowel movements compared with those who consume a meat- or fish-based diet [59].

Similarly, diet can play an important role for patient with FI, which is exacerbated by loose or liquid stool, and selected fibres can normalize stool consistency. Selected fibres absorb fluid and increase stool bulk. Furthermore, a diet low in FODMAPs [60] (fermentable oligosaccharides, disaccharides, monosaccharides and polyols) may be another useful tool for managing FI. Short-chain carbo-hydrates are osmotically active and rapidly fermented, leading to increased water secretion and gas production within the gut lumen. Preliminary data suggest that dietary reduction of these carbohydrates may improve FI. Diet modification for patients with constipation and FI should be made with a regular dietician support. For this reason, we advocate that dietician should be part of multidisciplinary pelvic floor team.

Obstetricians and midwifes have an important role in multidisciplinary pelvic floor meeting to discuss patients who underwent recent obstetric anal sphincter injury as a result of vaginal delivery [61]. Furthermore, obstetricians and midwifes have an important role, considering that pregnancy and childbirth might have important consequence in female pelvic floor disorders. For instance, we are running a dedicated clinic for women with suspected third/fourth degree tear, who are followed up 12 weeks after the presumed event and assessed through, continence questionnaire, endoanal ultrasound, anaorectal manometry [61]. Moreover, we offer them the possibility to start a dedicated program including pelvic floor exercises, bowel and bladder retraining if symptomatic.

Chronic pelvic pain syndromes (CPSS) are another group of patients referred to pelvic floor specialists [62,63]. As recommended by the ICS, the evaluation of pain needs to individualized and take the patients' perception of pain into account as well as biopsychosocial aspects [62]. Symptoms may present in isolation or combined with anatomical abnormalities or a variety of pelvic floor symptoms. Chronic anal pain affects up to 11.6% of the US population. The main aim of the colorectal consultation is to exclude organic causes of anal pain, such as anal fissure, abscess, fistula and haemorrhoids (although only thrombosed haemorrhoids are usually painful) [62]. In addition to physical examination, pelvic magnetic resonance imaging (MRI) might be an useful tool to exclude deep perianal sepsis or other pathologies. Similarly, chronic pelvic pain can affect women and men, with similar symptoms,

and initial assessment is conducted respectively by gynaecologists [63] and urologists [60].

Female chronic pelvic pain (CPP) affects an estimated 26% of the world's female population. The ICS define chronic pelvic pain as persistent pain lasting longer than 6 months or recurrent episodes of abdominal/pelvic pain, hypersensitivity or discomfort often associated with elimination changes, and sexual dysfunction often in the absence or organic aetiology [62]. It often associated with negative cognitive, behavioural, sexual, and emotional consequences and symptoms suggestive of lower urinary tract, sexual, bowel myofascial, or gynaecologic dysfunction [63]. Patient assessment should include medical diagnoses, past surgeries, pain triggers (activity, menstruation, intercourse, stress), and urological, gastroenterological, gynaecologic, and myofascial symptoms. There is also a well-known relationship between trauma, abuse, or poor mental health and CPP [63] and history should focus on tis as well. Again, the main aim for the gynaecologist is to exclude or confirm organic causes of pelvic, including endometriosis, but if pain is considered idiopathic, a pain specialist should be involved. Moreover, CPP conditions often overlap with non-pelvic pain disorders (e.g. fibromyalgia, migraines) and non-pain co-morbidities (e.g. sleep, mood, cognitive impairment), and all these conditions should be considered part of the same central disorders, with different manifestations. Medical management and physical therapy are the mainstays of treatment, while pain specialist might be able to evaluate these chronic pain conditions and offer combined treatments for them [64,65].

