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Research Article

Journal of Current Trends in Women's Health & Complications

Bridging the Gap in Urogynaecological Services in Lahore: A Model for delivery of Health Care to A Neglected Group of Women

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Received Date: 02 September, 2020
Accepted Date: 12 September, 2020
Published Date: 21 September, 2020

Citation: Nazli Hameed, Muhammad Asghar Ali, Binyamin Butt (2020) Bridging the Gap in Urogynaecological Services in Lahore: A Model for delivery of Health Care to A Neglected Group of Women. J Cur Tre Women' s Health Compli 1(1): 101

Abstract

Introduction and Hypothesis: To determine if a dedicated urogynecology clinic was effective in alleviating the stress of women with lower urinary tract symptoms, in terms of effective communication, correct diagnosis, investigations offered and their management.

Methods: The case records of 326 patients were analyzed who reported with lower urinary tract symptoms to a urogynaecology clinic between September 2017 to March 2020, for a specialized care. The range of problems that they reported with were recorded in addition to the diagnostic facilities offered to them followed by the treatment they received and their satisfaction with the treatment.

Conclusion: There was a significant improvement in the patient's satisfaction with the quality of service they received starting from an adequate attention given to their symptoms, a thorough evaluation and an improvement in their quality of life following a cause specific treatment. It was concluded that a dedicated service in this neglected area is highly appreciated by women and their families and supports the need to establish these services in different cities in Pakistan.

Keywords: Urogynaecology, Pakistan

Introduction

The elderly population is rising globally and similar trends are being observed not only in Asia but also in Pakistan [1]. In a developing country, these elderly women are facing several challenges e.g., lack of economic growth, financial dependence, low savings of the elderly, weak pension, poor role quality and lower self-esteem. There is no widespread practice of health insurance coverage, hence, the population relies on out of pocket expenditure for the treatment of all ailments. Pakistan's demographic trends show that between 1990 till 2010, the population aged 60+ years increased by 75.1 %. It is projected that the life expectancy will increase to 72 years by 2023. WHO report (1998) projected that 5.6 % of Pakistan's population was over 60 years of age, with a probability of doubling to 11 % by the year 2025. Hence, the country needs to develop a National health policy for the aging, which would assist in integrating the aging population and offer them better social security and health care [2,3]. It has also been reported that up to 40% of the patients reporting in a general gynaecology clinic have urinary symptoms and the rising incidence is associated with increasing age and parity [4,5]. The major concerns for these women is that the specialized urogynaecology services are not available for them across the country.

The ambiguity of where to go and who is primarily responsible for the treatment of these women is a major health concern. There are very few people who are trained to deal with these patients and attempts should be made to guide these patients to the appropriate persons with a reduced waiting time in alliance with NHS policy to reduce waiting time for such patients [6]. Attempts have been made internationally to facilitate these patients across the world under policy guidelines [7]. There has been a consensus internationally that these patients need to be referred to a specialist trained in this sub speciality; and the need for an integrated service at primary and secondary health care level by appropriate awareness to facilitate such referrals cannot be overemphasized [8,9]. Such collaborative care clinics have been found to benefit patients in other disciplines and in urogynaecology [10-12]. This collaborative arrangement for these patients is not universally established in Pakistan. While the developed countries have moved on to one stop nurse led clinic for facilitating these patients, we are yet struggling for a urogynaecology clinic. The aim of this study was to look at how services can be improved to meet the above recommendations.

Methods

We started twice a week urogynaecology clinic at Shalamar hospital, where patients with lower urinary tract symptoms were referred from primary health care physicians, gynaecologist and other health care professional colleagues. Patients were also directed through search engine operations for these services.

The case records of 326 patients were analyzed who reported with lower urinary tract symptoms to a urogynaecology clinic between September 2017 to March 2020, for a specialized care. The range of problems that they reported with were recorded in addition to the diagnostic facilities offered to them followed by the treatment they received and their satisfaction with the treatment. The patients were evaluated in detail by using a structured questionnaire, pelvic ultrasound for pre void and post void urine measurements, urine routine examination and culture sensitivity. Where needed they were also asked to maintain a voiding diary for 3 days. Simple remedies like fluid modification, pelvic floor exercises, bladder drill, Kegel's exercises and medical treatment were started on an outpatient basis. Invasive investigations like cystoscopy and urodynamic investigations including cystometrogram (CMG) and uroflowmetry (UFM) were performed in complicated cases or those with persistent symptoms and further specialized treatments were offered as necessary.

