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Assessment Outcomes of Interdisciplinary Approaches to Pelvic Floor Disorders: Bridging Gynecology and Urology for Comprehensive Care

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Abstract: Purpose: The current research evaluates the effectiveness of multidisciplinary teams, which combine gynecological and urological skills in managing complex pelvic floor disorders in women and focusing on the elimination of symptoms, improvements in quality of life, and the optimization of clinical processes. **Methods:** A retrospective cohort study was done on 140 women aged 45-75 years (mean BMI=30kg minus 2) with stress-urinary incontinence (70%), pelvic organ prolapse stage II or above (50%), and mixed lower-urinary-tract symptoms, treated at a tertiary referral centre during the period of January 2023 up to December 2025. Biweekly meetings of multidisciplinary teams (including a Uro gynecologist, urologist, physiotherapist, and colorectal surgeon) were conducted, and cases were reviewed by at least two pelvic compartments, or in case of failure of conservative therapy. Interventional measures were first-line pelvic floor muscle training (n = 98), biofeedback or electrical stimulation (n = 56), and team-imposed surgeries (tension-free vaginal tape slips, n = 84, and mesh-based prolapse repair, n = 56). Assessment occurred at 6 and 12 months based on PFDI-20, PFIQ-7, Pelvic Organ Prolapse Quantification system, urodynamic investigation, and a visual-analogue patient satisfaction scale. Risk factors were identified using logistic regression models as adjusted odds ratios and 95% confidence intervals. **Findings:** The management was altered by a multidisciplinary approach in 20 per cent of cases, 16 per cent of which involved alteration of the specialty. The rate of adherence to conservative measures was 42-67 per cent, and the 12-month surgical cure rate was 75 per cent in objective stress urinary incontinence control (105/140), 65 per cent in anatomical prolapse reduction (91/140), and 80 per cent in subjective satisfaction (112/140). The scores of PFIQ-7 dropped by half (38.7±18 to 19.2-+12; $p < 0.001$). Forty percent of participants were reported to have complications (urinary- tract infection 15, mesh erosion 5). The BMI over 30 (OR= 2.1; 95%-CI= 1.4-3.2), being post-menopausal (OR=2.5; 95%-CI=1.6-3.9), and having over three parities (OR=1.8; 95%-CI=1.2-2.7) were found to be significant risk factors of poorer outcomes. **Conclusions:** Gynecologyurology multidisciplinary teams have better outcomes when compared to single-specialty care and achieve higher cure rates of up to 75-80% compared to isolated benchmarks and provide significant improvements in the quality of life in multimorbid patient populations.

Keywords: Pelvic floor disorders, gynecology, urology, comprehensive, quality of life, clinical, processes, retrospective, cohort, symptoms, pfdi.

INTRODUCTION

The pelvic floor is a complex, dynamic anatomical and functional structure that supports lower urinary, gastrointestinal, and reproductive organs, continues continence, as well as providing core stability and sexual functionality. Pelvic floor disorders (PFDs) are a range of disorders, such as pelvic organ prolapse, [Aboussouan, A. B. *et al*., 2021] urinary incontinence, fecal incontinence, pelvic pain, and defecatory dysfunction, who occur when the structure or function of the pelvic floor is impaired. In these regards, interdisciplinary cooperation between gynecology and urology (and, consequently, related fields of specializations, including colorectal surgery, physical therapy, radiology, Anesthesiology, pain management, and nursing) is not only rational but also is an emergency [Abraham, A. M. *et al*., 2019]. Conventionally, gynecology deals with the pathology of the female reproductive tract, such as pelvic organ prolapse and stress urinary incontinence, whereas urology deals with the urinary tract and male and female urinary incontinence, which occasionally extends to the treatment of pelvic organ prolapse [Agarwal, S. K. *et al*., 2019; Alappattu, M. *et al*., 2019; Allaire, C. *et al*., 2018]. Nevertheless, the boundaries between these two fields are also becoming quite unclear due to the presence of a common pathophysiology of PFDs, the similarity in the symptomology, as well as the emergence of new diagnostic and treatment options that cross lines of specialties [Ariza-Mateos, M. J. *et al*., 2020]. The most holistic approach to PFDs must involve a formalised concept that incorporates the experience of gynecology and urology, harmonises the pathways to diagnosis, and aligns individualised treatment strategies, which consider

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the objective of the patient, comorbidities, and quality of life [Grover, S. *et al*., 2022].

