ISSN NO: 2770-2936
Date of Publication:17-02-2023

Sexual Dysfunction in Women Suffering from Gynecological Diseases

Nasimova Nigina Rustamovna,
Jalalova Iroda Abduzhabborovna,
Shamsieva Malika Shuxratovna
Department of Gynecology №2, Samarkand State Medical University, Samarkand, Uzbekistan

Annotation: The analysis of long-term efficiency of operative treatment of pelvic prolapse for 213 women in periods ranging from 12 through questionnaire PISQ-12 (Pelvic Organ Prolapse and Incontinence Sexual Function Questionnaire), recommended for use in clinical practice of the international urogynaecologic Association and adapted by the authors for work . Method of evaluating the effectiveness of surgical treatment of pelvic and prostate has been streamlined through the introduction of a system of qualitative analysis of the results of the study of sexual function. Found that operational treatments pelvic prolapse have a positive effect on sexual function of women. Significant differences of sexual function in remote postoperative period depending on the type of operational benefits.The best effect with regard to the favourable dynamics of sexual function is achieved after laparoscopic operative treatment of pelvic prolapse compared with vaginal hysterectomy.

Key words: pelvic prolapse, surgery, remote effectiveness, sexual function.

The development of modern medicine is aimed at improving the quality of life in chronic diseases. Diseases associated with disorders in the human sexual sphere drastically reduce the quality of life [3]. Women's sexual dysfunction as a condition resulting from the combined effects of biological, psychological and interpersonal factors and manifested by various sexual disorders does not receive due attention in Russia [2]. Meanwhile, sexual disorders that sharply disturb the mental balance of patients and bring discord into interpersonal relationships may be primary specific sexological disorders or may occur in many organic diseases. Pelvic disorders such as pelvic organ prolapse, urinary and fecal incontinence occur in almost 33% of perimenopausal women, in 45% of menopausal women, which naturally negatively affects the social, psychological, physical and sexual health of women. Although there are a large number of valid and reliable questionnaires that examine sexual function, until recently their use in women with pelvic organ prolapse has been limited [3], which ensures the relevance of research on this topic.

The aim of the work was to optimize the system for evaluating the long-term results of surgical treatment of pelvic prolapse in women by dynamically analyzing the sexual function of patients after surgery.

Material and methods. Currently, the only specialized questionnaire for the study of sexual function in women with pelvic organ prolapse and urinary incontinence is the Pelvic Organ Prolapse and Incontinence Sexual Function Questionnaire (PISQ-31). This questionnaire was created by Professor Rebecca Rogers in 2002 [5] and included three sections describing the behavioral / emotional sphere, the physical side of sexual relations and relationships with a partner. PISQ-12 is a short version of PISQ, which represents its full form in sufficient detail and is recommended for use in clinical practice. Each item of the questionnaire contains five possible answers, which are evaluated in points. The result of the survey is expressed as the sum of points for all items. The maximum score is 48, which is an indication of the best sexual function.

Below Is A Sample Of Our Customized Questionnaire.

This survey is a list of questions about your sex life and your partner's sex life. All information is strictly confidential. Your responses will only be used to help doctors better understand what concerns patients about their sex life. Please mark the answer that best suits you: Have you had sexual contact in the last 6 months? Not really___

If not, please answer the questions according to the last year you were sexually active.

ISSN NO: 2770-2936
Date of Publication:17-02-2023

A. A. If you are not currently sexually active, why not? Urinary / fecal incontinence, fear of incontinence, pain in the bladder, pain, burning in the vagina, lack of desire, chronic diseases, stressful situation at home, powerlessness of the partner, lack of desire from the partner, absence of the partner. Another reason.

If you are not currently sexually active, why not? Urinary / fecal incontinence, fear of incontinence, pain in the bladder, pain, burning in the vagina, lack of desire, chronic diseases, stressful situation at home, powerlessness of the partner, lack of desire from the partner, absence of the partner. Another reason.

In the city of Samarkand, in the maternity complex No. 3 in the gynecological department from 2015 to 2020, 755 operations were performed for genital prolapse. We analyzed the results of a PISQ-12 survey of 325 sexually active women aged 22 to 64 years. The average age of women was 56.5±2.4 years. The survey was conducted 12 months after the operation. The study included responses from 213 patients, 128 questionnaires contained incomplete answers and were excluded from the analysis. Among women of the main clinical group (5.4%) patients were operated on for prolapse of the posterior vaginal wall, (16.5%) underwent surgery for prolapse of the anterior and posterior walls of the vagina, vaginal hysterectomy was required (20.7%) for incomplete uterine prolapse and (33.3%) patients with complete uterine prolapse. (4.1%) women were operated on for stress urinary incontinence. (20.2%) patients were after combined surgical treatment with a combination of genital prolapse and stress urinary incontinence: (3.1%) - prolapse of the anterior vaginal wall and stress urinary incontinence, (2.7%) - prolapse of the posterior vaginal wall and stress urinary incontinence, (14.4%) - prolapse of the anterior and posterior vaginal walls and stress urinary incontinence. As can be seen, the most common pathologies in the main group were complete (33.3%) and incomplete (20.7%) uterine prolapse, prolapse of the anterior and posterior walls of the vagina (21.9%), stress urinary incontinence (24.1%).

