



Recognition and Management of Pelvic Floor Disorders in Pregnancy and the Postpartum Period

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KEYWORDS

- Postpartum pelvic floor • Pregnancy pelvic floor • Obstetric anal sphincter injury
- Obstetric laceration • Pelvic floor disorders

KEY POINTS

- Start early. Women should be educated on their pelvic floor, normal changes, and pelvic floor disorders that can occur in pregnancy and postpartum.
- Screen often. Providers should make an effort to screen for pelvic floor symptoms in pregnancy and postpartum, as early recognition and management could improve quality of life during this critical time in a woman's life.
- Avoid overnormalization. Connect pregnant and postpartum women experiencing pelvic floor disorder symptoms with education, support, early treatment, and referral to subspecialty care, as needed.

INTRODUCTION

Although women have experienced pregnancy and childbirth since the beginning of humankind, there remains a lack in basic knowledge of its effect on the pelvis.^{1,2} Women report dismissive reactions by health care providers, personal lack of knowledge, and feelings of embarrassment and shame that keep them from accessing care that could significantly improve their quality of life.³ The American College of Obstetricians and Gynecologists recently acknowledged insufficiencies in postpartum care, including pelvic health.⁴ However, no consensus on the standard of care for pelvic health in pregnancy or postpartum exists. Diagnosis and management of postpartum

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pelvic floor disorders (PFDs) were extensively reviewed in a recent article by Meekins and Siddiqui.⁵ This article builds on that knowledge to recommend a broader clinical approach to education, recognition, and care for women with PFDs and perineal lacerations in pregnancy and postpartum.

DISCUSSION

Start Early: Education, Awareness, and Promotion of Pelvic Health

General knowledge of PFDs, including the effects of pregnancy and childbirth, is lacking for women of all ages.^{1,6–8} Women report a desire for more information, but antenatal education about PFDs is scant. Utilizing a team of nurses and physical therapists could help to initiate pelvic health education early in pregnancy, maintain awareness through the continuum of care, and promote early identification of PFDs.^{9,10} During pregnancy and early postpartum, it can be difficult to determine if symptoms are transient normal changes or indicative of a PFD. Educating women on what is normal, not normal, and what can be done to optimize pelvic health can start the conversation at the onset of pregnancy care and lead to earlier recognition of a disorder (Table 1).

Outcomes research on prenatal pelvic floor education programs is limited but has shown some improvement in symptoms with no change in mode of delivery.¹¹ Therefore, a belief that more knowledge would lead to fear and increased cesarean section rates is not supported by the literature. Education on the risks of pelvic floor injury and PFDs should be considered an important aspect of informed consent for delivery, especially during discussions about operative vaginal delivery and episiotomy.

Education: normal physiologic changes to the pelvis and related symptoms

The physiologic changes of pregnancy are vast, affecting nearly every organ system, in an effort to accommodate the gravid uterus and support the growing fetus, as well as prepare the body for the events necessary for parturition. Changes related to the pelvis and urinary tract during pregnancy are outlined in Fig. 1.^{12,13} As the bony pelvis progressively widens and tilts anteriorly to prepare for vaginal delivery, women are also predisposed to low back and pelvic girdle pain that can persist postpartum.¹² Physical examination studies show that women with relaxation in anterior, apical, and genital hiatus Pelvic Organ Prolapse Quantification (POP-Q) measurements in the third trimester were significantly more likely to have an uncomplicated spontaneous vaginal delivery that included no operative assistance or obstetric anal sphincter injury.¹⁴ Thus, changes to the pelvic floor muscles, vagina, and pelvic floor support serve an important role in mitigating the risk of neuromuscular injury during childbirth. However, it is not surprising that increased pressure from the gravid uterus

Symptom	Normal Symptoms	Pelvic Floor Disorder Symptoms
Urinary	Frequency, urgency, nocturia	Incontinence or other urinary symptoms affecting quality of life
Bowel	Slower transit	Constipation, straining, incomplete emptying, incontinence
Vaginal	Changes in vaginal caliber and vaginal support	Pelvic organ prolapse