Interstitial cystitis/bladder pain syndrome (IC/BPS) is a chronic pelvic pain condition characterized by bladder-centric pain in the absence of infection or other disease. According to the American Urological Association, the lack of definitive testing has made IC/BPS diagnosis subjective, relying on the clinician's ability to differentiate IC/BPS from other chronic pelvic pain conditions [66,67]. Patients often describe pain in the bladder region (suprapubic), with a strong sensation to want to urinate (urgency). This sensation is worsened by filling the bladder and is often relieved by passing urine more often (frequency). This may be during the daytime and/or during the night (nocturia). There may also be other symptoms such as pain or burning when passing urine (dysuria) and discomfort during sexual intercourse, known as dyspareunia. These chronic symptoms have a profound impact on the emotional, psychological, and social well-being of the patient as well as their quality of life [66,67].

Patients with pelvic floor disorders might also present with associated sexual dysfunction. Female sexual dysfunction (FSD) is a complex, multifactorial problem defined as 'a deviation from the normal sensation and/or function experienced by a woman during sexual activity' [68]. These dysfunctions have been classified as sexual interest/arousal disorder, orgasmic disorder and genito-pelvic penetration/pain disorder [69]. For all this, for the female population, the use of pelvic floor muscle training (PFMT) is favoured to control sexual dysfunction [70], due to its low cost and reasonable benefit. Male sexual dysfunction (MSD) can largely be divided into low libido, erectile dysfunction, Peyronie's disease and ejaculatory and orgasmic disorders [71,72]. It is estimated that a third of males will experience one form of MSD in their lifetimes [73]. Psychosexual counselling is an important consideration for both FSD and MSF since the psychogenic component is common; ideally it should be done with the patient's partner. It can assist to reduce psychological distress, aid in patient education and improve treatment compliance [71,72].

Furthermore, it is known that patients with pelvic floor disorders might have associated psychiatric diagnoses. In a retrospective study conducted among 6,461 patients seen in the Female Pelvic Medicine and Reconstructive Surgery (FPMRS) clinic at Northwest University of Chicago, 50% carried at least one comorbid psychiatric diagnosis [74]. Main pelvic floor disorders associated with psychiatric diagnosis on multivariate logistic regression are chronic bladder pan, overactive bladder (OAB), FI, and neurogenic bladder. Anxiety disorders correlated highly with all PFDs associated with having a psychiatric disorder [74]. Anorexia Nervosa and bulimia might be associated with constipation and long term rectal or pelvic organ prolapse, years after the disease onset. Focused psychological and psychiatric support should be offered to these patients to achieve symptoms' improvement, which, in most cases, cannot be obtained with physiotherapy and/or surgery alone.

The pelvic floor report from the UK in 2021, supported by the ICS, made a series of recommendations as to the future of pelvic floor services. It was recognized that many pelvic floor problems do not require hospital care and that we should strive to provide care within the community. Close working between the hospitals, tertiary referral centres and community services, such as bowel and bladder continence nurses, is essential to provide joined up, patient centred care. Those making up the multidisciplinary team in the hospital have responsibility to educate and collaborate with other health care professionals, including those in the community and primary care.

9. Conclusion

In conclusion, pelvic floor disorders encompass a wide range of symptoms attributable to multicompartmental pelvic floor failure with both functional and anatomical contributing factors as well as the influence from other generalized factors such as dietary habits and psychological health. Consequently, a multidisciplinary approach is vital to allow for comprehensive initial assessment and optimized treatment pathways.

Initial assessment may be provided with standardized questionnaires, ensuring the thorough evaluation of all aspects of pelvic floor dysfunction. Several instruments are available to guarantee comprehensive and global management of these complex disorders by the multidisciplinary team with the full involvement and engagement of different specialties. These includes telephone triage assessment clinics, pelvic floor tests, multidisciplinary meetings, combined pelvic floor clinics and joint surgical procedures.

The assessment and treatment of these patients should be centralized in specialized tertiary referral centres, with the aim to offer a wide range of strategies for symptoms' improvement and control. While the core of a pelvic floor unit should be made by physicians, nurses, physiotherapists from colorectal, urogynaecology and urology department, other specialties such as dietetics, pain teams and a psychologist may be required. A combination of all these personnel, working in a cohesive team, will enable a tailored approach to provide an individualized treatment pathway most likely to meet the patients' specific needs.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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