Original Article

# Urogynecology Service at a District General Hospital in the United Kingdom – Changing Needs or a Better Understanding?

*Farah Wali Lone, Ainharan Raveendran*

Department of Obstetrics and Gynaecology, Royal Cornwall Hospital NHS Trust, Truro, TR1 3LJ, United Kingdom

**Abstract**

**Context:** The urogynecological problems in women increase with age. The National Health Services (NHS) is experiencing an increase in the demand for and costs of health and social care for women in midlife. It is a relatively new subspecialty which requires a holistic approach to a patient symptoms and expert skills to overcome demands from aging female population and fulfilling patient expectations. **Aims:** The aim of the study was to analyze the referral pattern in relation to urogynecological symptoms referred to district general hospital in the United Kingdom and in turn to understand the gravity of the situation for improving the care of these women. **Subjects and Methods:** This was a retrospective study of case notes of women attending the gynecological outpatient clinic led by an urogynecology subspecialist at district general hospital in the United Kingdom having attended the clinic with symptoms suggestive of pelvic floor dysfunction. **Results:** We identified 777 women who attended the clinic with symptoms of pelvic floor dysfunction. The most frequently stated reason for referral was pelvic organ prolapse, followed by primary urinary incontinence. Majority of the patients (44%) had prolapse at diagnosis and 26% of the patients had multiple symptoms related to pelvic floor dysfunction after a urogynecologist's consultation, 5% of the patients had combined symptoms diagnosed at urogynaecology clinic. Majority of the referrals were from the general practitioners (43%). **Conclusions:** The study revealed that health practitioner referring the women needs better understanding of the urogynecological symptoms and with a better understanding and a thorough symptom treatment can be initiated for various symptoms at the same time. This allows patients' multiple symptoms improvement, avoids repeat referrals from primary care, avoids repeat visits to the clinics, avoids repeat interventions, and improves patients' satisfaction and therefore saves NHS resources.

**Keywords:** *Incontinence, pelvic floor, prolapse, subspecialty, urogynecology*

## Introduction

The UK population is aging rapidly, with 51% of the population predicted to be over 65 years of age by 2030 compared to 2010.[1] The urogynecological problems in women increase with age affecting over 20% of the adult population.[2] The National Health Services (NHS) will have to transform to deal with very large increases in demand for and costs of health and social care. A study forecasting the prevalence of urogynecological problems in the US forecasted a 50% increase in the service for urogynecological conditions.[2] Role of integrated continence services within acute hospitals is gaining interest. A remarkable shift in NHS services will need good joined up primary and specialist care, community care, and social care, with effective out of hour's service. Urogynecology offers a mix of problems affecting the pelvic floor in women. It involves treating women with urinary and/or

Access this article online

Quick Response Code:

Website: www.jmidlifehealth.org

DOI: 10.4103/jmh.JMH_50_18

***Address for correspondence:*** Dr. Ainharan Raveendran, Department of Obstetrics and Gynaecology, Royal Cornwall Hospital NHS Trust, Truro, TR1 3LJ, United Kingdom.
E-mail: ainharanraveendran@nhs.net



**How to cite this article:** Lone FW, Raveendran A. Urogynecology service at a district general hospital in the United Kingdom – Changing needs or a better understanding? J Mid-life Health 2019;10:131-4.

anal symptoms (urgency, incontinence, and incomplete emptying), pelvic organ prolapse (POP), and impact of these symptoms on sexual function. It is a relatively new subspecialty which requires a holistic approach to a patient symptoms and expert skills to overcome demands from aging female population and fulfilling patient expectations.

## Subjects and Methods

This was a retrospective study of case notes of women attending the gynecological outpatient clinic led by an urogynecology subspecialist at a district general hospital in the United Kingdom over a period 24 months (October 2012 to October 2014). An anonymized Excel datasheet was developed to record information about the demographic details of the study population, source of referral, reason for referral, patients' presenting symptoms, diagnosis, and the treatment offered.

## Results

We identified 777 women who attended the clinic with symptoms of pelvic floor dysfunction. The most frequently stated reason for referral was POP, followed by primary urinary incontinence. The wide range of diagnosis referred to urogynecology service is shown in Table 1. Majority of the patients (44%) had prolapse at diagnosis and 26% of the patients had multiple symptoms related to pelvic floor dysfunction after a urogynecologist's consultation, but only 5.6% of the patients had multiple symptoms at referral. None of the patients had combined urinary frequency urgency symptoms at referral, but 5% of the patients had combined symptoms diagnosed at urogynecology clinic. Majority of the referrals [Table 2] were from the general practitioners (43%), followed by the gynecologist (40%), other specialties (12%), and nurse practitioners (5.5%).

