National Institute for Health and Care Excellence

Final

Pelvic floor dysfunction: prevention and non-surgical management

[R] Community-based multidisciplinary teams

NICE guideline NG210

Evidence review underpinning recommendations 1.6.1 to 1.6.3 as well as a research recommendation in the NICE guideline

December 2021

Final

These evidence reviews were developed by the National Guideline Alliance which is a part of the Royal College of Obstetricians and Gynaecologists

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The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or service users. The recommendations in this guideline are not mandatory and the guideline does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Local commissioners and/or providers have a responsibility to enable the guideline to be applied when individual health professionals and their patients or service users wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with compliance with those duties.

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Community based multidisciplinary teams

Review question

What competencies should be involved in a community-based multidisciplinary team for the management of symptoms associated with pelvic floor dysfunction?

Introduction

Women with symptoms associated with pelvic floor dysfunction should be treated in primary care and have community-based care before needing to be referred to a specialist centre, which often specialises in surgery. However, pelvic floor dysfunction is a complex condition, and input may be required from a range of healthcare professionals with different skills and knowledge. The aim of this review is to determine which competencies should be available to women with symptoms of pelvic floor dysfunction to ensure the best overall care is received.

Summary of the protocol

See Table 1 for a summary of the Population, Intervention, Comparison and Outcome (PICO) characteristics of this review.

Table 1: Summary of the protocol (PICO table)

Population	Women and young women (aged 12 years and older) with symptoms associated with pelvic floor dysfunction
Intervention	• Any community-based care team • Any multi-disciplinary team
Comparison	• Any alternative community-based care team (with different competencies of included members to that in the intervention team) • Any alternative multi-disciplinary team (with different competencies of included members to that in the intervention team) • No care team • An individual (for example General Practitioner (GP) alone)
Outcome	**Critical** • Satisfaction with care received • Adherence to prescribed care • Health-related quality of life (only validated scales will be included) • Changes in referral rate to secondary care **Important** • Subjective measure of change in the following symptoms: ○ urinary incontinence ○ emptying disorders of the bladder ○ faecal incontinence ○ emptying disorders of the bowel ○ pelvic organ prolapse ○ sexual dysfunction ○ chronic pelvic pain syndromes • Anxiety and depression

GP: general practitioner

For further details, see the review protocol in appendix A.

Methods and process

This evidence review was developed using the methods and process described in Developing NICE guidelines: the manual. Methods specific to this review question are described in the review protocol in appendix A and the methods document (supplementary document 1).

Declarations of interest were recorded according to NICE's conflicts of interest policy.

Clinical evidence

Included studies

One randomised controlled trial (RCT) was included for this review (Du Moulin 2007).

The included study is summarised in Table 2.

This study aimed to assess the short-term and long-term effects of introducing a continence nurse to the care of community-dwelling women with urinary incontinence (UI). Women would either be seen by a continence nurse (intervention) or the GP (control group). We note that this study did not involve a multidisciplinary team in all assessment, treatment and decision-making areas of the woman's care. However, the continence nurse had a protocol written by a multidisciplinary team (MDT) comprising of a GP, urologists, physiotherapist and continence nurse to help guide treatment. The GP also had access to a physiotherapist and urologist. The evidence from this study has been downgraded for indirectness.

See the literature search strategy in appendix B and study selection flow chart in appendix C.

Excluded studies

Studies not included in this review are listed, and reasons for their exclusion are provided in appendix K.

Summary of studies included in the evidence review

Summaries of the studies that were included in this review are presented in Table 2.

Table 2: Summary of included studies.

Study	Population	Intervention	Comparison	Outcomes
Du Moulin 2007 RCT Netherlands	N=45 Intervention n=35 Control n=10	Assessed and treated by a continence nurse	Assessed and treated by a GP	All outcomes at 6 months and 12 months • Incontinent episodes • Pads used • IIQ • UDI • EQ-5D (12 months only) • Satisfaction

IIQ, incontinence impact questionnaire; EQ-5D, EuroQol; UDI, urogenital distress inventory; UI, urinary incontinence; RCT: randomised controlled trial

See the full evidence tables in appendix D. No meta-analysis was conducted (and so there are no forest plots in appendix E).

Quality assessment of studies included in the evidence review

See the evidence profiles in appendix F.

Economic evidence

Included studies

A single economic search was undertaken for all topics included in the scope of this guideline but no economic studies were identified which were applicable to this review question. See the literature search strategy in appendix B and economic study selection flow chart in appendix G.

Excluded studies

Economic studies not included in this review are listed, and reasons for their exclusion are provided in appendix K.

