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Ambulatory care related to female pelvic floor disorders in the United States, 1995–2006

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Abstract

OBJECTIVE—Describe trends for pelvic floor disorders (PFDs)-related ambulatory visits.

STUDY DESIGN—Data were derived from the National Ambulatory Medical Care Survey (NAMCS) and the National Hospital Ambulatory Care Survey (NHAMCS). PFD-related visits were based on ICD-9 codes. We collapsed 12 survey years into three study periods (1995–1998, 1999–2002, 2003–2006) to evaluate numbers, rates and trends for PFD-related visits.

RESULTS—The average annual number of PFD-related visits was 3.9 million (95% CI 3.1–4.7 million). The annual rate of PFD-related visits per 1000 women was 35.2 in 1995–1998, 40.6 in 1999–2002, and 36.3 in 2003–2006. PFD visits represent 0.9% of all ambulatory visits for adult women in the United States. Women 60 years and over had higher rates of PFD-related visits compared to women younger than 60 years.

CONCLUSIONS—The annual number of PFD-related visits is significant, representing 0.9% of all ambulatory visits made by adult women in the United States.

Keywords

pelvic floor disorders; incontinence; prolapse; ambulatory care; national trends

Introduction

Female pelvic floor disorders (PFDs) are a heterogeneous group of conditions that include urinary incontinence (UI), pelvic organ prolapse (POP) and fecal incontinence. These conditions can have a negative impact on a woman's quality of life. Estimates from population-

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based studies in the United States reveal that in older, community dwelling women, the prevalence of UI is as high as 41%¹ and POP is 25%.^{2, 3} It is estimated that 23.7% of adult women in the U.S. have symptoms of at least 1 PFD.⁴ Although PFDs are common, it is estimated that a small proportion of affected individuals will ever seek care for their symptoms. For example, it is estimated that only 26% of symptomatic women will seek care for UI.⁵ Despite the relatively small proportion of women seeking care, the utilization of health-care resources attributable to PFDs is substantial and studies on surgical treatment estimate that a woman's lifetime risk of undergoing surgical treatment for PFDs is 11%.^{6, 7} In 1997, approximately 135,000 women underwent inpatient surgical treatment for stress urinary incontinence.⁸ In that same year, it is estimated that more than 200,000 women underwent inpatient surgical treatment for POP⁹ and more than \$1 billion was spent on direct costs of surgical treatment based on Medicare reimbursements.¹⁰

One aspect of health-care utilization that has not been well explored is ambulatory care related to female PFDs. Examining ambulatory care visits over time can identify trends in health-care utilization and disease-specific characteristics of patients seeking care for PFDs, and help to predict future health care needs. The aims of this study were to 1) estimate the number and rate of PFD-related ambulatory visits from 1995–2006; 2) describe national trends in PFD-related visits from 1995–2006; and 3) describe the population characteristics of women who had PFD-related visits.

Material and Methods

Data Sources

We used the National Ambulatory Medical Care Survey (NAMCS) and the National Hospital Ambulatory Medical Care Survey (NHAMCS) to collect data for female PFDs in the United States. Both surveys are conducted by the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention to gather information regarding ambulatory care, the predominant method of providing health care services in the United States. Complete descriptions of these federally sponsored annual surveys can be found at the website <http://www.cdc.gov/nchs>. This study used national de-identified data and was determined to be exempt by the Institutional Review Board of Women and Infants Hospital of Rhode Island.

The NAMCS is an annual sample of outpatient visits to office-based physicians including private practices, freestanding clinics, public health clinics, family planning clinics, and faculty practices. Approximately 1500 physicians are sampled each year, with a response rate above 60%. The NHAMCS collects data on the utilization and provision of ambulatory care services in hospital facilities that provide non-urgent ambulatory care under the supervision of a physician, as well as emergency departments. A fixed panel of 600 non-federal hospitals is used for the NHAMCS sample, with a response rate above 90%. The basic sampling unit for both databases is the patient visit. Visits are sampled by using a multi-stage clustered probability based sampling design based on geographic location, provider specialty, and visits within individual practices and hospitals. Because of the sampling design used, data from the NAMCS and NHAMCS can be extrapolated to the over 1 billion visits to physician offices and hospital outpatient departments that occur in the United States annually.