## Discussion

Urogynecology history has number of questions that are not part of standard history taking format, and therefore, it is important to understand what information is expected to gain when taking a gynecological history in a woman with pelvic floor disorders.[3] History must be taken in a sensitive and nonjudgmental manner. Women delay seeking help due to embarrassment and reticent about discussing anything to do with the genital tract. Even naming the areas can cause embarrassment and euphemisms. Marinating good communication skills with the patient in order to elicit proper history and to accurately recognize her problems is an important part of urogynecology history.

To our knowledge, this is the first study looking into the details of referral pattern and presenting symptoms in an urogynecology clinic at a district general hospital in the United Kingdom. In our study, the referrals were mainly from general practitioners and hospital consultants (other gynecologists and other specialty consultants) equally. Since the establishment of urogynecology subspecialty by the Royal College of Obstetricians and Gynaecologists (RCOG), UK, in 1982, the rift between the generalist, urogynecologists,

**Table 1: Reported symptoms of the study population at primary referral and at assessment in urogynecology clinic**

| Reported symptom | At primary referral, *n* (%) (total=777) | At assessment in urogynecology clinic, *n* (%) (total=777) |
|---|---|---|
| Prolapse | 388 (49.9) | 347 (44.6) |
| Primary prolapse | 366 (47.1) | 290 (37.3) |
| Recurrent prolapse | 81 (10.4) | 22 (2.8) |
| SUI | 82 (10.5) | 162 (20.8) |
| Recurrent SUI | 1 (0.1) | 0 (0) |
| OAB | 22 (2.8) | 22 (2.8) |
| Mixed incontinence | 45 (5.7) | 96 (12.3) |
| Recurrent urinary tract infection | 11 (1.4) | 36 (4.6) |
| Voiding dysfunction | 12 (1.5) | 75 (9.6) |
| Urinary frequency/urgency | 0 (0) | 39 (5) |
| Urethral problems | 4 (0.5) | 11 (1.4) |
| Vaginismus | 1 (0.1) | 2 (0.2) |
| Vaginal stenosis | 2 (0.2) | 2 (0.2) |
| Primary dyspareunia | 11 (1.4) | 21 (2.7) |
| Female sexual dysfunction | 1 (0.1) | 2 (0.2) |
| Obstructed defecation syndrome | 11 (1.4) | 58 (7.4) |
| Fecal urgency/incontinence | 15 (1.9) | 0 (0) |
| Perineal tear | 9 (1.1) | 0 (0) |
| Multiple diagnosis | 44 (5.6) | 209 (26.8) |

OAB: Overactive bladder, SUI: Stress urinary incontinence

**Table 2: Referral Pattern**

| Source of referral | Number of referral, *n* (%) |
|---|---|
| General practitioner | 332 (42.7) |
| Gynecologists | 309 (39.7) |
| Other specialities | 93 (11.9) |
| Nurse practitioners | 43 (5.5) |

and urologist is settling with urogynecologist taking the lead in managing women with continence issues and prolapse which in turn increase the number of referrals. This could be partly due to the litigations associated with incontinence surgeries and use of mesh in the urogynecology.[4,5]

Problems with the bladder affect >14 million people in the UK and about 6.5 million have bowel problems. In addition, 900,000 children and young people reportedly suffer from bladder and bowel dysfunction.

Most women have been through the conservative advice for managing their pelvic floor problem. The National Institute for Clinical Excellence highlights the importance of conservative management with input from continence nurse specialist and physiotherapist as the first-line treatment for patients with urinary incontinence, to make this a reality local empowerment in an independent unit that could treat its own patients and train its own staff.[6] Most successful urogynecological units are run not just by single clinician but also include specialist nurses, physiotherapists, trainee doctors, and urogynecologists. The concept of multidisciplinary team (MDT) management of urogynecology patients ensures that a balanced approach to treatment with all team members contributing has become the norm in such units.[7] Our unit over the past couple of years since the introduction of subspecialty urogynecology service has developed an MDT approach in managing women with pelvic floor disorders.