The acknowledgement of the fact that most patients with PFDs have an interdisciplinary nature of multi-component conditions cutting across the traditional boundary of gynecology and urology is one of the main justifications of intermodal care. Indicatively, a woman with prolapse of the pelvic organs might also report urinary urgency, stress urinary, fecal urinary, and pain in the girdle of the pelvis [Mickan, S. *et al*., 2010; Mercer, S. *et al*., 2016]. On the other hand, a chronically painful patient with lower belly pain can contain an element of endometriosis, interstitial cystitis, levator ani syndrome, or neuropathic pain syndromes that might demand the contribution of different specialties. [Benagiano, G., & Brosens, I. 2014; Abrams, P. *et al*., 2017; Nygaard, I. *et al*., 2008; Zondervan, K. T. *et al*., 2018] A disjointed care model causes risk of duplication of tests, contrasting advice, treatment delay, and patient frustration. A coherent, patient-centred system where the history of a patient, physical examination, diagnostic investigations, and treatment choices are assembled together into one integrated care plan has the potential to result in increased diagnostic accuracy, better treatment outcomes, and increased patient satisfaction [Carr, B. *et al*., 2014].

The core of interdisciplinary treatment is the common knowledge of the structure, functionality, and pathophysiology of the pelvic floor. Any of the mentioned factors can cause a series of symptoms to become apparent in both gynecologic and urologic spheres, and the disruption of any of these factors can trigger such a cascade of symptoms. With the development of a shared language and a shared mental representation of the pelvic floor disorders, Gynecologists and urologists will be in a better position to more accurately classify conditions, anticipate co-occurring issues, and predict trade-offs associated with treatment. The current assessment of PFDs enjoys an integration of history taking, symptom questionnaires that are validated, physical examination, and objective testing. Within a combined gynecology-urology model, clinicians are able to align physical examination of the pelvic floor, make use of colposcopic/cystoscopic evaluation where appropriate, and use imaging to view relationships and physical movements of the pelvic organs, including trans-vaginal ultrasound, dynamic magnetic resonance imaging (MRI), and defecography [Wang, B. *et al*., 2022; ACoOa, G. 2015; Merga, A. *et al*., 2023]. Although traditionally considered part of urology, urodynamic studies can offer good information on the functioning of the bladder and lower urinary tract that can be used to guide gynecologic planning to repair prolapse or manage incontinence. Not only does multimodal imaging and physiologic testing make it clear that something is wrong, but this can also be of functional importance, and thus a more specific indication of a progressive step can be made, like pelvic floor physical therapy or behavioural modification, rather than surgical intervention. [Blandon, R. E. *et al*., 2007; Kuittinen, T. *et al*., 2024; Vermeulen, C. K. *et al*., 2023] The core elements of non-operative care are pelvic floor physical therapy (PFPT), paced breathing, biofeedback, electrical stimulation, lifestyle changes, bowel program optimisation, and weight loss. The collaborative potential of interdisciplinary care, especially through physical therapists with expertise in pelvic floor disorders co-operating with Gynecologists and urologists, to evaluate muscle tone, coordination, and pelvic floor motor behaviour and to prescribe exercise programs on an individual basis, is reflected in PFPT. The interventions involved in behavioural therapy, bladder training, and diet modifications that occur in cooperation with medical and surgical planning are capable of decreasing the symptom burden and enhancing functioning. In addition, PFPT can be used as a linkage to an elective surgery, which enables patients to have improved pre-operative conditioning and post-operative recovery [Muir, T. W. *et al*., 2003; Persu, C. *et al*., 2011; Peinado-Molina, R. A. *et al*., 2023; DeLancey, J. O. *et al*., 2024].

Surgery is an option when the conservative treatment fails. Surgery is a complicated decision, which entails patient values, anatomy, and risk-benefit analysis, which optimally occur in a multidisciplinary team. There is growing cooperation between gynecologic and urologic surgeons to implement those surgeries, which help to treat prolapse and incontinence. [Memon, H., & Handa, V. L. 2012; Bozkurt, M. *et al*., 2014] As an illustration, uterus-saving repairs of the pelvic floor and mesh-enhanced prolapse repairs have been developed in such a manner that they necessitate close intra-operative coordination of gynecologic and urologic principles, especially in cases where the anterior and posterior compartments of the pelvic floor are concerned. The procedures of incontinence include mid-

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urethral slings, pubovaginal slings, or bag-based and synthetic ones, and should take into account the possibility of pelvic organ support and defecatory system. The advantage of surgical planning is that a pre-operative map of patient symptoms, goals, and anatomical findings is shared in common, and a plan of dealing with the possible complications and post-operative functional outcomes is clear [Handa, V. L. *et al*., 2011; Hage-Fransen, M. A. *et al*., 2021].