Data for the NAMCS and NHAMCS are recorded by the participating physician or by office staff who complete visit encounter forms. The encounter forms include patient demographics, up to three diagnoses for each visit coded using The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9), and whether medical treatment was provided. The NAMCS and NHAMCS data can be used to address questions about patterns of disease, disease-specific patient characteristics and diagnoses. Both databases provide data on

physician subspecialty, including general practice, internal medicine, obstetrics and gynecology, urology (NAMCS only), and general surgery to name a few.

Female pelvic floor disorders-related visits

We defined PFD-related visits based on ICD-9 codes for UI (ICD-9 codes 599.81, 599.82, 625.6, 788.3, 788.31, 788.33, 788.37, 788.38, 788.39), POP (ICD-9 codes 618.0–618.9), fecal incontinence (ICD-9 code 787.6), fistula (ICD-9 code 619), and chronic interstitial cystitis and urethral syndrome (ICD-9 codes 595.1, 597.80–597.81). Visits with one of these diagnosis codes listed as the reason for the visit were considered PFD-related visits. We restricted our study population to females 21 years of age and older presenting for non-emergency department ambulatory visits.

Data analysis and statistical methods

To evaluate longitudinal trends, we collapsed 12 survey years into three equal study periods (1995–1998, 1999–2002, and 2003–2006), combining data over 4-year periods to increase the power of our analyses. We first estimated the national average annual number of total and new patient PFD-related visits. To estimate annual visit rates, rate denominators were obtained from the U.S. Census Bureau's annual inter-censal estimates of the resident population (<http://www.census.gov/popest/datasets.html>). For each time period, we divided the number of PFD-related ambulatory visits by the estimated population of U.S. resident women 21 years of age and older. We then evaluated trends in the visit numbers and rates over the 12-year period, including trends specifically for urinary incontinence and pelvic organ prolapse. The number of visits for fecal incontinence, fistula and interstitial cystitis were insufficient to produce separate stable national estimates for each of these diagnoses; therefore, separate estimates are reported for urinary incontinence and pelvic organ prolapse only. We also evaluated population characteristics of women who had PFD-related visits over the study period. Data for all years were screened for potential differences in diagnosis codes that may have changed over time.

We analyzed ambulatory care for PFDs at the level of the patient visit. To account for the complex survey design and to make our point estimates and 95% confidence intervals (CIs) nationally representative, we used the survey weights provided in the NAMCS and NHAMCS documentation and Taylor series linearized variance estimation (STATA SVY commands). For years prior to 2002, ultimate cluster design variables (CSTRATM and CPSUM) were calculated from multi-stage sampling design variables as indicated by the NCHS. We compared proportions using chi-square and second-order correction of Rao and Scott to account for the survey sampling design. Estimates based on fewer than 30 records or with relative standard errors greater than 30% were considered unreliable and were not reported, per NCHS standards. All analyses were performed using SAS 9.0 (SAS Institute, Cary, NC) and STATA SE 9.0 (Stata Corp., College Station, TX). $P < 0.05$ was considered statistically significant.

Results

Numbers, rates and longitudinal trends for PFD-related visits

The average annual number of PFD-related ambulatory visits was 3.4 million in the 1995–1998 period, 4.1 million in the 1999–2002 period, and 3.9 million in the 2003–2006 period (Figure 1). However, this trend was not statistically significant ($P > 0.05$). Overall, PFD-related visits represented 0.9% of all ambulatory care visits for adult women in the United States. The average number of annual new patient visits related to PFDs, UI and POP are presented in Table 1. New patient visits related to PFDs decreased from 20% of all PFD-related visits in 1995–1998 to 18.1% in 1999–2002 to 14.9% in 2003–2006.