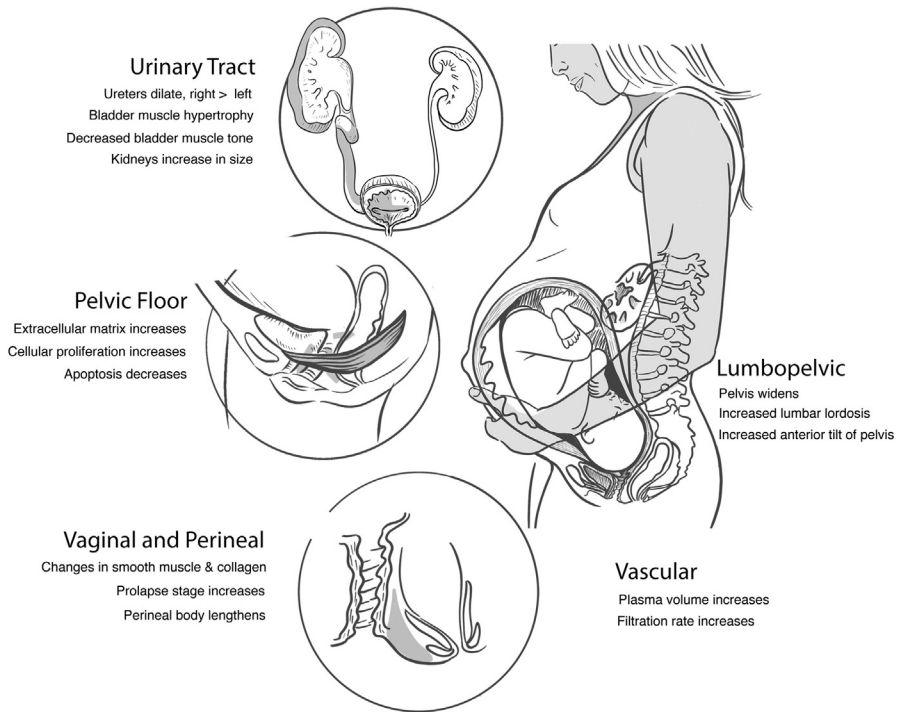


Fig. 1. Changes to the pelvis and urinary tract in pregnancy. (Courtesy of Polina Sawyer, MD, University of Texas Southwestern).

in addition to these changes can impose early, transient symptoms of defects in pelvic floor support.¹⁵

Defining normal pelvic floor support after vaginal or cesarean delivery is complex and an area of ongoing research.^{16,17} Studies demonstrate increases in the levator hiatus and bladder neck mobility and relaxation in all POP-Q measurements, most commonly the anterior wall.¹⁸ These changes are more notable after vaginal compared with cesarean delivery, but tend to improve during the first 6 postpartum months, with little change between 6 months and 1 year.^{18,19} The only change independently associated with the later development of symptomatic pelvic organ prolapse is an enlarged genital hiatus.¹⁹

The urinary system undergoes significant changes in pregnancy, starting as early as the first trimester.^{12,13} Despite an increase in functional bladder volume, an increase in urine production caused by increased plasma volume and glomerular filtration rate causes women in pregnancy to experience urinary frequency and nocturia, which are the most common lower urinary tract symptoms in pregnancy.^{12,13} Both estrogen and progesterone can exert a negative impact on urethral pressure, which when combined with chronically increased intra-abdominal pressure from the gravid uterus and decreased pelvic floor muscle tone, likely exacerbate stress-related urinary incontinence.¹³ Taken together, these changes can explain the prevalent urinary tract symptoms women experience in pregnancy. Postpartum, urinary frequency and urgency may persist for 3 to 4 months.²⁰ Although postpartum incontinence can improve with time, it should not be considered normal.

Awareness: Pelvic floor disorder recognition, risks, and impact in pregnancy, postpartum, and beyond

In contrast to transient physiologic changes that can be normal in pregnancy, PFDs are persistent conditions that negatively impact quality of life and include urinary incontinence, anal incontinence, and pelvic organ prolapse. These symptoms can start in pregnancy and persist postpartum or develop after delivery.

