Urogynecology digest

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Panman CMCR, Wiegersma M, Kollen BJ, Berger MY, Lisman-Van Leeuwen Y, Vermeulen KM, Dekker JH. Two-year effects and cost-effectiveness of pelvic floor muscle training in mild pelvic organ prolapse: a randomised controlled trial in primary care. BJOG 2017;124:511–520.

This was a randomized controlled trial that was conducted in the Netherlands (October 2009 to October 2012) at 15 general practices involving 287 women (aged 55 years or over) with mild pelvic organ prolapse. The objective was to compare the effects and cost-effectiveness of pelvic floor muscle training (PFMT) and watchful waiting in older women with symptomatic mild prolapse in primary care during a 2-year follow-up. The participating centres selected all women aged 55 years or over registered in their general practice who were not excluded. The exclusion criteria were current prolapse treatment or treatment in the past year, current treatment for another (uro)gynaecological disorder, malignancy of pelvic organs, impaired mobility, severe or terminal illness, cognitive impairment, or insufficient command of the Dutch language. Participants were randomized to PFMT ($n = 145$) or watchful waiting ($n = 142$). The primary outcome measure was change in pelvic floor symptoms measured using the Pelvic Floor Distress Inventory-20 (PFDI-

20), a validated patient-completed questionnaire with 20 questions about prolapse, anorectal and urinary symptoms. Secondary outcome measures were condition-specific and general quality of life, costs, sexual functioning, prolapse stage, pelvic floor muscle function and women's perceived improvement in symptoms.

Participants randomized to PFMT more often reported improved symptoms (43% versus 14% for watchful waiting). The difference was statistically significant, but below the presumed level of clinical relevance. PFMT more often led to women's perceived improvement in symptoms and lower costs for absorbent pads, and was more effective in women experiencing higher pelvic floor symptom distress.

The main strengths were the randomized trial design, large sample size, long follow-up, focus on patient-reported outcomes using validated questionnaires and the low drop-out rate. Despite these strengths, a number of limitations deserve mention. Participants could not be blinded because of the nature of the interventions. Although all physiotherapists were registered with the Dutch Association for Pelvic Physiotherapy and participants were therefore trained according to the same basic exercise guidelines, programmes were tailored to each woman's specific needs. This may have resulted in differences in interventions and practices among physiotherapists.

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