The average annual rate of ambulatory care visits for PFDs increased from 35.2 per 1000 women in the 1995–1998 period to 40.6 per 1000 women in the 1999–2002 period, and slightly decreased to 36.3 per 1000 women in the 2003–2006 period (Table 2), although this trend was not statistically significant suggesting that rates have likely remained stable ($P>0.05$). The rates for UI visits steadily increased over time, whereas the rates for POP visits increased between the 1995–1998 and 1999–2002 time periods and subsequently decreased in 2003–2006. The visit rates for UI remained significantly higher than visits for POP for all time periods ($P<0.05$). Visit rates are not reported separately for fecal incontinence, fistulas, or interstitial cystitis due to small numbers and unstable estimates.

Not all PFD-related visits are associated with medical treatment. Using this available data in the databases, we estimated that the average annual number of PFD-related visits associated with medical treatment was 2.6 million (95% CI 2.1–3.2 million) in 2003–2006. Breaking this down by diagnosis, the proportion of ambulatory visits for UI associated with medical treatment increased from 72% in 1995–1998 to 85% in 2003–2006 ($P=0.01$). On the other hand, the proportion of visits for POP associated with medical treatment remained stable at 67% in 1996–1998 and 71% in 2003–2006 ($P=0.4$).

We also evaluated trends in the type of physician seen for PFD-related visits. The majority of PFD-related visits at physician offices (NAMCS data) were with obstetrician-gynecologists, whereas the majority of PFD-related visits at hospital-based outpatient settings (NHAMCS data) were with general medicine physicians (See Figure 2). These trends remained stable during the study period. In 2003–2006, 35% of all physician-office PFD-related visits (NAMCS data) were with obstetrician-gynecologists, 26% with urologists, and 39% with other specialties. Obstetrician-gynecologists evaluated a significantly higher proportion (62–70%) of women for POP than any other subspecialty and evaluated a slightly lower proportion of women for UI (24%) compared to urologists (32%) and other specialties (43%). The NHAMCS did not include urology as a separate specialty and therefore, this data is not available for hospital-based settings.

The NAMCS and NHAMCS include up to three ICD9-CM diagnosis codes per patient visit. For PFD-related visits between 2003–2006, 40% of visits had a primary diagnosis of UI, 38% had a secondary diagnosis, and 23% had a tertiary diagnosis. In the same time period, 61% of visits had a primary diagnosis of POP, 34% had a secondary diagnosis, and 13% had a tertiary diagnosis. For all years between 1995–2006, 61% of visits had a primary diagnosis of any PFD (includes all ICD-9 codes), 33% had a secondary diagnosis, and 16% had a tertiary diagnosis. Of note, these proportions may sum to greater than 100% due to the possibility of overlapping diagnoses and multiple diagnoses within categories.

Pelvic floor disorders visits, by patient population characteristics

There was a trend for an increasing proportion of African-American women to present for PFD-related visits in more recent years (Table 3). The proportion of Hispanic women who presented for PFD-related visits also increased during the study period ($P<0.05$). The majority of patients had private insurance coverage, and this trend remained stable during the study period. By region, the South had the highest proportion of PFD-related visits in the U.S., and this trend was stable during the study period. Using multinomial logistic regression to adjust for race, ethnicity and age, these geographic patterns remained the same, with the South having the highest proportion of all PFD-related visits (39.2%) compared to the Northeast (14.4%), Midwest (29%), and West (17.3%) between 2003–2006. The mean age of women seeking care for PFDs remained stable throughout the study period, ranging from 60.8 to 62.2 years. The highest proportion of PFD-related visits was in younger women aged 21–59 years. However, the visit rate per 1000 U.S. women increased significantly with age (Figure 3), with all age

groups over 59 years having significantly higher rates of PFD-related visits compared to the youngest age group.

Comment

The NAMCS and NHAMCS data are used by public health policy makers, health services researchers, physician associations and epidemiologists to describe and understand changes that occur in medical care requirements and practices. Our study supports that the number of ambulatory visits for PFDs is significant, representing 0.9% of all ambulatory visits for adult women in the United States. These 3.9 million annual visits suggest that continued training of physicians to care for women with PFDs remains an important goal.