Urogynecologist have a lead role in a MDTs in implementing a service with appropriate audit and undertake research which is likely to benefit the health-care system overall. Subspecialists' urogynecologists can also provide support to those with special interest in urogynecology which will ease the workload that will be shared so that primary prolapse and incontinence will be treated by generalists with special interest in urogynecology, while complicated continence work would be a domain of subspecialist.[8]

It is estimated that 50 subspecialists and about 225 special interest consultants will be required over the next 10 years.[9] NHS is changing, patient expectations are changing, evidence is changing, and there is a need to review how the urogynecology service will be delivered safely within the given framework considering future training issues and workforce requirements.

Since 1992, urogynecology has moved from general gynecology training after the first urogynecology subspecialty training (SST) was set up at St Geroge's Hospital, London. As of June 2010, there were 16 approved SST centers and 18 approved programs in the UK. There are 11 trainees registered for urogynecology SST and a further 37 who have already completed RCOG SST programs (June 2010). SST and Advanced Training Skills Modules programs have a well-defined syllabus produced by RCOG and BSUG. A recent survey of new consultant appointments indicates that <50% of those who complete SST in urogynecology are appointed as a subspecialist in urogynecology; this position is very different from other subspecialties.

The data from our study is confined to a single center in Cornwall in a relatively affluent part of West of England, and it may not reflect the population in the other parts of the country. The referral pattern could be due to the availability of a subspecialist in the urogynecology. Despite the limitations of data derived from retrospective case notes review, there are strong indications that more urogynecologists are needed for delivery of this specialist care. We identified that in women when referred with one pelvic floor symptom, on a thorough assessment is performed of symptoms, there are often other related symptoms which are only revealed if explored as these are embarrassing to the patient and they might not mention about these unless asked. However, if these areas are not explored at the outset, the related symptoms might worse after an intervention. Therefore, a more holistic approach to patient assessment with ability to make real and lasting changes to raise standards of care for pelvic floor dysfunction is of benefit. This certainly demands for more time; however, with team working together nurse specialist and conservative bowel and bladder management service, this is achievable, as shown in our newly organized service. This does require perseverance and patience and collaborative work and enthusiasm of like-minded and progressive members of the team.

With a better understanding and a thorough symptom assessment of multicompartment pelvic floor dysfunction, treatment can be initiated for various symptoms at the same time. This allows patients' multiple symptoms improvement, avoids repeat referrals from primary care, avoids repeat visits to the clinics, avoids repeat interventions (medical/surgical), improves patients' satisfaction, and therefore saves NHS funding and resources.

## Financial support and sponsorship

Nil.

## Conflicts of interest

There are no conflicts of interest.

## References

1. Population Ageing: Statistics – House of Commons Library; 10 February, 2012. Available from: http://www.parliament.uk/briefing-papers/sn03228.pdf. [Last downloaded on 2016 Mar 06].
2. Gerten KA, Markland AD, Lloyd LK, Richter HE. Prolapse and incontinence surgery in older women. J Urol 2008;179:2111-8.
3. National Audit of Continence Care. Pilot Audition Evaluation Report. Published by the Royal College of Physicians; June, 2012. Available from: https://www.rcplondon.ac.uk/file/906/download?token=0RtX9EF5. [Last downloaded on 2016 Mar 06].
4. Mayne C, Cutner A, Toozs-Hobson PM. Subspecialty training in urogynaecology. Obstet Gynaecol 2008;10:263-6.
5. Mesh Working Group Interim Report, Published by NHS England; December, 2015. Available from: https://www.england.nhs.uk/wp-content/./12/mesh-wg-interim-rep.pdf. [Last downloaded on 2016 Mar 06].
6. Urinary Incontinence in Women: management. NICE Guidelines [CG171]; September, 2013. Available from: https://www.nice.org.uk/guidance/cg171. [Last downloaded on 2016 Mar 06].
7. Excellence in Continence Care: Practical Guidance for Commissioners, Providers, Health and Social Care Staff and Information for the Public. Published by NHS England; November, 2015. Available from: https://www.england.nhs.uk/./wp./EICC-guidance-final-document.pdf. [Last downloaded on 2016 Mar 06].
8. Accreditation of Units – The British Society of Urogynaecology. Available from: https://www.bsug.org.uk/accreditation-of-units.php. [Last accessed on 2016 Mar 06].
9. The Future Workforce in Obstetrics and Gynaecology England and Wales. Published by the Royal College of Obstetricians and Gynaecologists; May, 2009. Available from: https://www.rcog.org.uk/globalassets/./rcogfutureworkforcesummary.pdf. [Last downloaded on 2016 Mar 06].