PFDs starting in pregnancy are relatively common. In a cohort of pregnant women in the third trimester who were assessed using the validated Pelvic Floor Distress Inventory, 29.0% reported prolapse symptom distress; 41.8% reported urinary symptom distress, and 24.2% reported colorectal symptom distress.²¹ Colorectal symptoms specific to fecal incontinence are rare, occurring in 3.9% of women at 12 weeks of gestation.²² During delivery, obstetric perineal lacerations are the most commonly identified form of pelvic trauma and classified by degree, summarized in **Table 2**.²³ Up to 79% of women experience an obstetric laceration at the time of vaginal delivery, and most these are first- or second-degree lacerations.²³ Severe perineal lacerations that injure the anal sphincter complex are called obstetric anal sphincter injuries (OASIs) and include third- and fourth-degree lacerations.²³ OASIs occur in up to 3.3% of vaginal deliveries and are independently associated with fecal incontinence at 12 months postpartum.²²

Women can develop postpartum pelvic floor disorders without a clear perineal injury. The role of occult neuromuscular injury, especially to the levator ani, and the subsequent development of PFDs, is an area of ongoing research.²⁴ Currently, the main factors associated with developing a postpartum PFD are vaginal delivery and presence of OASI, described in **Table 3**.^{16,19,25,26} Aging, increasing parity, vaginal birth, and especially operative vaginal birth, are all associated with development of PFDs later in life.¹⁹ Additionally, 76% of women who experience urinary incontinence at 3 months postpartum reported urinary incontinence at 12 years, even if it initially resolved.²⁷ This indicates that women with postpartum urinary incontinence are a high-risk group of women who would benefit from screening because they have a high probability of experiencing incontinence in their lifetime.

Regardless of the long-term implications, the significant impact of PFD symptoms experienced during pregnancy and postpartum should not be underestimated. In a longitudinal study of over 600 women during pregnancy, urinary incontinence, fecal incontinence, and perineal pain increased between first and third trimesters, with third-trimester urinary incontinence associated with a significant decrease in quality of life.²⁸ During pregnancy, up to 52% of women report psychological strain attributed to at

Laceration Degree	Description of Injury
1st	Involves only perineal skin
2nd	Involves skin and muscles of the perineal body
3rd	Extends into anal sphincter complex 3a: <50% of external anal sphincter torn 3b: >50% of the external anal sphincter torn 3c: injury to the internal and external anal sphincters
4th	Extends through perineal body muscles, anal sphincter complex, and anal-rectal epithelium

Data from: ACOG Practice Bulletin No. 198: Prevention and Management of Obstetric Lacerations at Vaginal Delivery. *Obstet Gynecol* 2018;132(3).

Pelvic Floor Disorder	Postpartum Vaginal Delivery	Postpartum Vaginal Delivery + OASI^a	Postpartum Cesarean Delivery
Urinary incontinence	35% at 6 wks 31% at 6 mo	34% at 6 wks 33% at 6 mo	25% at 6 wks 22% at 6 mo
Fecal incontinence	11% at 6 wks 8% at 6 mo	26% at 6 wks 17% at 6 mo	10% at 6 wks 7% at 6 mo
Pelvic organ prolapse (Stage 2 on examination)	29% at 6–12 mo 7% at 5–10 y 14% at 20 y	38% at 6–12 mo	21% at 6–12 mo 6% at 20 y

^a OASI: obstetric anal sphincter injury.

Data from Handa VL, Nygaard I, Kenton K, et al. Pelvic organ support among primiparous women in the first year after childbirth. *Inter Urogynecol J* 2009;20(12):1407-1411; Handa VL, Blomquist JL, Roem J, et al. Longitudinal study of quantitative changes in pelvic organ support among parous women. *Am J Obstet Gynecol* 2018;218(3):320; Borello-France D, Burgio KL, Richter HE, et al. Fecal and urinary incontinence in primiparous women. *Obstet Gynecol* 2006;108(4):863-872; Gyhagen M, Bullarbo M, Nielsen T, et al. Prevalence and risk factors for pelvic organ prolapse 20 years after childbirth: a national cohort study in singleton primiparae after vaginal or caesarean delivery. *BJOG* 2013;120(2):152-160.

least 1 domain of bladder, bowel, prolapse, or sexual dysfunction symptoms.²⁹ Urinary incontinence and pain have also been independently associated with postpartum depression.³⁰ Qualitative studies reveal a negative impact on partnership and sexual function, somatic and psychological effects, and trauma.³ Even more concerning is patient report of feelings of isolation, embarrassment, and shame when their symptoms were dismissed by comments such as “it will get better” without further information or attention by their health care provider.³ Health care providers must be equipped to provide resources, support, and care to women who have the courage to mention their pelvic floor symptoms in pregnancy and postpartum.