For comparison, a recent study by Shah, et al evaluated trends in constipation-related visits in the United States also utilizing the NAMCS and NHAMCS.¹¹ For this common condition, the authors found that the rate of visits for constipation-related care was 28.0 per 1000 for the U.S. population, including men, women and children. On average, this includes 7.95 million visits annually, which represents 0.18% of all ambulatory care visits in the United States. Our findings show that the proportion of PFD-related visits for adult women was higher than these reported estimates for constipation for the general population.

There has been a growing body of literature regarding national trends for surgical treatment of female PFDs. Boyles et al reported that the rate of inpatient surgery for UI doubled between 1979 and 1997.¹² However, these rates remained relatively stable between 1994–1997, ranging from 0.55 to 0.60 per 1000 women. During this same time period, the rate of inpatient procedures for POP decreased from 2.2 to 1.5 per 1000 women.⁹ Boyles et al also reported that rates for ambulatory surgical procedures for UI doubled between 1994–1996.¹³

In contrast to data on surgical trends, there has been limited information regarding ambulatory care. In 2001, Luber et al estimated projected future demands for UI and POP care based on patients evaluated within the Kaiser Permanente Health Care Program in Southern California.¹⁴ At the time, the authors estimated that in the year 2000, there would be approximately 618,000 consults for pelvic floor disorders. Based on our findings, between 1999–2002 the average annual number of new patient visits for PFDs in the U.S. was over 750,000 visits, not far from Luber's projections. Differences and strengths of our study include that visits with all types of physicians are included (general medicine, obstetrics-gynecology, urology, etc) and our data reflect that of the general U.S. population.

Based on data regarding surgical treatment trends for PFDs, we anticipated that the number of ambulatory and new patient visits for PFDs would have increased over the past few years. Although there was a modest increase between the periods 1995–1998 and 1999–2002, ambulatory visit rates have likely remained stable in more recent years. Previous studies on surgical trends have included time periods prior to 1998,^{9,12,13} whereas our study evaluates more recent data from 1995–2006. Therefore, it is possible that surgical rates may have remained stable or even decreased in more recent years since 1997. It is also possible that although more women may be experiencing PFD symptoms, the number of women seeking medical care has not changed. We did find a trend that women 60 and older have higher rates of PFD-related visits compared to women younger than age 60. The first generation of baby boomers is expected to reach age 65 by the year 2011, with an anticipated steady increase in the older population for many subsequent years. Therefore, we expect that even if the rates PFD-related visits remain stable in the older population, the total number of women who will seek care for PFDs will increase.

Consistent with studies evaluating surgical treatments for PFDs,¹⁵ the majority of PFD-related ambulatory visits were for Caucasian women. Previous studies have suggested that there may

be racial disparities associated with surgical treatment for PFDs.¹⁵ Anger et al reported that among Medicare beneficiaries, white women were more likely than black women to be diagnosed and surgically treated for stress urinary incontinence.¹⁶ Population studies have been inconsistent regarding the role of racial differences in the prevalence, incidence and risk of urinary incontinence.^{1, 17, 18} In a study by Nygaard, et al utilizing the 2005–2006 National Health and Nutrition Examination Survey, no differences in prevalence for PFDs were found by race or ethnic group. In their study, Non-Hispanic whites, Non-Hispanic blacks, and Hispanic women all had a 20–25% prevalence of having at least one PFD, although these women did not necessarily seek medical care. Although our findings show that the proportion of African American and Hispanic women with PFD-related visits increased in recent years, this may reflect population changes and not necessarily any changes in disparities. It is important to continue to identify barriers and promote help-seeking for all women, particularly minority groups.