(83.8%) women at the time of the survey were in menopause (159 - in natural, 18 - in surgical). In addition to pelvic disorders, most of the examined women had other gynecological pathologies: uterine fibroids - (31.1%), endometriosis - (13.51%), endometrial pathology - (8.1%), uterine fibroids and endometriosis - (2.7 %), endometriosis and endometrial pathology - (5.4%).

Depending on the type of operation undergone, all patients were divided into three groups:

group 1 (n=48) - patients who underwent surgical treatment for genital prolapse in volume: anterior colporrhaphy or posterior colporrhaphy and perineolevathoroplasty or anterior, posterior colporrhaphy, perineolevathoroplasty;

group 2 (n=120) - women who underwent vaginal hysterectomy due to total genital prolapse;

Group 3 (n=45) - women with a combination of pelvic organ prolapse and stress incontinence. He underwent combined operations: anterior colporrhaphy and posterior colporrhaphy, perineolevathoroplasty. The procedure for statistical processing of the obtained data was carried out using the Statistica 7.0 software package and Excel 2007 spreadsheets.

Results

Depending on the total number of points that patients received when answering the questions of the PISQ-12 questionnaire, the results of the questionnaire were interpreted as: from 0 to 10 points - worsening; from 11 to 20 points - no change, from 21 to 30 points - improvement in the state of sexual function, from 31 to 40 points - good and from 41 to 48 points - excellent result.

The dynamics of sexual function in patients of clinical groups in the late period of surgical treatment of pelvic prolapse is reflected in table.1.

Table 1 Dynamics of sexual function in patients of clinical groups in the late period of surgical treatment of pelvic prolapse

Result	Group 1	Group 2	Group 3	Total
Deterioration	0	3	0	3
%	0,0 %	2,5 %	0,0 %	1,4 %
no change	6	12	3	21

ISSN NO: 2770-2936
Date of Publication:17-02-2023

%	12,5 %	10,0 %	6,7 %	9,5 %
Improvement	9	39	15	66
%	18,8 %	32,5 %	33,3 %	29,7 %
Good result	24	45	21	93
%	50,0 %	37,5 %	46,7 %	41,9 %
Excellent result	9	21	6	39
%	18,8 %	17,5 %	13,3 %	17,6 %
Total	48	120	45	213

In the first group - no one scored less than 10 points, in the category "no change" there were (12.5%) people, (18.8%) patients felt improvement, from 31 to 40 points - the category "good result" - scored (50%) women, "excellent result" showed (18.75%) people.

In the second group, the situation was different: worsening of the condition after the operation was noted by (2.5%) patients, the state of "no change" was typical for (10%) people, (32.5%) patients began to feel better, while most of them - 37.50% (n=45) and 17.5% (n=21), respectively, noted good and excellent results. In the third group, no one experienced a worsening of their condition, 3 patients (6.7%) noted their sexual life unchanged, 15 women (33.3%) improved their sexual life, felt “good” and “excellent results” (46, 67%) and (13.33%) patients, respectively. The average score (M±s) in the first group was 33.5±7.7, in the second 31.9±8.0, in the third - 33.3±8.6, in the fourth group - 32.3±6, 9 points. Comparative analysis of results between groups 1 and 2 (p=0.399), groups 1 and 3 (p=0.867), groups 1 and 3 (p=0.395), groups 2 and 3 (p=0.732), group 3 (p=0.722) showed no significant differences.

The study showed that the results of assessing the sexual function of patients according to the PISQ-12 questionnaire after surgery on the pelvic organs for genital prolapse and/or urinary incontinence were quite high and did not differ significantly in the groups. This indicated that all types of surgical care studied did not cause a deterioration in sexual function, and, on the contrary, in the vast majority of cases, this side of the patients' lives improved significantly after surgical removal of existing defects. However, in the largest group of patients, the most traumatic surgery (vaginal hysterectomy), in 10% of cases, the patients did not notice any improvements, and in 2.5% of cases, the surgery worsened the quality of sexual function. Moreover, the lowest scores were obtained when answering questions that characterize the physical aspects of sexual life, that is, the greatest discomfort was caused by pain (dyspareunia) in sexual relations. With regard to the nature of the surgeries, it can be concluded that the best results are obtained by minimally invasive surgical interventions, which do not cause massive surgical trauma, do not change the anatomical relationships of the pelvic organs, and during which the risk of perioperative complications is significantly lower.