Promotion of pelvic health and prevention of pelvic floor disorders

No comprehensive evidence-based prevention strategies for PFDs or prediction models that clearly improve outcomes exist. A Cochrane review describing the effects of pelvic floor muscle exercises performed in pregnancy showed a lower incidence of new urinary symptoms in pregnancy, but no clear benefit in treatment of existing urinary incontinence or prevention and treatment of fecal incontinence.³¹ Evidence for the benefits of physical therapy in treating all types of pelvic floor disorders in nonpregnant women is strong.³² There are also significant gaps in knowledge of general exercise and pelvic floor disorders.³³ Evidence supports the recommendation that women be encouraged to exercise in pregnancy and postpartum for promotion of overall mental and physical well-being and to incorporate pelvic floor muscle exercise into their general exercise routine.³⁴ The best types of general exercise to perform, or avoid, in pregnancy for the promotion of pelvic health are unclear. National guidelines on prevention of pelvic floor injury also vary significantly, with no current international consensus.³⁵ Pregnancy and intrapartum measures of limiting pelvic floor trauma and OASI have limited supportive data and are described in [Table 4](#).^{23,36}

Screen Often: Recognition of Pelvic Floor Disorders in the Clinical Setting

Women with pre-existing or new-onset PFDs may benefit from early identification and support. Clinicians may miss these diagnoses due to lack of screening questions.³⁷

Risk Factors	Odds Ratio (95% Confidence Interval)
Forceps-assisted delivery	5.50 (3.17–9.55)
Forceps-assisted delivery + midline episiotomy	
Fourth degree laceration	10.55 (10.29–10.81)
Third degree laceration	5.65 (5.55–5.75)
Vacuum-assisted delivery	3.98 (2.60–6.09)
Midline episiotomy	3.82 (1.96–7.42)
Primiparity	3.24 (2.20–4.76)
Occiput posterior position	3.09 (1.81–5.29)
Asian ethnicity	2.74 (1.31–5.72)
Labor induction	1.08 (1.02–1.14)
Epidural anesthesia	1.95 (1.66–2.32)
Birthweight >4000g ^a	2.10 (1.60–2.60)
Second stage of labor (>30 min) ^a	1.80 (1.40–2.30)
Prevention Strategies	<i>Relative Risk (95% CI)</i>
Perineal massage started at 34 weeks' gestation	0.91 (0.86–0.96)
Restricted (versus routine) use of mediolateral episiotomy	0.67 (0.49–0.91)
Perineal massage in second stage of labor (versus hands off)	0.52 (0.29–0.94)
Warm compresses on perineum during second stage of labor	0.48 (0.28–0.84)
Perineal protection during delivery	Inconsistent data
Birth position	I data

^a Data on risk for recurrent OASI from: van Bavel J, et al. Risk factors for the recurrence of obstetric anal sphincter injury and the role of a mediolateral episiotomy: an analysis of a national registry. *BJOG* 2020;127(8):951 to 56.

Data from: ACOG Practice Bulletin No. 198: Prevention and Management of Obstetric Lacerations at Vaginal Delivery. *Obstet Gynecol* 2018;132(3):e87-e102.

There are no known pregnancy-specific PFD screening tools, but the B³ (Bulge, Bladder, Bowel) questionnaire is straight-forward and could be easily implemented into a typical review of systems (**Box 1**).³⁸

Clinical evaluation and diagnosis of PFDs was previously reviewed, but the primary consideration is a woman's report of her symptoms.⁵ Various symptom and quality of life questionnaires are available. Although none are specifically validated for pregnant or postpartum populations, these can be efficient, useful adjuncts to screen and evaluate women for pregnancy-related PFDs. The Pelvic Floor Distress Inventory (PFDI-20) and Pelvic Floor Impact Questionnaire (PFIQ) are commonly used, because they assess urinary, prolapse, and bowel symptoms.³⁹ The PFIQ is the only tool validated in a postpartum population and is especially useful, because all questions are asked in relation to before childbirth.⁴⁰ Five domains are used to assess sexual function, pelvic floor function, and pelvic organ support, but it does not include urinary or bowel symptoms.

Avoid Overnormalization: Addressing Pelvic Floor Concerns in Pregnancy and Postpartum

Pregnancy and postpartum can be a difficult time for new mothers as they adjust to the challenges of a new baby and significant changes to their body. Providers must

Box 1**B³ (bulge, bladder, bowel) screening tool for pelvic floor disorders****Bulge**

Do you have a sensation that there is a bulge in your vagina or that something is falling out of your vagina?

Bladder

Do you experience bothersome leakage of urine?

Bowel

In the past month, have you experienced accidental bowel leakage (liquid or solid stool)?