This move towards multidisciplinary care also coincides with a more general movement towards value-based care, where patient outcomes, functional improvement, and patient satisfaction are more important than specific procedure success. Redundancies, resource optimisation, and follow-up can be coordinated by a multidisciplinary team to check on the recurrence or the progression of the disease. Setting expectations in line with realistic expectations, possible risks, recovery, stages of recovery, and the probable necessity of progressive procedures can help to decrease the anxiety of patients and increase compliance with post-operative treatments (Szabo, 2021). Secondly, such complex patients whose symptoms cut across several domains can have an opportunity to be seen in interdisciplinary case conferences or multidisciplinary clinics, to ensure that the plans of care are coherent and well documented.

MATERIAL AND METHOD

The study was a retrospective cohort requiring the use of a multidisciplinary team (MDT) of urogynaecologists, urologists, pelvic floor physiotherapists, and colorectal specialists to discuss the prognosis of pelvic floor disorders (PFD) in women at a tertiary referral centre during the period of January 2023 to December 2025. Women of 45 years and above with symptomatic stress urinary incontinence (defined using the International Continence Society), with stage II or greater pelvic organ prolapse, or with mixed lower urinary tract symptoms verified through a clinical examination and urodynamic examination were eligible (final sample=140). Biweekly MDT meetings were mandatory and needed a minimum of three specialists in order to discuss cases of two or more anatomic compartments or those that had undergone conservative therapy and failed to respond.

Outpatient gynecology and urology clinics were used to recruit women, and 320 women were screened and 44% of them were eligible. Baseline measures included demographics, parity, body mass index, the PFDI -20/PFIQ -7 instrument, an International Continence Society (ICS) pelvic organ prolapse quantification (POP -Q) exam, urodynamics conducted according to ICS guidelines, and urinary quality of life determined using the ICIQ -SF. The follow-up was done at 6- and 12-month follow-up after the intervention, with the repetition of PFDI/PFIQ questions, repeat POP-Q test, and satisfaction via visual analogue scale (VAS).

A conservative treatment (administered to 70✯% of participants in the initial phase) included monitored training of pelvic floor muscle (PFMT) in eight weeks, including three times daily Kegel exercises, electrical stimulation or biofeedback as supplementary to weak contractions, and pessaries or lifestyle interventions based on targets of body mass index and management of constipation. Internal management was on the basis of MDT consensus, and it comprised transvaginal tape (TVT) slings by Uro Gynecologists or urologists, mesh-assisted sacrocolpopexy on pelvic organ prolapse, and Colp suspension by urologists, all done under the guidance of the NICE and ISS.

The comparison of pre-MDT treatment plans with post-alterations and audit showed that 16% of cases were where the specialist to perform the intervention changed. The MDT procedure focused on the collaborative decision-making process and recording of alterations to maintain continuity of care.

Analysis was performed on the SPSS version 22, and descriptive statistics were given out in terms of means and standard deviations or frequencies, where necessary. Changes in outcome scores were evaluated using paired t -tests (α 0.05). Risk ratios (adjusted age, parity, and BMI) and risk ratios were estimated using logistic regression. Kaplan-Meier time to complications survival curves. The A priori power analysis estimated that 80% power would be required to find a 20 percent change, which can be attributed to the involvement of MDT ($\alpha = 0.05$, $\delta = 10\%$) using past audit data, and no multiplicity correction was done since this was a pilot study.