Summary of studies included in the economic evidence review

See the economic evidence tables in appendix H and economic evidence profiles in appendix I.

Economic model

No economic modelling was undertaken for this review because the committee agreed that other topics were higher priorities for economic evaluation and because there was unlikely to be any comparative effectiveness data.

Brief summary of the evidence

Continence nurse compared to GP

- Very-low quality evidence showed that treatment from a continence nurse resulted in no difference in incontinence episodes, pads used, IIQ and UDI scores compared to treatment from a GP at both 6 and 12 months follow-up.
- Very-low quality evidence showed that treatment from a continence nurse resulted in better satisfaction with care at both 6 and 12 months' follow-up compared to treatment from a GP.
- Very-low quality evidence showed that treatment from a continence nurse resulted in no difference in EQ-5D scores compared to treatment from a GP at 12 months' follow-up.

No evidence was identified for the outcomes adherence to prescribed care, changes in referral rate to secondary care, and anxiety and depression. The evidence did also not address any other symptoms of pelvic floor dysfunction apart from urinary incontinence (such as, emptying disorders of the bladder, faecal incontinence, emptying disorders of the bowel, pelvic organ prolapse, sexual dysfunction and chronic pelvic pain syndromes).

The committee's discussion of the evidence

Interpreting the evidence

The outcomes that matter most

The committee agreed that satisfaction with care, adherence to care, health related quality of life and changes in referral rate to secondary care were the most critical outcomes for this

review question. These outcomes are likely to have the most impact on service delivery within the NHS. Improvement of symptoms and changes in anxiety and depression were considered important outcomes as these are most likely to impact the woman's life, and many women report the psychological impact that pelvic floor dysfunction has on their lives.

The quality of the evidence

The quality of the evidence for this review was assessed using GRADE and was rated very low quality. The evidence was downgraded due to serious concerns with the risk of bias. Serious concerns were identified in the randomisation domain and some concerns were identified in the deviation from intended interventions, missing outcome data, measurement of the outcome and selection of the reported results domains. The evidence was also downgraded for indirectness as the intervention (a continence nurse) and comparator (a GP) are not strictly a MDT. The evidence was also downgraded for imprecision as the confidence intervals crossed either one or both the calculated minimal important differences (MIDs).

No evidence was found comparing community based care teams to other types of care team.

Benefits and harms

The committee were conscious that only one study was identified, which was very low in quality. However, they agreed that it was important to make a recommendation as the initial assessment of pelvic floor dysfunction can be complex (due to the number of symptoms that are associated with it and the wide age range), meaning women may benefit from a community-based multidisciplinary team management with members who have the relevant competencies. Therefore, the recommendations made were based on their expertise, experience and by consensus.

The committee did not recommend including specific roles (such as specialist incontinence nurses) in the team, because community healthcare professionals can be trained to carry out non-specialist management, and because specific specialists may not be available in all areas and the inclusion of such roles in every team could have substantial costs. Due to the potential substantial costs the committee recognised that a community-based multidisciplinary team approach may not be a routine management strategy for pelvic floor dysfunction but that it should be considered on a case by case basis. The committee envisaged that a multidisciplinary approach is primarily a mechanism to ensure effective communications between those involved in the management of a woman's pelvic floor dysfunction rather than a team that is co-located which would more difficult to implement. Due to the wide age range and number of symptoms associated with pelvic floor dysfunction the committee highlighted that there may be more than one team that deals with pelvic floor dysfunction potentially in different settings or for different groups of women or focussed on different symptoms. However, the committee did not want to be prescriptive about how this may be divided since there was insufficient evidence to base this on.

Access to experienced and trained multidisciplinary team members is likely to vary widely in different areas. They noted that such a team would need to be community based to ensure it is accessible to all women with pelvic floor dysfunction. The committee focused on competencies, based on their own experience of the key knowledge and experience that is needed in the team to implement the other recommendations in this guideline (ranging from an awareness of the psychological impact, to identification of risk factors, being able to assess symptoms or the impact of symptoms on mobility and personal care and manage symptoms and provide training to women and healthcare professionals).

The evidence identified showed that by introducing a nurse with competencies in continence care into the community care, patient satisfaction improved. Although the evidence was not directly relevant to multidisciplinary or community-based teams, it supported the committee's experience that the inclusion of a range of clinicians with competencies in pelvic floor dysfunction improves symptoms through better management and planning of treatment

following on from assessment in primary care. They also discussed that competencies of healthcare professionals in supervising pelvic floor muscle training would have a positive impact on other outcomes such as adherence and satisfaction. These outcomes are important factors in effective management of pelvic floor dysfunction because they have an indirect impact on improving symptoms because women are more likely to be motivated to continue with their treatment plan.

