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Exploring the Unspoken: Women's Experiencing Symptoms of Pelvic Floor Dysfunction through a Survey

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ABSTRACT

Background: Pelvic floor dysfunction (PFD) caused by imbalances in pelvic floor muscles affects the urinary, bowel, and pelvic systems. The symptoms related to PFD are often overlooked. Identifying the prevalence is the first step in making a definitive diagnosis, thereby facilitating treatment and preventing complications. This study aimed to find the prevalence of symptoms related to PFD in non-pregnant women residing in Sangli city.

Methods: A cross-sectional house-to-house survey was conducted in which 400 non-pregnant women aged 20 years or older residing in Sangli city were interviewed via a Google Form over 6 months. The form consisted of questions on symptoms related to urinary, bowel, and sexual dysfunction. Data analysis was done using SPSS (version 25). The statistical tests used were frequency distributions and percentages for demographic characteristics, the prevalence of PFD, Bladder Symptoms, Bowel Symptoms, and Sexual Symptoms, and the Chi-square test to assess the association between demographic characteristics and symptoms.

Results: The overall prevalence of PFD was 21.46%. Prevalence rate of urinary symptoms was 25.6%, bowel symptoms was 25.4%, and Sexual symptoms was 13.4%. Significant associations ($p<0.05$) between pelvic floor dysfunction symptoms and demographic/medical factors were found.

Conclusion: The prevalence of symptoms related to pelvic floor dysfunction is high, which highlights the need for definitive diagnosis and its treatment. Awareness and educational programs can be held so that women identify their symptoms at an early stage, get them diagnosed, and prevent further complications.

Keywords: Pelvic floor Disorders, Urinary bladder, Overactive, Underactive, sexual dysfunction, Prolapse, dyspareunia, urinary incontinence, surveys, and questionnaires.

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INTRODUCTION

Pelvic floor muscles comprise a group of muscles that are divided into two layers: deep and superficial. The deep layer consists of the levator ani and coccygeus muscles, whereas the superficial layer consists of the bulbospongiosus, transverse perinei, external anal sphincter, and ischiocavernosus. Altogether, these muscles play a crucial role in providing support and maintaining the function of the pelvic organs [1]. The mechanism by which they maintain the function is the coordinated 'squeeze and lift' contraction of muscles. Voluntary activation shortens fibers to narrow the urethral and anal openings while elevating pelvic organs against intra-abdominal pressure. When the coordination between contraction and relaxation fails, muscle function is impaired, leading to a condition known as pelvic floor dysfunction (PFD). The organs affected include the bladder, bowel, and sexual organs, with a wide range of symptoms for each [1,2,3].

PFD symptoms depend on the tone of the muscles, i.e., whether the muscles are tight and weak or lengthened and weak. Overly tight or hypertonic pelvic floor muscles make it difficult for a person to relax and coordinate movements. Symptoms due to hypertonic muscles include a sensation of incomplete emptying, difficulty initiating urination, urinary incontinence (UI), or frequent desires to urinate (bladder function); constipation, straining, or the need to shift positions to pass excrement and rectal pain (bowel function); and dyspareunia and pelvic pain (sexual function). Weak, underactive, or hypotonic pelvic floor muscles are unable to produce sufficient force when needed. Symptoms caused by a hypotonic pelvic floor include inadequate stress incontinence (leakage with coughing, for example) or bladder emptying (bladder function), rectal incontinence or a rectum prolapse (bowel function), pelvic organ prolapse (POP), or loss of vaginal sensations (sexual function) [1,3,4]. Physical activity, social engagement, intimacy, and emotional well-being are all restricted by PFD, which lowers health-related quality of life (HRQoL) [5].

According to epidemiological research, PFD is a prevalent chronic disorder that affects women of all ages. According to national and population-based surveys, nearly 25% of adult women report symptoms of at least one pelvic floor dysfunction, the rates of which rise substantially with age. Also, community-based research from low- and middle-income countries shows between 30 and 35 percent of women report having at least one type of PFD, with incontinence being the most often reported symptom [5,6].

The onset and course of PFD have been linked to both controllable and non-modifiable risk factors. Non-modifiable variables include advanced age, genetic susceptibility or family history, and previous pelvic surgery, such as a hysterectomy. There may be a heritable component to the integrity of the connective tissue and pelvic floor muscles in women who have a family history of POP or UI. A higher risk of recurrent PFD, including UI and POP, is linked to vaginal deliveries, especially those with protracted second stages, instrumental help, or macrosomic children [3,6,7].

Obesity, trauma from childbirth, lifestyle choices, and persistent intra-abdominal pressure overload are modifiable risk factors. Urinary incontinence and POP are consistently associated with high body mass index (BMI), as a 5-unit increase in BMI is linked to a 20–70% increase in the risk of UI. Frequent heavy lifting, persistent constipation, a chronic cough (from smoking, asthma, or chronic lung illness), and jobs involving extended standing or lifting also increase risk by repeatedly raising intra-abdominal pressure and straining pelvic-floor structures [7].

