Editorial

A new teaching initiative from Pelviperineology

A section on management of difficult pelvic floor problems by application of the Integral System

Many patients present with symptoms, stress or urge urinary incontinence, nocturia, frequency, voiding dysfunction, chronic pelvic pain, bowel evacuation problems and fecal incontinence. Surgeons who use the International Continence Society's urodynamic paradigm consider surgery contraindicated with all these symptoms except *genuine stress incontinence (GSI)*. The Integral Theory System (ITS) views all these symptoms as secondary manifestations of a laxity in the pelvic suspensory ligaments and therefore surgically curable.

Since its inception Pelviperineology has led the world in publishing scientific articles based on the ITS. We'll continue our dedication to bringing the ITS to the notice of the scientific community in a practical way, by introducing a section dedicated to solving difficult pelvic floor clinical problems through application of the ITS, a unique diagnostic system which diagnoses laxity in specific pelvic ligament and therefore symptoms and prolapse causation.[1] Such an anatomical paradigm becomes ever more relevant as cysto-colpo-defecography, anorectal manometry and electromyography, based on anatomical variations and visceral and somatic muscles functions, as well as the urodynamic paradigm based on bladder pressure measurements, seem to be invalid as predictors of surgical success or failure.[2,3] The ITS provides a minimally invasive alternative to issues raised by the FDA as regards the use of mesh for repair of POP. Morphologic and functional pelvic floor tests and paradigms were nevertheless seminal events in pelvic floor science, as they were the first scientific approach to the problem of urinary and fecal incontinence and retention.

The urodynamic test was a product of the International Continence Society (ICS) in the 1970s to evaluate bladder and bowel incontinence problems. The ICS drew attention to the problem of incontinence and created a forum where these problems could be practically and scientifically addressed. The initial problems ICS faced in these endeavours were that urine leakage had seemingly multiple causations with a wide individual variability in symptoms, and that surgery needed to be done with caution, as it did not work on many patients. Expert standardization committees were set up to create a common language and definitions such as *urge* or *stress incontinence*, etc. The next problem was objective diagnosis of *detrusor instability* (DI),[4] and since the ICS system was based on the concept that urodynamic findings were *objective* and therefore *reliable* and unstable bladder symptoms were said to be unreliable, not surgically curable and required drug therapy, the outcome of this was the concept that only patients with GSI were surgically curable, and patients with mixed incontinence, stress and urge, frequency, nocturia should not be operated on if urodynamics demonstrated DI, now known as *overactive bladder* (OAB).[6] It seems that with the passage of time the urodynamic paradigm, now almost 40 years old, began to falter. In 2006 the Cochrane collaboration[2] found that urodynamics had no predictive value and this was more recently substantiated by a major article by Nager et al. in NEJM.[3]

In the *colorectal field* anorectal manometry, also based on pressure measurements, has been overestimated in the past, and similarly has little predictive value. Both manometry and evacuation proctography retain a definite but limited place in investigating pelvirectal disorders.[7] Their contribution to the diagnosis of *anismus* and to the work-up of patients with *fecal incontinence* is also limited,[8] nor do they provide sufficient grounds for the diagnosis of *slow transit constipation* or *obstructed defecation*.[9] Clinician must be thoughtful and prudent when considering the numerous investigations commonly applied in anorectal and colonic disorders.[10] There is not a story for the anorectal function through well structured international scientific societies as for bladder studies. A passive acceptance of fecal incontinence as a fatal event of the elderly, and a lack of financial interest in low cost laxatives by the industry and therefore a lack of support to research and to sponsorship has not favored a significant progress in this field.

The ITS is an entirely anatomical management system based on a validated questionnaire[1] and a three zone diagnostic flowchart indicating the site of damage/laxity of the four suspensory ligaments and perineal body and therefore the site to be enforced in a site specific way with polypropylene tapes. There is an increasing body of data demonstrating that reinforcing with minisling these structures is sufficient to cure not only cystocele, rectocele and uterine/apical prolapse but also bladder and bowel symptom dysfunction and many instances of chronic pelvic pain.[11-13] In the new section *Management of difficult pelvic floor problems* the ITS will be applied to solve cases that cannot be addressed by the common laboratory paradigms. A full account of this system with case reports is available online from a previous publication.[14]

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