To tailor management to the women's needs and preferences it was noted that a shared decision-making approach should be taken with the woman to agree a management plan.

The committee acknowledged that the evidence was insufficient in helping service managers and commissioners to decide on the optimal mix of professionals to manage this complex condition in non-specialist settings. They therefore decided to make a research recommendation for this topic.

Cost effectiveness and resource use

In the absence of any economic evidence, the committee made a qualitative assessment of cost-effectiveness to inform recommendations based on their experience and expertise.

With some supporting evidence from the clinical review the committee believed that the inclusion of clinicians with competencies in pelvic floor dysfunction in a multidisciplinary team is likely to result in improved patient outcomes. The committee recognised that there may be some costs associated with their recommendations as there is variation in current practice. There were likely to be some upfront training costs associated with obtaining the necessary competencies required for those belonging to a community-based pelvic floor dysfunction multidisciplinary team. There may also be some time costs associated with the operation of the multidisciplinary team itself. However, the committee considered that these costs were likely to represent value for money for the NHS as they would be outweighed by better outcomes and potential cost savings in the long term. However, the committee envisaged that the multidisciplinary team approach was primarily a means of achieving effective communications between those involved in the management of a woman's pelvic floor dysfunction (such as continence teams and primary care) and that this is unlikely to have significant implications for staffing, workload or resources.

Recommendations supported by this evidence review

This evidence review supports recommendations 1.6.1 to 1.6.3 as well as a research recommendation on the roles needed in a community-based multidisciplinary team in the NICE guideline.

References

Du Moulin 2007

Du Moulin, M. F., Hamers, J. P., Paulus, A., Berendsen, C. L., Halfens, R., Effects of introducing a specialized nurse in the care of community-dwelling women suffering from urinary incontinence: a randomized controlled trial, Journal of wound, ostomy, and continence nursing: official publication of the wound, ostomy and continence nurses society, 34, 631-640, 2007

Appendices

Appendix A – Review protocol

Review protocol for review question: What competencies should be involved in a community-based multidisciplinary team for the management of symptoms associated with pelvic floor dysfunction?

Table 3: Review protocol

ID	Field	Content
0.	PROSPERO registration number	CRD42020170333
1.	Review title	Community-based multidisciplinary teams
2.	Review question	What competencies should be involved in a community-based multidisciplinary team for the management of symptoms associated with pelvic floor dysfunction?
3.	Objective	Women with symptoms associated with pelvic floor dysfunction should be treated in primary care and have community-based care before needing to be referred to a specialist centre, which often specialises in surgery. However, pelvic floor dysfunction is a complex condition, and input may be required from a range of healthcare professionals with different skills and knowledge. The objective of this review is to determine which competencies should be available to women with symptoms of pelvic floor dysfunction to ensure the best overall care is received.
4.	Searches	The following databases will be searched: • Cochrane Database of Systematic Reviews (CDSR) • Cochrane Central Register of Controlled Trials (CENTRAL) • MEDLINE & Medline in Process • Embase • CINAHL or Emcare • PsycINFO Searches will be restricted by: • Date limit: 1980 onwards (see section 10 for justification) • English language • Human studies Other searches:

ID	Field	Content
		Inclusion lists of potentially relevant systematic reviews The full search strategies for MEDLINE database will be published in the final review. For each search, the principal database search strategy is quality assured by a second information scientist using an adaptation of the PRESS 2015 Guideline Evidence-Based Checklist.
5.	Condition or domain being studied	The following symptoms will be addressed as long as they are associated with pelvic floor dysfunction: urinary incontinence, emptying disorders of the bladder, faecal incontinence, emptying disorders of the bowel, pelvic organ prolapse, sexual dysfunction and chronic pelvic pain syndromes.
6.	Population	Inclusion • Women and young women (aged 12 years and older) with symptoms associated with pelvic floor dysfunction Exclusion • Studies which include women, with urinary incontinence, emptying disorders of the bladder, faecal incontinence, emptying disorders of the bowel, pelvic organ prolapse, sexual dysfunction and chronic pelvic pain syndromes which are not due to pelvic floor dysfunction will be excluded. For example women who have urinary incontinence due to a neurological condition or pelvic cancer will be excluded. If any ambiguity exists, at least two reviewers will make the final decision if to include or exclude the study. • Men • Babies and children
7.	Intervention	• Any community-based care team • Any multi-disciplinary team
8.	Comparator	• Any alternative community-based care team (with different competencies of included members to that in the intervention team) • Any alternative multi-disciplinary team (with different competencies of included members to that in the intervention team) • No care team • An individual (for example GP alone)
9.	Types of study to be included	• Systematic reviews of RCTs • RCTs If there is no RCT evidence then other studies designs will be considered, namely • Non-randomised controlled, comparative studies or quasi randomised trials • Comparative prospective cohort studies • Comparative retrospective cohort studies Note: For further details, see the algorithm in appendix H, Developing NICE guidelines: the manual.