For several types of PFD, including UI and early-stage POP, conservative therapies such as pelvic floor muscle training, bladder and bowel training, lifestyle changes, and weight control are advised as first-line remedies. When used early and consistently, these strategies can greatly reduce symptoms and improve HRQoL. However, a lot of women are still ignorant about the pelvic-floor structures (muscles, ligaments, and organs), their roles, and the availability of conservative treatment choices, which causes them to put off getting help and manage themselves poorly. Studies show that fewer than 50% of women with UI consult healthcare providers, often due to embarrassment or lack of awareness about effective treatments. This treatment gap is particularly pronounced in low- and middle-income nations, where access to pelvic floor physiotherapy and specialized women's health services remains limited [6,7,8].

Pelvic floor symptoms are underreported in India, particularly in small cities, due to social stigma, the belief that urinary and bowel problems are 'normal,' reluctance to seek help, embarrassment, lack of awareness, and poor routine screening [5]. Therefore, studying the occurrence of PFD is crucial. Identifying the prevalence is the first step in aiding a definitive diagnosis, thereby facilitating treatment and preventing complications. Thus, the objective behind this study was to determine the prevalence of urinary, bowel, and sexual symptoms related to PFD in non-pregnant women using a Google form [Appendix 1].

METHODOLOGY

STUDY DESIGN AND SETTINGS

A cross-sectional study was conducted among 600 non-pregnant women residing in Sangli city. The study was conducted over a period of six months, from November 2024 to April 2025. The study is reported in accordance with the STROBE guidelines [10].

PARTICIPATION

Women aged 20 years and older who were not currently pregnant and willing to participate were included in the study. Women who had given birth within 12 months, with neurological disorders like stroke or Parkinson's disease, and with orthopedic conditions like spondylosis or SI joint dysfunction affecting pelvic floor muscles, were excluded. Throughout the study, participant confidentiality was rigorously maintained.

SAMPLING AND DATA COLLECTION

The study used cluster sampling, in which the Sangli-Miraj area was divided into clusters of different regions, and systematic sampling was used to select the samples.

The sample size was determined to be 369 using the formula $N = Z^2 * P(1-P) / e^2$. A house-to-house survey was conducted to interview the women at their residences using a non-validated questionnaire via Google Forms. The questionnaire consists of 4 sections: Section A: Sociodemographic data, medical history, obstetric history, and personal history; Section B: urinary symptoms; Section C: bowel symptoms; and Section D: sexual symptoms [Appendix 1]. The answers were collected as YES or NO, depending on whether the women were experiencing any symptoms. All the questions used in the Google form were taken from peer-reviewed publications and standard obstetrics and gynecology textbooks authored by recognized authors. They were thoroughly reviewed and approved by experts [1,2,11,12,13,14].

Statistical Analysis:

Microsoft Excel 2021 was used for data entry, and SPSS version 25 was used for analysis. To evaluate demographic variables and PFD symptoms, descriptive statistics such as frequencies and percentages were used, and point prevalence for bladder, bowel, and sexual functions was calculated as percentages.

RESULTS

A total of 600 women were assessed for eligibility; 400 met the inclusion criteria and were included in the study. The participants' demographic details are described in Table 1.

Table 1: Description of demographic variables of all participants (N=400)

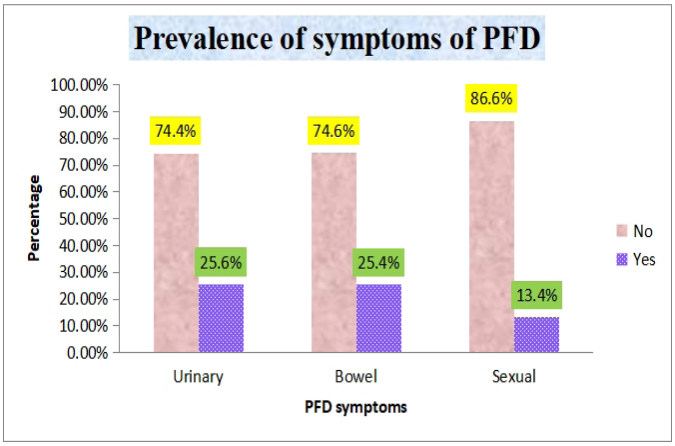
Demographic variables		Frequency	Percentage
Age (in yrs.)	20-30	126	31.3
	31-40	82	20.3
	41-50	80	19.9
	51-60	42	10.4
	61-70	33	8.2
	71-80	31	7.7
	81-90	9	2.2
BMI	Underweight	28	6.9
	Normal	209	51.9
	Overweight	147	36.5
	Obese	19	4.7
Any medical history	No	265	65.8
	Yes	138	34.2
Any infection history	No	368	91.3
	Yes	35	8.7
No. of delivery	0	110	27.3
	1 – 3	246	61
	4 – 6	47	11.7
Type of delivery	No delivery	110	27.3
	Normal	199	49.4
	LSCS	94	23.3

The overall point prevalence of women with PFD was 21.46%, indicating a considerable burden of pelvic floor dysfunction in this population. Regarding the prevalence of individual organ function, women with urinary, bowel, and sexual symptoms were 25.6%, 25.4%, and 13.4%, respectively [Table 2 & Graph 1].