Patients' satisfaction with the entire process of being referred to a specialized clinic and the care offered to them was recorded compared to the time when they were struggling through general gynaecology or other clinics. Prior to these services the patients were completely at loss of whether such symptoms are a part of normal aging and should be reported or not. If they need to be reported, where should it be done? They felt that nobody owned them as cases pertaining to their domain. The primary care physicians and general gynaecologists were also not very clear on the proper disposal of these patients. The experience after the introduction of a focused service was recorded and the satisfaction levels compared before and after introduction of a committed urogynaecology clinic.

Results

The demographics of these 326 patients were analyzed. Their mean age was 56 years (14-70 years). 105 of these patients had a previous surgery (Table 1)

Table 1: Previous surgeries in reporting patients

Previous surgeries	Patient numbers
Hysterectomy	70 (66.6%)
Perineal repair	26 (24.76%)
Fistula repair surgeries	9 (8.57%)

98 patients were referred by primary healthcare physicians, 82 patients were referred by gynaecologists and 146 patients were referred by other specialists including urologists. The duration of symptoms was variable with the longest being more than 10 years (Table 2).

Table 2: Duration of symptoms in the reporting patients

Duration of symptoms	Number of patients
Less than a year	58 (16.02%)
1-5 years	94 (25.9%)
5-10 years	105 (29%)
more than 10 years	95 (26.24%)

82 patients were tested by urodynamic investigations for refractory symptoms. Of these 19 patients had normal results, 24 patients had detrusor instability, 21 patients had genuine stress incontinence,whereas 18 patients had mixed incontinence (Table 3).

Table 3: Outcome of Urodynamic investigations

Urodynamic findings	Number of patients
Normal results	19 (23.17%)
Detrusor instability	24 (29.26%)
Genuine stress incontinence	21 (25.6%)
Mixed incontinence	18 (21.95%)

Of the 362 patients 294 responded to simple conservative treatments like fluid modification, bladder drill, pelvic floor exercises, medical treatment or pessary insertion. 23 needed pelvic floor repair, 18 needed a trans-vaginal or transobturator sling, 15 patients repair of fistula, 11 had cystoscopies due to bladder pain, recurrent urinary tract infections or haematuria. 1 patient needed Botulinum toxin for intractable bladder pain (Table 4).

Table 4: Treatment offered to these patients

Intervention	Number of patients
Conservative measures	294 (81.2%)
Pelvic floor repair	23 (6.3%)
Sling operation	18 (4.9%)
Fistula repair	15 (4.1%)
Cystoscopy	11 (3.03%)
Botulinum toxin	1 (0.27%)

Discussion

This study was performed to assess the efficacy of a dedicated urogynaecology clinic to effectively deal with patients suffering from lower urinary tract symptoms. The demographic pattern confirmed that the incidence of these problems increase with the increasing age of the women with the mean age of reporting being 56 years [13]. 29% of the patients have had a previous surgery suggesting common underlying pathophysiology for pelvic floor disorders. A significant proportion had long standing symptoms pointing to the reluctance of the women to get the treatment for these symptoms out of embarrassment and because no single health-care professional owns the treatment of these cases. Referrals from any source were welcomed to shorten the pathway for the patients. a wide majority of the patients responded to conservative measurements in accordance with international guidelines [14]. A small proportion of patients (22.6%) underwent urodynamic investigations and a quarter of them were candidates for sling procedures. So, a wide majority of the patients could be managed with just appropriate clerking and conservative treatments given whole wholeheartedly in a dedicated urogynaecology clinic. Our results were in alignment with the international results [15,16]. Invasive investigations and treatments were needed in only a smaller group of patients. However, those who did undergo these invasive procedures were the ones having long standing problems and were really satisfied after the treatment addressed their problems. The management under one roof eased out the patient's journey. The streamlined service and focused management greatly enhanced the patient satisfaction, having such dedicated clinics is surely more beneficial than treating them in a generic clinic where the pressures of finishing a general or an obstetric outpatient load takes preference over a patient with patients with lower urinary tract symptoms. These clinics can offer evidence based treatment to the patients in a structured way.

A large number of patients was the strength of this study while the limitation was it's retrospective design. However, it still clearly demonstrates that such a structured care delivery system is feasible for these patients.

Conclusions

The results show that such a structured management in a dedicated clinic optimizes the service delivery to this neglected group of patients and is feasible considering the patient satisfaction from this service.

No conflict of interest

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