Data from: Barr SA, Crisp CC, White AB, Malik SA, Kenton K. FACE: Female Pelvic Medicine and Reconstructive Surgery Awareness Campaign: *Increasing Exposure*. Female Pelvic Med Reconstr Surg 2018;24(2):115-19.

walk a line to avoid overnormalization of PFDs while also providing reassurance about normal body changes. Although postpartum PFD management was extensively reviewed recently, the clinical approach to intervening in pregnancy and the postpartum period, addressing prior pelvic surgeries, and incorporating future childbearing goals into a woman's management plan are additional considerations for providing comprehensive care.⁵

Pregnancy in women with pre-existing pelvic floor disorders or prior pelvic surgery

Pregnant women with pre-existing PFDs are at risk of worsening symptoms with increasing gestation and childbirth. Evidence-based recommendations for these women is lacking. The authors recommend providing support through early optimization of conservative management strategies, team-based care with a physical therapist, and a proactive postpartum care plan to provide reassurance. Women who have undergone prior treatments or surgery for a PFD should be counseled on the potential impacts of subsequent pregnancy and delivery.⁴¹

Potential risks include:

1. Voiding dysfunction and urinary retention with a history of stress urinary incontinence surgery⁴¹
2. Pain or uterine constriction with increasing gestation with a history of mesh placement for pelvic organ prolapse⁴¹
3. Lead migration, need for revision, or decreased postpartum efficacy of a sacral neuromodulation device⁴¹

Despite these potential risks, current knowledge supports the safety of pregnancy and vaginal delivery following all types of PFD surgery.⁴¹ Although there may be a risk of PFD recurrence, this does not appear to be affected by mode of delivery.⁴¹

The decision regarding delivery mode after OASI repair is especially complex. A recent meta-analysis reports overall risk of OASI of 5.7% in first pregnancy, with a risk of recurrent OASI increasing to 6.3% with a second pregnancy compared to 1.5% in women with no prior OASI.⁴² Although prior OASI certainly increases the risk of subsequent OASI, the overall risk is low, and no evidence supports that mode of subsequent delivery is protective of long-term anal incontinence outcomes.⁴³ Among women with anal incontinence, cesarean section may prevent worsening of anal incontinence.⁴⁴ Providers should engage patients in a shared decision-making process, taking into consideration modifiable and nonmodifiable risk factors, current symptoms and prior wound complications, emotional trauma related to their prior birth

experience, and the outcomes most important to each individual.²³ As risk for OASI is greatest in the setting of operative vaginal delivery and/or episiotomy, discussion of these potential interventions is an important part of the shared decision-making process.

Another special consideration is women with history of type 3 circumcision (female genital cutting), who are at increased risk of complex perineal lacerations and episiotomy during delivery. Comprehensive antenatal and postpartum care for women with circumcision is summarized by the World Health Organization and includes starting in preconception or early pregnancy with evaluation, counseling on risks, and

Box 2

Proposed clinical approach to new-onset pelvic floor symptoms in pregnancy and postpartum

1. Consider symptom time course.
 - Review normal changes in pregnancy and postpartum.
 - Provide reassurance that early symptoms can improve with time and care.
2. Do not overnormalize bothersome symptoms.
 - Although symptoms may improve, a significant proportion of women with postpartum PFDs will have persistent or recurrent symptoms.
 - A proactive, supportive, and reassuring approach is recommended.
3. Recommend early, low-risk interventions.
 - Self-directed pelvic floor muscle exercises can improve symptoms in women who are able to correctly perform them on clinical examination.
 - Kegel apps are available and can be a good adjunct to a home regimen.
 - Physical therapy is low-risk, although associated with a cost, and is likely to provide benefit. This is especially helpful for women who need additional support or are unable to contract pelvic floor muscles on clinical examination
 - Consider pessary management for improvement in prolapse or urinary symptoms, even if symptoms may be transient.
 - Vaginal estrogen therapy can benefit vaginal and urinary symptoms in breastfeeding women.
4. Outline a follow-up plan.
 - Recommend earlier postpartum follow-up (2 weeks) for women with complex perineal lacerations or PFD symptoms.
 - Consider referral to subspecialty female pelvic medicine and reconstructive surgery or postpartum perineal care clinic for
 - Severe perineal lacerations
 - Wound breakdown
 - Complex symptoms requiring close monitoring or surgical intervention
 - Women with significant concerns who need additional support
 - Define a follow-up timepoint to check on symptomatic improvement to decrease anxiety:
 - 3-month follow-up for women performing independent home exercises or attending physical therapy
 - Women with severe symptoms, complex lacerations, or poor wound healing need closer follow-up, possibly weekly, until improvement is seen
5. Provide reassurance that symptoms can improve with treatment.
 - Affirm that the patient has options for management and need not suffer until childbearing is complete.
 - Consider the patient's goals, in light of the risks and benefits of each management option, at any age.
 - Remember that PFD surgery does not always require hysterectomy, can improve quality of life and functioning, and is not an absolute contraindication for future childbearing in women who understand their risks.