Table 2: Prevalence of symptoms of pelvic floor dysfunction among non- pregnant women.

Symptoms	No	Yes
Urinary	74.4%	25.6%
Bowel	74.6%	25.4%
Sexual	86.6%	13.4%

Graph 1: Prevalence of symptoms of pelvic floor dysfunction among non- pregnant women.



The chi-square test revealed that the prevalence of bladder-related symptoms was significantly associated with age (common in 41-50 years), history of urinary infection, type of delivery (common in FTNVD), and number of deliveries (common in 1-3 deliveries). Bowel dysfunction was significantly associated with age (above 60 years), medical history mainly diabetes, type of delivery (mainly after FTNVD), and number of deliveries (4-6 deliveries). While Sexual dysfunction was significantly associated with age (mainly in 20-30-year-olds), history of any vaginal or urinary infection, type of delivery (commonly in LSCS), and number of deliveries (1-3 deliveries). At the same time, variables such as educational status and occupation did not demonstrate a significant relationship ($p > 0.05$), Table 3.

Table 3: Relationship between urinary symptoms, bowel symptoms, and sexual symptoms with selected demographic variables.

	URINARY SYMPTOMS		BOWEL SYMPTOMS		SEXUAL SYMPTOMS	
Demographic Variable	chi-square	p-value	chi-square	p-value	chi-square	p-value
Age	13.72	0.033	22.93	0.001	32.96	0
BMI	4.25	0.24	3.09	0.37	6.75	0.08
Medical History	0.005	0.94	13.98	0	0.093	0.76
History Of Infection	16.09	0	0.268	0.7	10.39	0.001
No. Of Delivery	11.69	0.003	11.033	0.004	31.21	0
Type Of Delivery	11.27	0.004	11.25	0.004	32.6	0

DISCUSSION

The results of the present study showed the prevalence of PFD to be 21.46%, with 25.6% bladder, 25.4% bowel, and 13.4% of sexual. Urinary incontinence emerged as the most

frequently reported complaint, and sexual dysfunction was the least.

In a study conducted by Bhamini Krishna Rao, et al. (2015) was reported to be 21% indicating a relatively high prevalence. The results of this study are consistent with our study, suggesting a comparable prevalence in both regions [3].

Firthous. Jannathul et al. (2022) reported PFD prevalence of 54.7%, significantly higher than in our study, with bowel incontinence at 50% and urinary incontinence at 82.4%. The difference in eligibility criteria was that all women between 3 months and 1 year postpartum were excluded from the study [15].

A recent study conducted by Divya Rathod, et al. (2024) found urinary incontinence to be 32%, which is again quite higher than our study. This difference may be due to differences in the exclusion criteria between the two studies. The study excluded women with psychiatric disorders, while in the current study, women with any neurological or orthopedic conditions that have a direct impact on the pelvic floor were all excluded [16].

Pelvic floor dysfunction with respect to bladder function showed a statistically significant association with age. The common age group affected was between 41 and 50 years in our study. This can be attributed to a number of factors, including hormonal changes linked to menopause and perimenopause, decreased estrogen levels that affect the integrity of bladder and urethral tissue, and age-related weakening of pelvic support structures [17,19,20].

The history of infection, the mode of delivery, and the number of deliveries are significantly associated with bladder-related symptoms. Women who have had infections in the past are more likely to develop urinary disorders due to bladder irritation and abnormal voiding reflexes [24]. Additionally, women who have undergone FTNVD and given birth one to three times are most frequently impacted since repeated pregnancy and childbirth put more strain on the pelvic floor muscles, especially in those who have given birth vaginally [21,22].

Women aged 60 years and above had more bowel-related dysfunction. This could be due to age-related changes, physiological decline, weakened pelvic floor and abdominal musculature, decreased rectal compliance and anal sphincter tone, and degeneration of enteric nervous system function [18,19]. Medical History, Number of deliveries, and Type of delivery have a positive association with bowel-related dysfunction. This could be due to decreased physical activity, dehydration, a low-fibre diet, and polypharmacy (particularly with regard to opioids, antacids, antidepressants, and calcium supplements), which increases the risk of diabetes or other gastrointestinal issues [18,19,20]. Due to repeated overstretching of the pelvic floor muscles, progressive weakening of the pelvic support, and an increased risk of anal sphincter and pudendal nerve injury, women who have given birth 4-6 times are more likely to experience bowel disorders [10]. Normal vaginal delivery contributes to levator ani muscle stretching and potential perineal tears that compromise anorectal continence mechanisms. These anatomical and neurological abnormalities may eventually result in fecal incontinence, urgency, constipation, or blocked defecation [21,22,25].