ID	Field	Content
10.	Other exclusion criteria	• Studies with a mixed population (specifically women with symptoms such as urinary incontinence which are associated with pelvic floor dysfunction and women with symptoms that are not associated with pelvic floor dysfunction) will be excluded, unless subgroup analysis for those women with symptoms associated with pelvic floor dysfunction has been reported • Conference abstracts will be excluded because these do not typically provide sufficient information to fully assess risk of bias • Qualitative studies will not be included • Only articles published after 1980 will be included. This was agreed by the committee as this is the date that the condition "pelvic floor dysfunction" was recognised to include agreed terminology on symptoms. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2815805/
11.	Context	Studies which explicitly demonstrate a change in outcomes for symptoms associated with pelvic floor dysfunction will be prioritised for decision making in regard to recommendations, and these recommendations will apply to those receiving care in any the community, in primary a care, and secondary care. Included studies will be relevant for developing and improving multidisciplinary care practice for women with symptoms associated with pelvic floor dysfunction.
12.	Primary outcomes (critical outcomes)	• Satisfaction with care received • Adherence to prescribed care • Health-related quality of life (only validated scales will be included) • Changes in referral rate to secondary care
13.	Secondary outcomes (important outcomes)	• Subjective measure of change in the following symptoms: ○ urinary incontinence ○ emptying disorders of the bladder ○ faecal incontinence ○ emptying disorders of the bowel ○ pelvic organ prolapse ○ sexual dysfunction ○ chronic pelvic pain syndromes • Anxiety and depression For the above outcomes, only validated tools will be included (for example: ICIQ-UI, ICIQ-VS, BFLUTS, KHQ, UDI, HADS, ISI, ePAQ, POPSS, PISQ, POPQ, FISI, FIQL, GIQLI, PAC-QM, PAC –SYM, PDI, BPI)
14.	Data extraction (selection and coding)	All references identified by the searches and from other sources will be uploaded into STAR and de-duplicated.

ID	Field	Content
		Titles and abstracts of the retrieved citations will be screened to identify studies that potentially meet the inclusion criteria outlined in the review protocol. Dual sifting will not be conducted for this review question. Full versions of the selected studies will be obtained for assessment. Studies that fail to meet the inclusion criteria once the full version has been checked will be excluded at this stage. Each study excluded after checking the full version will be listed, along with the reason for its exclusion. A standardised form will be used to extract data from studies. One reviewer will extract relevant data into a standardised form, and this will be quality assessed by a senior reviewer. Information to be extracted from studies includes: study type, study dates, location of study, funding, inclusion and exclusion criteria, participant characteristics, and details of the intervention and comparator.
15.	Risk of bias (quality) assessment	Risk of bias of individual studies will be performed using the following checklists: • ROBIS tool for systematic reviews • Cochrane RoB tool v.2 for RCTs and quasi-RCTs • Cochrane ROBINS-I tool for non-randomised (clinical) controlled trials and cohort studies The quality assessment will be performed by one reviewer and this will be quality assessed by a senior reviewer.
16.	Strategy for data synthesis	Depending on the availability of the evidence, the findings will be summarised narratively or quantitatively. Data Synthesis Where possible, pair wise meta-analyses will be conducted using Cochrane Review Manager software. A fixed effect meta-analysis will be conducted and data will be presented as risk ratios for dichotomous outcomes. Peto odds ratio will be used for outcomes with zero events Mean differences or standardised mean differences will be calculated for continuous outcomes. Heterogeneity Heterogeneity in the effect estimates of the individual studies will be assessed using the I2 statistic. I2 values of greater than 50% and 80% will be considered as significant and very significant heterogeneity, respectively. In the presence of heterogeneity sub-group analysis will be conducted • According to risk of bias of individual studies • According to socioeconomic status of population included • By ethnicity of included populations Exact subgroup analysis may vary depending on differences identified within included studies. . If heterogeneity cannot be explained through subgroup analysis then a random effects model will be used for meta-analysis. If heterogeneity remains above 80% reviewers will consider if meta-analysis is appropriate given the characteristics of included. Minimal important differences (MIDs)