shared decision-making on deinfibulation and mode of delivery.⁴⁵ Women with circumcision can also develop PFDs and may experience additional barriers to seeking care. Starting respectful pelvic health conversations early can improve communication, provide best care at the right time in pregnancy, limit misunderstanding and expectation mismatch at the time of delivery, and avoid under-recognition of PFDs in this group of women.

Pelvic Floor Condition	Initial Intervention
Stress urinary incontinence: Involuntary leakage of urine with coughing, laughing, sneezing, or activity	<ul style="list-style-type: none"> ● Pelvic floor muscle exercises ● Pelvic floor physical therapy ± biofeedback for women who lack ability to squeeze pelvic floor muscles or do not improve with pelvic floor muscle exercises ● Incontinence pessary
Overactive bladder: Urinary urgency, frequency and/or nocturia in absence of infection Urgency urinary incontinence: Involuntary leakage of urine associated with a sense of urgency	<ul style="list-style-type: none"> ● Behavioral and dietary modification <ul style="list-style-type: none"> ○ Limitation of excessive fluid intake ○ Avoidance of irritants (ie, caffeine) ○ Timed voiding ○ Bladder calming techniques ● Pelvic floor physical therapy ± biofeedback ● Vaginal estrogen therapy in breastfeeding women ● Judicious prescribing of anticholinergic medications (pregnancy category B; may reduce lactation)
Fecal incontinence (accidental bowel leakage): Involuntary loss of feces	<ul style="list-style-type: none"> ● Behavioral and dietary modification <ul style="list-style-type: none"> ○ Avoidance of irritants (ie, lactose, caffeine) ○ Dietary fiber or fiber supplement ● Pelvic floor physical therapy ± biofeedback ● Occasional loperamide for loose stool (pregnancy category B; low level of breastmilk secretion)
Constipation: Although not a PFD, this can be a symptom of, or contribute to, pelvic floor dysfunction and can be caused by slow colonic transit and/or outlet obstruction	<ul style="list-style-type: none"> ● Dietary fiber or fiber supplement ● Adequate hydration ● Osmotic laxatives (polyethylene glycol) or stool softeners (docusate sodium) ● Pelvic floor physical therapy ± biofeedback
Pelvic organ prolapse: Symptomatic descent of one or more of the vaginal walls or uterus, typically to the level of the hymen or beyond	<ul style="list-style-type: none"> ● Pelvic floor physical therapy ± biofeedback ● Vaginal pessary <ul style="list-style-type: none"> ○ Need for pessary may decrease with increasing gestation and may be needed again postpartum
Vaginal pain and sexual dysfunction: Although not a PFD, this may be a symptom of underlying pelvic floor dysfunction	<ul style="list-style-type: none"> ● Vaginal estrogen therapy in breastfeeding women ● Pelvic floor physical therapy ± biofeedback

Data from: Meekins AR, Siddiqui NY. Diagnosis and management of postpartum pelvic floor disorders. *Obstet Gynecol Clin North Am* 2020;47(3):477-86.

Clinical approach to new-onset pelvic floor disorder symptoms in pregnancy and postpartum

Box 2 summarizes a proposed clinical approach to women who develop new symptoms in pregnancy and postpartum. The American College of Obstetrician Gynecologists recommends all patients have contact with an obstetric provider within the first 3 weeks following delivery.⁴ For patients who experienced an OASI, follow-up within 2 weeks of delivery is recommended, given the increased prevalence of wound complications and bowel control issues.^{46,47} Similar consideration for early