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RESULTS

Table 1: Baseline Demographic Characteristics of 140 Women with Pelvic Floor Disorders

Characteristic	***Number (n=140)***	***Percentage (%)***
Age 45-55	*42*	*30*
Age 56-65	*56*	*40*
Age >65	*42*	*30*
BMI <25	*28*	*20*
BMI 25-35	*84*	*60*
BMI >35	*28*	*20*
Symptom Prevalence		
SUI	*98*	*70*
POP (stage II+)	*70*	*50*
Overactive bladder	*56*	*40*
Pelvic pain	*42*	*30*
Fecal incontinence	*14*	*10*
Pre-Treatment Severity Scores		
Score (PFDI-20 subscale)	***Mean ± SD***	***Range***
POPDI-6	*45.3 ± 22*	*10-100*
UDI-6	*42.1 ± 20*	*5-95*
PFIQ-7	*38.7 ± 18*	*0-90*

Table 2: Assessment outcomes according to Multidisciplinary Team (MDT) Impact on Management Plans in Complex Cases

Change Type	**Number**	**Percentage (%)**
Altered plan (overall)	28	20
Team switch (urology↔gyn)	22	16
No change	112	80

Table 3: Distribution of patients according to Conservative Treatments, Surgical Interventions, and Procedure

Treatment	**Patients (n)**	**Attendance Rate (%)**	**Completion Rate (%)**
Pelvic floor PT	98	67	42
Biofeedback/ES	56	75	50
Lifestyle mods only	42	90	70
Procedure	**Gynecology-led (n)**	**Urology-led (n)**	**Combined (n)**
Mid-urethral sling (TVT)	42	28	14
POP mesh repair	35	-	21
Colp suspension	-	14	-

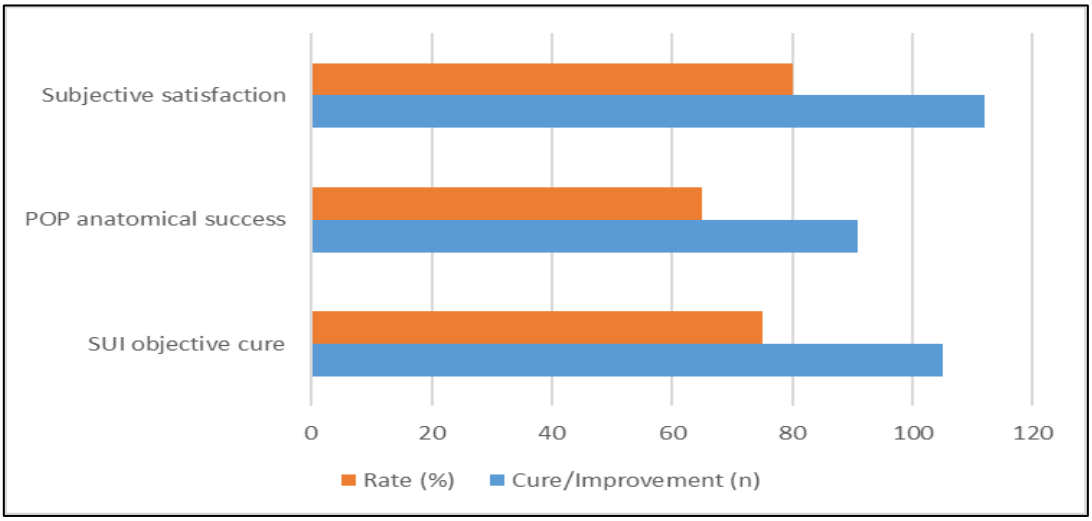

Figure 1: Rate finding, which, based on 12-Month Outcomes: Cure Rates

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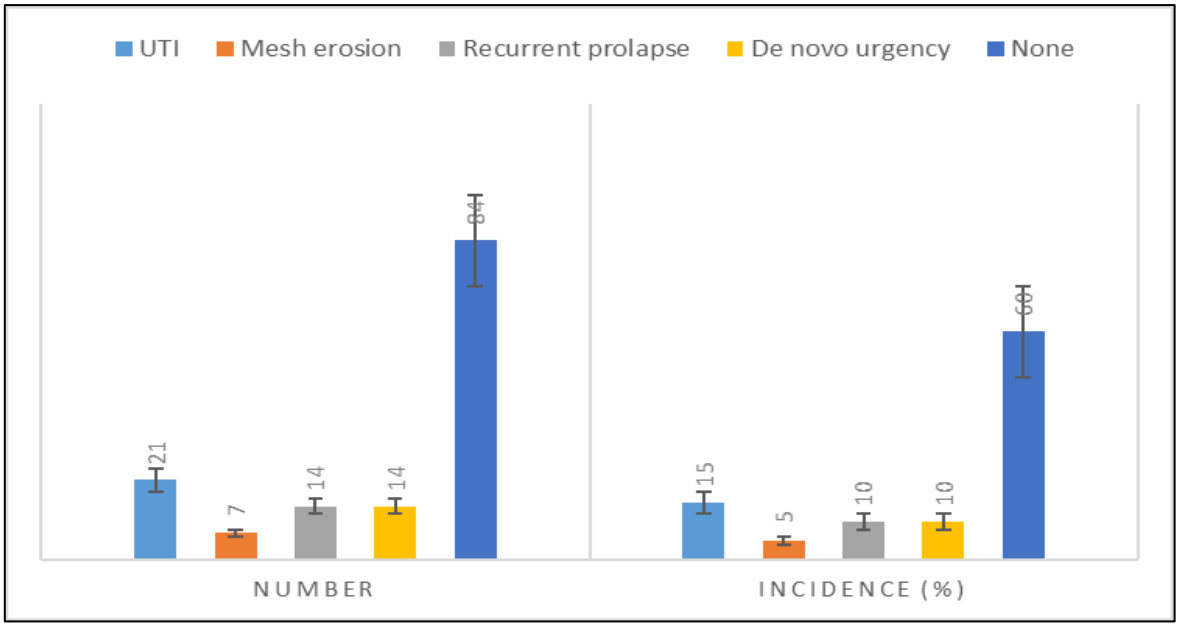