Conclusion

1. Operative treatments for pelvic prolapse have a positive effect on women's sexual function. There were no significant differences in sexual function in the late postoperative period, depending on the type of surgical aids.
2. The best effect in terms of favorable dynamics of sexual function is achieved after minimally invasive surgical treatment of pelvic prolapse compared with vaginal hysterectomy.

References

1. Wu JM, Hundley AF, Fulton RG, Myers ER. Forecasting the prevalence of pelvic floor disorders in U.S. women: 2010 to 2050. Obstet Gynecol. 2009;114(6):1278–83.
2. Novi JM, Jeronis S, Morgan MA, Arya LA. Sexual function in women with pelvic organ prolapse compared to women without pelvic organ prolapse. J Urol. 2005;173(5):1669–72.

ISSN NO: 2770-2936
Date of Publication:17-02-2023

3. Hoen LA, Utomo E, Steensma AB, Blok BFM, Korfage IJ. The pelvic organ prolapse/urinary incontinence sexual questionnaire (PISQ-12): validation of the Dutch version. Int Urogynecol J. 2015;26(9):1293–303.
4. Freeman RM, Pantazis K, Thomson A, Frappell J, Bombieri L, Moran P, et al. A randomised controlled trial of abdominal vs. laparoscopic sacrocolpopexy for the treatment of posthysterectomy vaginal vault prolapse: LAS study. Int Urogynecol J. 2013;24(3):377–84.
5. Lane FE. Repair of posthysterectomy vaginal-vault prolapse. Obstet Gynecol. 1962;20:72–7. 6. Rosati M, Bramante S, Bracale U, Pignata G, Azioni G. Efficacy of
6. laparoscopic sacrocervicopexy for apical support of pelvic organ prolapse. JSLS. 2013;17:235–44.
7. Sarlos D, Brandner S, Kots L, Gygax N, Schaer G. Laparoscopic sacrocolpopexy for uterine and post-hysterectomy prolapse: anatomical results, quality of life and perioperative outcome-a prospective study with 101 cases. Int Urogynecol J. 2008;19:1415–22.
8. Geller EJ, Parnell BA, Dunivan GC. Pelvic floor function before and after robotic sacrocolpopexy: one-year outcomes. J Minim Invasive Gynecol. 2011;18:322–7.
9. Geller EJ, Parnell BA, Dunivan GC. Robotic vs abdominal sacrocolpopexy: 44-month pelvic floor outcomes. Urology. 2012;79(3):532–6.
10. Gupta P, Payne J, KillingerKA, EhlertM, Bartley J,Gilleran J, et al. Analysis of changes in sexual function in women undergoing pelvic organ prolapse repair with abdominal or vaginal approaches. Int Urogynecol J. 2016;27(12):1919–24.
11. van Iersel JJ, de Witte CJ, Verheijen PM, Broeders IAMJ, Lenters E, Consten ECJ, et al. Robot-assisted sacrocolporectopexy for multicompartment prolapse of the pelvic floor: a prospective cohort study evaluating functional and sexual outcome. Dis Colon
12. Rectum. 2016;59(10):968–74.
13. Swift S, Morris S, McKinnie V, Freeman R, Petri E, Scotti RJ, et al. Validation of a simplified technique for using the POPQ pelvic organ prolapse classification system. Int Urogynecol J. 2006;17(6):615–20.
14. Parekh M, Swift S, Lemos N, Iskander M, Freeman B, Arunkalaivanan AS, et al. Mulitcenter inter-examiner agreement trial for the validation of simplified POPQ system. Int Urogynecol J. 2011;22:645–50.
15. Rogers RG, CoatesKW, Kammerer-Doak D, Khalsa S, Qualls C. A short form of the pelvic organ prolapse / urinary incontinence sexual questionnaire (PISQ-12). Int Urogynecol J. 2003;14:164–8.
16. Diez-Itza I, Aizpitarte I, Becerro A. Risk factors for the recurrence of pelvic organ prolapse after vaginal surgery: a review at 5 years after surgery. Int Urogynecol J. 2007;18(11):1317–24.
17. Clifton MM, Pizarro-Berdichevsky J, Goldman HB. Robotic female pelvic floor reconstruction: a review. Urology. 2016;91:33–40.
18. Handa VL, Zyczynski HM, Brubaker L, Nygaard I, Janz NK, Richter HE, et al. Sexual function before and after sacrocolpopexy for pelvic organ prolapse. Am J Obstet Gynecol. 2007;197:629.e1–6.
19. Ellerkmann RM, Cundiff GW, Melick CF, Nihira MA, Leffler K, Bent AE. Correlation of symptoms with location and severity of pelvic organ prolapse. Am J Obstet Gynecol. 2001;185(6):1332–8.
20. Lethaby A, Ayeleke RO, Roberts H. Local oestrogen for vaginal atrophy in postmenopausal women. Cochrane Database Syst Rev. 2016;8
21. Gruenwald I, Mustafa S, Gartman I, Lowenstein L. Genital sensation in women with pelvic organ prolapse. Int Urogynecol J. 2015;26:981–4.