Table 6		
Patient education resources on postpartum pelvic health and pelvic floor disorders		
Resource	Website	Description
American Urogynecologic Society: Patient Fact Sheets	https://www.augs.org/patient-fact-sheets/	Printable fact sheets on pelvic floor disorders and treatment options, including one specifically addressing third and fourth degree perineal tears Information in English and Spanish
American Urogynecologic Society "Voices for PFD" Web site: Information for New Moms	https://www.voicesforpfd.org/new-mothers/new-moms/	Covers basics on the pelvic floor and postpartum changes, patient stories, pregnancy-related pelvic floor symptoms, and additional patient resources both on the web and in print Information in English and Spanish
International Urogynecological Association: Your Pelvic Floor	https://www.yourpelvicfloor.org/leaflets/	Printable patient leaflets on pelvic floor disorders and treatments, including maternal pelvic floor trauma and third and fourth degree perineal tears Information in multiple languages
Royal College of Obstetricians & Gynecologists (RCOG)	https://www.rcog.org.uk/en/patients/tears?source=tearsPIL	Comprehensive Web site on perineal tears and episiotomies in childbirth, the pelvic floor, perineal breakdown. Also provides anticipatory guidance before and after delivery. <i>Information in English</i>
RCOG Patient Experience	https://www.rcog.org.uk/en/guidelines-research-services/audit-quality-improvement/oasi-care-bundle/oasi-videos/	Patient experience videos Information in English

follow-up should be given for patients with advanced obstetric injury not involving the anal sphincter complex or for women experiencing PFDs immediately postpartum. At this point of contact, in addition to a comprehensive history and physical examination, the patient can be screened for difficulties with bladder or bowel control, breastfeeding, pain, and postpartum mood disorders. Further follow-up, either via an in-person visit with the obstetric provider or a subspecialist referral, can be arranged if needed.⁴⁸

The authors recommend providing support and conservative management of PFDs during pregnancy and up to 6 months postpartum, as summarized in [Table 5](#).⁵ However, women with persistent postpartum PFDs should be offered the full spectrum of management options. Although it has been typically recommended to delay surgical management until childbearing is complete, given the growing literature on the safety of pregnancy after PFD surgery and increasing popularity of hysteropexy techniques, this decision is best made as a shared decision between a patient and surgeon through comprehensive counseling on the risks and benefits of all options. There is a growing number of subspecialty peripartum pelvic floor disorder clinics nationally and internationally.⁴⁸ These clinics are typically run by subspecialists in female pelvic medicine and reconstructive surgery and serve as an excellent resource for pregnant or postpartum women experiencing advanced obstetric lacerations or PFDs.

Patient education and support resources

Educational resources on pregnancy-related PFDs are available from major national and international organizations for patients and providers ([Table 6](#)). Although many women turn to social media and Web site searches to find relevant information and peer support postpartum, directing them to sites such as these ensures accurate and useful information is provided.

SUMMARY

Often considered a condition of aging women, PFDs will initially present during pregnancy and postpartum for a subset of individuals. These conditions can have a negative impact on quality of life during this important time and also increase a woman's lifetime risk of persistent or recurrent PFD symptoms. Whole-woman care should integrate pelvic health beginning early in pregnancy and continue postpartum. Routine screening for PFDs can be efficiently accomplished with a brief questionnaire and should be routinely performed throughout pregnancy and the postpartum period to reach women who may otherwise not seek care out of embarrassment and shame. Avoidance of overnormalization, validating patient concerns, and providing support, resources, treatment, and referrals for women with PFD symptoms could improve the peripartum experience and connect women at high risk for PFDs with early access to pelvic health care.

CLINICS CARE POINTS

- Normal physiologic changes in pregnancy and postpartum may result in urinary frequency, urgency, nocturia, changes in pelvic organ support, and slower bowel transit.
- PFDs, in contrast to normal changes, are persistent conditions affecting the bowel, bladder, and vaginal support that negatively affect quality of life and may lead to psychological stress, trauma, depression, and decreased sexual function in postpartum women.
- PFDs are more common with vaginal delivery compared with cesarean section, and anal incontinence is associated with vaginal delivery that involves an anal sphincter injury.

- A simple screening tool can be used to identify women with a PFD in pregnancy and postpartum.
- Conservative treatments for PFDs include behavioral and dietary changes, pelvic floor muscle exercises or physical therapy, and medications.
- Prior surgery for a PFD is not an absolute contraindication for pregnancy or vaginal delivery, and women of all ages should be comprehensively counseled on the risks and benefits of all PFD management options and delivery decisions.

DISCLOSURE

All authors have nothing to disclose.

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