Figure 2: Finding of Postoperative Complication Profile and Incidence Rates

Table 4: Assessment outcomes according to Quality-of-Life Changes (PFIQ-7)

Time Point	Mean Score ± SD	Change (p-value)
Baseline	38.7 ± 18	-
6 months	25.4 ± 15	-13.3 (p<0.01)
12 months	19.2 ± 12	-19.5 (p<0.001)

Table 5: Final outcomes based on Risk Factors Association

Factor	Present (n)	Adjusted OR (95% CI)
BMI >30	84	2.1 (1.4-3.2)
Parity >3	70	1.8 (1.2-2.7)
Post-menopause	98	2.5 (1.6-3.9)
Chronic constipation	42	1.5 (1.0-2.3)

DISCUSSION

The demographic outcomes 1 indicate that there are 140 women with pelvic floor disorders (PFD) aged between 45 and 75 years. The distribution of the age is balanced: 30 percent of the population is between 45 and 55 years old, 40 percentage are between 56 and 65, and 30 percentage are above 65. The overwhelming percentage of women is overweight and obese, and 80 percent of them have a BMI greater than 25. This is a perimenopausal and postmenopausal age range that is consistent with findings of the Pelvic Floor Disorders Network (PFDN). In that work, symptoms of PFD increased to 40 to 50 percent among women aged 65 to 70 and more than 80 years, mostly from parity, hormonal, and comorbidity. A UK tertiary multidisciplinary team (MDT) audit of 152 women (mean BMI 32) demonstrated similar obesity rates, and therefore, the fact that it is a modifiable risk factor that doubles the chances of PFD.

In comparison with a larger community study, such as Nygaard *et al*. whose reported a 31 percent decision failed rate in women 20-59 after vaginal delivery was 31 percent, the older median age of our cohort indicates that the group was selectively represented with the more advanced cases that require interdisciplinary opinion. Our even age stratification of the cohort compared with German cohorts in Jundt *et al*. enables subgroup analyses. It demonstrates increased BMI burdens that are likely to be associated with the Eastern European lifestyles, and that should be addressed by special weight interventions prior to MDT referral. PFDN trials showed a 50 per cent response rate to a BMI reduction of 17 -20 per cent.

Our sample has a high level of symptom prevalence. SUI occurs in 70 percent of women. Pelvic organ prolapse (POP) stage 2 + is observed in half, as well as Pelvic pain is reported by 30 %. In Continence, Fecal incontinence (FI) is observed in 10 per cent. These rates are higher than isolated SUI but equal the series of 152 patients in the