<table>
<tr><th>ID</th><th>Field</th><th colspan="2">Content</th></tr>
<tr><td></td><td></td><td colspan="2">For outcomes where validated tools are included (for example ICIQ), then the published MIDs will be used.
Where no published MID is available, default MIDs will be used:
• For risk ratios: 0.8 and 1.25.
• For continuous outcomes:
o For one study: the MID is calculated as +/-0.5 times the baseline SD of the control arm.
o For two studies: the MID is calculated as +/-0.5 times the mean of the SDs of the control arms at baseline. If baseline SD is not available, then SD at follow up will be used.
o For three or more studies (meta-analysed): the MID is calculated by ranking the studies in order of SD in the control arms. The MID is calculated as +/- 0.5 times median SD.
o For studies that have been pooled using SMD (meta-analysed): +0.5 and -0.5 in the SMD scale are used as MID boundaries.

<u>Validity</u>
The confidence in the findings across all available evidence will be evaluated for each outcome using an adaptation of the ‘Grading of Recommendations Assessment, Development and Evaluation (GRADE) toolbox’ developed by the international GRADE working group: http://www.gradeworkinggroup.org/</td></tr>
<tr><td>17.</td><td>Analysis of sub-groups</td><td colspan="2">All data will initially be pooled for overall analysis; however, if data is available, separate analysis will also be conducted on:
• Women who are pregnant or after pregnancy
• Women before and after gynaecological surgery
• Women aged 65 or older
• Young women (aged 12 to 18)
• Women with physical disabilities
• Women with cognitive impairment
• Women who are in perimenopause (pre- and post-)
• According to those who do not identify themselves as women, but who have female pelvic organs
Recommendations will apply to all those with pelvic floor dysfunction unless there is evidence of a difference in these stratified groups</td></tr>
<tr><td>18.</td><td>Type and method of review</td><td>☒</td><td>Intervention</td></tr>
<tr><td></td><td></td><td>☐</td><td>Diagnostic</td></tr>
<tr><td></td><td></td><td>☐</td><td>Prognostic</td></tr>
<tr><td></td><td></td><td>☐</td><td>Qualitative</td></tr>
<tr><td></td><td></td><td>☐</td><td>Epidemiologic</td></tr>
</table>

ID	Field	Content		
		☐	Service Delivery	
		☐	Other (please specify)	
19.	Language	English		
20.	Country	England		
21.	Anticipated or actual start date	July 2020		
22.	Anticipated completion date	August 2021		
23.	Stage of review at time of this submission	Review stage	Started	Completed
		Preliminary searches	☐	☐
		Piloting of the study selection process	☐	☐
		Formal screening of search results against eligibility criteria	☐	☐
		Data extraction	☐	☐
		Risk of bias (quality) assessment	☐	☐
		Data analysis	☐	☐
24.	Named contact	5a. Named contact National Guideline Alliance 5b Named contact e-mail PreventionofPOP@nice.org.uk 5e Organisational affiliation of the review National Institute for Health and Care Excellence (NICE) and National Institute for Health and Care Excellence (NICE) and National Guideline Alliance		
25.	Review team members	NGA technical team		
26.	Funding sources/sponsor	This systematic review is being completed by the National Guideline Alliance, which receives funding from NICE.		

ID	Field	Content	
27.	Conflicts of interest	All guideline committee members and anyone who has direct input into NICE guidelines (including the evidence review team and expert witnesses) must declare any potential conflicts of interest in line with NICE's code of practice for declaring and dealing with conflicts of interest. Any relevant interests, or changes to interests, will also be declared publicly at the start of each guideline committee meeting. Before each meeting, any potential conflicts of interest will be considered by the guideline committee Chair and a senior member of the development team. Any decisions to exclude a person from all or part of a meeting will be documented. Any changes to a member's declaration of interests will be recorded in the minutes of the meeting. Declarations of interests will be published with the final guideline.	
28.	Collaborators	Development of this systematic review will be overseen by an advisory committee who will use the review to inform the development of evidence-based recommendations in line with section 3 of Developing NICE guidelines: the manual. Members of the guideline committee are available on the NICE website: https://www.nice.org.uk/guidance/indevelopment/gid-ng10119/documents	
29.	Other registration details		
30.	Reference/URL for published protocol	https://www.crd.york.ac.uk/prospero/display_record.php?RecordID=170333	
31.	Dissemination plans	NICE may use a range of different methods to raise awareness of the guideline. These include standard approaches such as: • notifying registered stakeholders of publication • publicising the guideline through NICE's newsletter and alerts • issuing a press release or briefing as appropriate, posting news articles on the NICE website, using social media channels, and publicising the guideline within NICE.	
32.	Keywords	Multidisciplinary care, community-based care, pelvic floor dysfunction	
33.	Details of existing review of same topic by same authors	Not applicable	
34.	Current review status	☒	Ongoing
		☐	Completed but not published
		☐	Completed and published
		☐	Completed, published and being updated
		☐	Discontinued
35..	Additional information		
36.	Details of final publication	www.nice.org.uk	