Sexual symptoms among non-pregnant women become more noticeable and clinically relevant in the age group 20 to 30 years, as it is the most sexually active stage of life. Sexual issues are therefore more frequently reported in this age group [18]. Mode of delivery, number of deliveries, and history of infection are positive. Like issues with dyspareunia, reduced libido, difficulty achieving orgasm, and restricted sexual involvement, which can be a result of reflex hypertonicity or weakening of the pelvic floor muscles, persistent inflammation, pelvic pain, and irritation of the bladder or vagina [1,2,18,26].

Limitations

In Indian settings, stigma may be a contributor to underreporting of symptoms related to PFD, especially when it comes to sexual symptoms. The study's outcome might have been impacted by an uneven distribution of age groups. Recall bias may be introduced by self-reported data.

Clinical Implication

The results of this study emphasize the significance of early screening and detection of PFD symptoms from a clinical perspective. Early detection can enable prompt physiotherapeutic measures, perhaps stopping progression, enhancing quality of life, and lowering long-term morbidity in women. Therefore, the current study highlights the need for greater awareness and preventive measures in women's health care and adds important evidence regarding the incidence of PFD symptoms.

CONCLUSION

The prevalence of symptoms related to pelvic floor dysfunction is high, which highlights the need for definitive diagnosis and its treatment. Awareness and educational programs can be held so that women identify their symptoms at an early stage, get them diagnosed, and prevent further complications.

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Appendix 1: Pelvic Floor Dysfunction Questionnaires

SECTION 1 - DEMOGRAPHIC DATA					
Name:			Age:		
Address:			Occupation:		
Height:	Weight:		BMI:		
Marriage status:			Duration of marriage:		
Medical history:					
Surgical history:					
History of infection: (UTI/ TORCH/ STD/ HIV/ Candidiasis/ PID)					
How many times have you become pregnant or conceived? If not, then mention n/a			Type of delivery: (Episiotomy/ Normal/ C-section/ instrumental (forceps/vaccum)		
Are your periods regular: YES/ NO					
Have you attended menopause? If yes, Age at which menopause occurred.					
Are you currently experiencing any menopausal symptoms? (Tick all that apply)					
Hot flashes	Night sweats	Mood swings	Vaginal dryness	Sleep disturbances	None of the above
How many litres of water do you consume each day?					
How many times do you empty your bladder in a day?					
Upto 7	8-10	11-15	> 15		
How many times a day do you pass stool?					
Once a Day	Twice a Day	> 3 Times / day	May Or May Not Pass Daily		
Are you comfortable talking about your problems with pelvic floor dysfunction? (Yes/No)					

SECTION 2: SYMPTOMS RELATED TO URINARY DYSFUNCTION **Select the option that best describes how often you face the following symptoms in YES/NO format**	
1) Do you experience a burning sensation only at the start of urine?	
2) Do you feel unable to empty your bladder?	
3) Do you have difficulty starting or frequent stopping/ starting of the urine stream?	

4) Do you experience voiding within a few minutes of a previous void?	
5) Are you unable to contract or hold hard to maintain bladder control?	
6) Do you need to rush or hurry to pass urine?	
7) Do you usually experience urine leakage related to coughing, sneezing, or laughing?	
8) Do you have a feeling of increased pelvic pressure	

SECTION 3: SYMPTOMS RELATED TO BOWEL DYSFUNCTION **Select the option that best describes how often you face the following symptoms in YES/NO format**	
1) Do you feel something falling out of your rectal area?	
2) Do you have pain when you pass your stool?	
3) Do you have to push hard a lot to empty your bowel?	
4) Do you experience pain at your lower back after/while passing stool	
5) Are you dealing with constipation?	
6) Is there any visible blood in your stool?	
7) Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	
8) If your stool is loose, is it usually out of your control?	

SECTION 4: SYMPTOMS RELATED TO SEXUAL DYSFUNCTION **Select the option that best describes how often you face the following symptoms in YES/NO format**	
1) Are you sexually active?	
2) Do you regularly participate in sexual activity with your partner?	
3) Do you currently experience pain during/ after intercourse?	
4) Do you currently experience pain in between or during half process?	
5) Do you avoid or limit sexual activity because you are afraid of leaking urine and stool?	
6) Do you have decrease sensation in vaginal canal?	
7) Do you leak stools or urine when performing any kind of sexual activity?	