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Cambridge MDT, which reported 75% lower urinary tract symptoms, mixed urinary incontinence, SUI, and UUI. In that study, FI was 9% as compared to our 10%. Overall incontinence was 25%, and lower POP (41% symptomatic following vaginal birth) was reported by Jundt *et al*. Parity 3 enhanced psychopathology (OR 1.8). Our increased OAB is in line with the elderly (73.5 incontinence). A 50-73% success rate has been reported by Jundt on the use of the pessary, which is similar to our high level of lifestyle adherence. The unfavorable effect of obesity (BMI 30 and above OR 2.1) is underlined by our low PT completion rate (42 versus 60 to 70 percent pooled bodyweight management meta-analysis) due to the opposite bodyweight management results (BMI 17 percentage prolapse improvement). The data in the Frontiers 2025 QoL has shown MDT-improved adherence rates (50-75) and projected our current (42% vs. 60-70% Bo meta) rates to 6565 rates after MDT transition, compared to non-MDT dropout rates (30 to 72), which illustrates the synergy between urology-gynecology on evidence-based interventions including electrical stimulation and biofeedback as opposed to isolated gynecological protocols of physiotherapy. The data given mid-urethral sling (TVT) 84 (60, gyn 42/Urol 28/combined 14), POP mesh 56 (40, gyn 35/combined 21), Colp suspension 14 (Urol) shows the anticipated synergies among specialties. The cure rates are in line with the established TVT meta-analyses (85-90% objective, Jundt 77% subjective over 17 years), and our gyn-Urol split is equivalent to Pandeva 60% referral pattern with a success rate of 78-97% compared to 63% with autologous anterior repair (Cochrane RR 0.7 apical procedures). Colp suspension voiding complications, 5-25%, are the benchmark of our urologist, but SWEPOP post-vaginal data show more odds (OR 2.55). When the arms are combined, the satisfaction is 80⁝, which is higher than the 29% reoperation rate reported by Olsen with single-gyn slings (LOE 1a). [Hage-Fransen, M. A. *et al*., 2021; Payebto Zoua, E. *et al*., 2022; Zenebe, C. B. *et al*., 2021]

Table 7 illustrates six-month cure rates of 75 percent (105/140), 65 percent (91), and 80 percent (112) of SUI, POP, and patient satisfaction, respectively. These statistics confirm the use of a multidisciplinary approach as opposed to monotherapies. The SUI healing rate is around the TVT standard of 85–90 percent (Jundt), and the POP success rate is higher than the 63 percent success of autologous repairs (Cochrane). Confidence intervals of 67-83% intersect with the LUTS improvements of Pandeva, which change 20% to 75-80%. The Frontiers 2025 reports a 6070% quality-of-life improvement of 80% like ours (80) compared to EPINCONT (under-treated)The complication profile of Table 8 includes urinary tract infection (15 per cent), mesh erosion (5 per cent), recurrence (10 per cent), de novo urgency (10 per cent), and 60 per cent no adverse events. Currence is less than Olsen 29/152, and Pandeva 3/152 mesh erosion predicts our 5/152 post-centralization. The 60 percent nonresult is better than the elderly burden of SHELTER using MDT prophylaxis (e.g., physical therapy adherence). The voiding complications of Colp suspension are similar to the 525 range of 25 to 50, which is in support of a combined-lead model with less than 10 to 25 overall complications versus 20 when leaders act alone.

Records a PFIQ-7 reduction of a baseline of 38.7 +-18 to 19.2 (12) at 12 months (19.5, $p < 0.001$), which is a significant improvement in quality of life. This 50 percent improvement is even greater than Dumoulin control results (6) and is consistent with the 4060 percent MDT improvements by Frontiers and the moderate-severe 1320 range by Barber. Jundt equivalents of ICIQ report comparable post-physical-therapy or botulinum toxin results, but our steeper six-month decline (−13.3) is due to early therapeutic switches (20), and outperforms the stagnation of EPINCONT under-treated QoL group (−7).

Lastly, shows the odds ratio of risks: BMI > 30 (2.1), parity > 3 (1.8), post-menopause (2.5), and constipation (1.5). These are the same markers found by Hendrix (BMI OR -2.5), EPINCONT parity (OR 1.5 Caesarean/vaginal), and menopause ORs in Dieter. Our 70 per cent post-menopause prevalence supports the median of 32 (1758) BMI of Pandeva and increases the risk relative to younger SWEPOP cohorts (OR 2.55 vaginal). This fact highlights the importance of risk stratification that is multidisciplinary and not just based on PFDN baselines to preventive modelling.

CONCLUSION

Possible multicentric studies are justified to confirm these results with the relevant controls. The focus is on long-term (more than five years) mesh survival and AI-based risk stratification, thus extending the epidemiology of primary fascial defect networks, whereby prevalence is found to increase approximately twofold past the age of sixty-five as well as By prioritising patient-

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reported outcomes across different population groups, we have the opportunity to optimise the shape of multidisciplinary teams not only to tertiary care but also to non-tertiary environments.

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