Although we found that the majority of PFD-related visits occurred with obstetrician-gynecologists and urologists, a significant number of visits occurred with general medicine physicians. Over 44% of hospital-based clinic visits for PFDs were with general medicine physicians. Clearly, primary care physicians play an important role in the care of women with PFDs, including diagnosis and evaluation, initiation of treatment and timely referral when appropriate. This emphasizes the importance of simple screening measures for PFDs that may be easily utilized in primary care offices to identify women with PFDs who want to seek help.¹⁹

There are potential limitations to our study that should be recognized. Like any database study, our data are subject to accurate and complete coding in the NAMCS and NHAMCS. Our estimates do not describe the prevalence of PFDs but only PFD-related ambulatory visits in the United States. If a PFD diagnosis was not included as one of the three reasons for that visit, it is unlikely that a woman was seeking care for PFDs during that specific visit. We would expect that coding errors would most likely result in an underreporting of PFD-related visits and therefore, our findings may provide an underestimate of the true prevalence of PFD-related visits. The precision of our estimates is limited because of the overall small sample sizes for PFD-related visits and we were unable to provide specific estimates for fecal incontinence, fistulas or interstitial cystitis visits. Also, the NAMCS and NHAMCS include national probability-based samples which provide estimates but not total counts of all patients evaluated; however, our methods were conducted according to the NAMCS and NHAMCS documentation and we have only reported those estimates that are stable and reliable.

In conclusion, there are a significant number of PFD-related ambulatory visits. With the aging population, we expect that health care utilization for these chronic conditions will increase in the future.

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Figure 1.

Average annual number of PFD-related ambulatory visits, 1995–2006*

*Data from NAMCS and NHAMCS combined

Figure 2.

Proportion of PFD-related visits by provider specialty, 1995–2006*

*Data source for office visits is NAMCS and clinic visits is NHAMCS.

Figure 3.
Annual PFD-related visit rates per 1,000 U.S. women by age group, 1995–2006

Table 1

Number of PFD-related new patient visits by time period*

Type of visit	1995–1998	1999–2002	2003–2006
Average annual number of PFD-related new patient visits	0.69 (0.49–0.87)	0.75 (.44–1.1)	0.58 (0.38–.78)
Average annual number of UI new patient visits	0.33 (0.24–0.42)	0.38 (0.22–0.54)	0.36 (0.23–0.48)
Average annual number of POP new patient visits	0.32 (0.19–0.45)	0.42 (0.18–0.67)	0.22 (0.11–0.34)

* Data presented in millions of visits and (95% Confidence Interval)

PFD = Pelvic floor disorders UI = Urinary incontinence POP = Pelvic organ prolapse

Table 2Annual rates for PFD-related ambulatory visits by time period^{*†}

Type of visit	1995–1998	1999–2002	2003–2006
All PFD-related visit rates	35.2 (29.7–40.8)	40.6 (31.7–49.5)	36.3 (28.8–43.8)
Urinary incontinence visit rates	17.5 (14.2–20.8)	21.2 (15.9–26.6)	21.7 (16.7–26.7)
Pelvic organ prolapse visits rates	14.7 (11.5–17.8)	16.4 (11.4–21.4)	13.5 (10.0–16.9)
Any PFD-related new patient visit rates	7.1 (5.1–9.0)	7.4 (4.3–10.4)	5.4 (3.6–7.2)

* Data presented as average annual rate per 1000 U.S. adult women and (95% Confidence Interval)

† Rates based on annual intercensal estimates of the U.S. resident population of women 21 years and older

Table 3

Population characteristics for women receiving ambulatory care for pelvic floor disorders*

Patient characteristic	1995–1998	1999–2002	2003–2006
Total visits, by age group (%)			
21–59 years	47%	43%	42%
60–69 years	17%	20%	24%
70–79 years	25%	23%	18%
>80 years	11%	14%	16%
Race (%)			
White	90%	91%	86%
African American	7%	6%	11%
Other	3%	3%	3%
Ethnicity (%)			
Hispanic	3%	8%	10%
Non-Hispanic	97%	92%	90%
Source of payment (%)			
Private	49%	51%	44%
Medicare	33%	38%	39%
Medicaid	5%	6%	10%
Other	13%	5%	7%
Region (%)			
Northeast	16%	24%	17%
Midwest	20%	19%	27%
South	40%	33%	37%
West	24%	24%	19%

* Out of all PFD-related visits during the time period