BFLUTS: Bristol Female Lower Urinary Tract Symptoms Questionnaire; BPI: Brief pain inventory; CDSR: Cochrane Database of Systematic Reviews; CENTRAL: Cochrane Central Register of Controlled Trials; ePAQ: Electronic personal health questionnaire; FIQL: Faecal incontinence quality of life scale; FISI: Faecal incontinence severity index;

GIQLI: Gastrointestinal quality of life index; GRADE: Grading of Recommendations Assessment, Development and Evaluation; ICIQ-UI: International Consultation on Incontinence Questionnaire- Urinary incontinence; ICIQ-VS: International Consultation on Incontinence questionnaire – vaginal symptoms; ISI: Incontinence symptom index; KHQ: Kings health questionnaire; MID: minimally important difference; NGA: National Guideline Alliance; NHS: National health service; NICE: National Institute for Health and Care Excellence; PAC-QL: patient assessment of constipation - quality of life; PAC-SYM: Patient assessment of constipation symptoms; PDI: Pain disability index; PFMT: pelvic floor muscle training; PISQ: Pelvic organ prolapse/urinary incontinence sexual questionnaire; POPQ: Pelvic organ prolapse quantification system; POP-SS: Pelvic organ prolapse symptom score; QoL: Quality of Life; RCT: randomised controlled trial; RoB: risk of bias; SD: standard deviation: UDI: Urinary distress index

Appendix B – Literature search strategies

Literature search strategies for review question: What competencies should be involved in a community-based multidisciplinary team for the management of symptoms associated with pelvic floor dysfunction?

Clinical Search

Database(s): Medline & Embase (Multifile) – OVID interface
Embase Classic+Embase 1947 to 2020 May 05; **Ovid MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily** 1946 to May 05, 2020
Date of last search: 6 May 2020

Multifile database codes: emczd = Embase Classic+Embase; ppez= MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily

#	Searches
1	Pelvic Floor/ or Pelvic Floor Disorders/ or exp *Urinary Incontinence/ or *Urinary Bladder, Overactive/ or exp *Pelvic Organ Prolapse/ or *Rectocele/ or *Fecal Incontinence/ or Urinary Retention/ or Fecal Impaction/ or Vaginismus/
2	1 use ppez
3	pelvis floor/ or pelvic floor disorder/ or exp *urine incontinence/ or *overactive bladder/ or *bladder instability/ or exp *pelvic organ prolapse/ or *rectocele/ or *feces incontinence/ or urine retention/ or defecation disorder/ or Feces Impaction/ or female sexual dysfunction/ or vaginism/
4	3 use emczd
5	(pelvi$ adj (floor$ or diaphragm$) adj3 (dysfunction$ or disorder$ or fail$ or impair$ or incompeten$ or insufficien$ or dyssynerg$ or symptom$ or laxity or change$ or care$ or health$ or wellbeing$ or well-being$ or prevent$ or rehabilitat$ or weak$ or hypertonic$ or overactiv$ or over-activ$)).tw.
6	(pelvi$ adj (dysfunction$ or disorder$ or fail$ or impair$ or incompeten$ or insufficien$ or dyssynerg$ or symptom$ or laxity or care$ or health$ or wellbeing$ or well-being$ or prevent$ or rehabilitat$ or weak$ or hypertonic$ or overactiv$ or over-activ$)).tw.
7	((stress$ or mix$ or urg$ or urin$) adj5 incontinen$).ti.
8	(bladder$ adj5 (overactiv$ or over-activ$ or instabilit$ or hyper-reflex$ or hyperreflex$ or incontinen$)).ti.
9	(detrusor$ adj5 (overactiv$ or over-activ$ or instabilit$ or hyper-reflex$ or hyperreflex$)).ti.
10	(frequency adj2 urgency).ti.
11	((urin$ or bladder$) adj2 (urg$ or frequen$)).ti.
12	(SUI or OAB).ti.
13	(pelvic$ adj3 organ$ adj3 prolaps$).ti.
14	(urinary adj3 bladder adj3 prolaps$).ti.
15	((vagin$ or urogenital$ or genit$ or uter$ or viscer$ or anterior$ or posterior$ or apical or pelvi$ or vault$ or urethr$ or bladder$ or cervi$ or rectal or rectum) adj3 prolaps$).ti.
16	(splanchnoptos$ or visceroptos$).ti.
17	(hernia$ adj3 (pelvi$ or vagin$ or urogenital$ or uter$ or bladder$ or urethr$ or viscer$)).ti.
18	(urethroc?ele$ or enteroc?ele$ or sigmoidoc?ele$ or proctoc?ele$ or rectoc?ele$ or cystoc?ele$ or rectoenteroc?ele$ or cystourethroc?ele$).ti.
19	((f?ecal or f?eces or f?ecally or anal or anally or stool or stools or bowel or double or def?ecat$) adj5 (incontinence or incontinent or urge$ or leak or leaking or leakage or soiling or seeping or seepage or impacted or impaction)).ti.
20	(urin$ adj3 (retention$ or retain$)).tw.
21	(voiding adj (disorder$ or dysfunction$ or problem$)).tw.
22	(empty$ adj disorder$ adj3 (bowel$ or bladder$ or vesical$ or stool$)).tw.
23	((urogeni$ or anorec$ or ano-rec$ or ano rec$) adj3 dysfunction$).tw.
24	((difficult$ or delay$ or irregular$ or infrequen$ or pain$) adj3 (def?ecat$ or stool$ or faeces or feces or bowel movement$)).tw.
25	(obstruct$ adj3 def?ecat$).tw.
26	((def?ecat$ or evacuat$) adj3 (disorder$ or dysfunction$)).tw.
27	outlet$ dysfunction$ constipa$.tw.
28	(dys?ynerg$ adj def?ecat$).tw.
29	(pelvi$ adj3 dyskines$).tw.
30	pelvi$ outlet$ obstruct$.tw.
31	anismus$.tw.
32	puborectal$ contract$.tw.
33	((rectal or rectum) adj3 urge$).tw.
34	(female adj sex$ adj (dysfunct$ or satisf$ or problem$ or symptom$ or arous$ or activit$ or disorder$)).tw.
35	(obstruct$ adj3 intercourse).tw.
36	(vagin$ adj3 laxity$).tw.
37	(vagin$ adj wind).tw.
38	vaginismus$.tw.
39	(vagin$ adj penetrat$ adj disorder$).tw.

#	Searches
40	or/2,4-39
41	Interdisciplinary Communication/ or *Physician-Patient Relations/ or Interprofessional Relations/ or Health Services Accessibility/ or "Delivery of Health Care"/ or Delivery of Health Care, Integrated/ or Total Quality Management/ or Comprehensive Health Care/ or Continuity of Patient Care/ or Primary Health Care/ or Community Health Services/ or *Family Practice/ or *"Referral and Consultation"/ or "Referral and Consultation"/og or Health Personnel/ or Patient Care Team/ or *Nursing, Team/ or *Nurse Clinicians/ or Community Health Nursing/ or *Public Health Nursing/ or Nursing Care/ or *Nurse's Role/ or Models, Nursing/ or Models, Organizational/
42	41 use ppez
43	interdisciplinary communication/ or *doctor patient relation/ or *health care access/ or *health care delivery/ or integrated health care system/ or *integrative medicine/ or *total quality management/ or *primary medical care/ or *community care/ or *general practice/ or *patient referral/ or *health care personnel/ or *patient care/ or teamwork/ or team nursing/ or clinical nurse specialist/ or community health nursing/ or *nursing care/ or *nursing discipline/ or nursing staff/ or *nursing/ or nursing organization/ or nurse attitude/ or *model/ or nonbiological model/ or multidisciplinary team/ or "multidisciplinary team care"/
44	43 use emczd
45	((multiprofess$ or multi-profess$ or interprofess$ or inter-profess$ or transprofess$ or trans-profess$ or multidisciplin$ or multi-disciplin$ or interdisciplin$ or inter-disciplin$ or transdisciplin$ or trans-disciplin$ or crossdisciplin$ or cross-disciplin$) adj3 communicat$).tw.
46	(integrat$ adj (clinic$ or unit or service$ or care or therap$ or management or approach$ or treat$ or system$ or model$)).tw.
47	((communitybase$ or community-base$ or community base$) adj3 (clinic$ or center$ or centre$ or service$ or team$ or group$ or meeting or staff$ or care or therap$ or management or approach$ or strateg$ or plan or role or cooperat$ or co-operat$ or treat$ or panel$ or program$ or system$ or setting$ or unit or training or examination$ or relationship$ or network$)).tw.
48	(refer$ adj (pattern$ or pathway$)).tw.
49	(peer adj network$).tw.
50	(((patient$ or medical or health) adj1 care team$) or healthcare team$).tw.
51	(teamwork$ or team-work$ or team work$ or teambased$ or team-based$ or team based$).tw.
52	(team adj approach).tw.
53	(collaborat$ adj3 (care or approach$ or management or treatment or therapy or protocol or model or team$ or working or patientcentre$ or patient-centre$ or patientfocus$ or patient-focus$ or multiple or multiprofess$ or multi-profess$ or interprofess$ or inter-profess$ or transprofess$ or trans-profess$ or multidisciplin$ or multi-disciplin$ or interdisciplin$ or inter-disciplin$ or transdisciplin$ or trans-disciplin$ or crossdisciplin$ or cross-disciplin$ or stake-holder$ or stakeholder$)).tw.
54	(speciali$ adj3 (continence or nurs$)).tw.
55	((multiprofess$ or multi-profess$ or interprofess$ or inter-profess$ or transprofess$ or trans-profess$ or multidisciplin$ or multi-disciplin$ or interdisciplin$ or inter-disciplin$ or transdisciplin$ or trans-disciplin$ or crossdisciplin$ or cross-disciplin$) adj (clinic$ or center$ or centre$ or service$ or team$ or group$ or meeting or staff$ or care or therap$ or management or approach$ or strateg$ or plan or role or cooperat$ or co-operat$ or treat$ or panel$ or program$ or system$ or setting$ or unit or training or examination$ or relationship$ or network$ or responsibility$ or consensus$)).tw.
56	((multiprofess$ or multi-profess$ or interprofess$ or inter-profess$ or transprofess$ or trans-profess$ or multidisciplin$ or multi-disciplin$ or interdisciplin$ or inter-disciplin$ or transdisciplin$ or trans-disciplin$ or crossdisciplin$ or cross-disciplin$) adj3 management plan$).tw.
57	(MDT$1 or MDM or MDMs).tw.
58	((communit$ or specialist$ or multiprofess$ or multi-profess$ or interprofess$ or inter-profess$ or transprofess$ or trans-profess$ or multidisciplin$ or multi-disciplin$ or interdisciplin$ or inter-disciplin$ or transdisciplin$ or trans-disciplin$ or crossdisciplin$ or cross-disciplin$) adj4 (continence or incontinence) adj (clinic or clinics)).tw.
59	(continence adj3 (service$ or team$)).mp.
60	(continence adj care).ti.
61	((multiprofess$ or multi-profess$ or interprofess$ or inter-profess$ or transprofess$ or trans-profess$ or multidisciplin$ or multi-disciplin$ or interdisciplin$ or inter-disciplin$ or transdisciplin$ or trans-disciplin$ or crossdisciplin$ or cross-disciplin$) adj3 (pelvi$ care or continence care or pelvi$ floor)).tw.
62	(pelvic floor adj3 (clinic or clinics or team$)).tw.
63	(pessar$ adj (clinic or clinics or service or services)).tw.
64	((multiprofess$ or multi-profess$ or interprofess$ or inter-profess$ or transprofess$ or trans-profess$ or multidisciplin$ or multi-disciplin$ or interdisciplin$ or inter-disciplin$ or transdisciplin$ or trans-disciplin$ or crossdisciplin$ or cross-disciplin$) adj pain).tw.
65	(pelvi$ pain adj3 (clinic or clinics or service or services or team or teams)).tw.
66	or/42,44-65
67	40 and 66 [General Exclusions filter applied]

Database(s): Cochrane Library – Wiley interface
Cochrane Database of Systematic Reviews, Issue 5 of 12, May 2020; **Cochrane Central Register of Controlled Trials**, Issue 5 of 12, May 2020
Date of last search: 6 May 2020

#	Searches
#1	MeSH descriptor: [Pelvic Floor] this term only
#2	MeSH descriptor: [Pelvic Floor Disorders] this term only

#	Searches
#3	((pelvi* NEXT (floor* or diaphragm*) NEAR/3 (dysfunction* or disorder* or fail* or impair* or incompeten* or insufficien* or dyssynerg* or symptom* or laxity or change* or care* or health* or wellbeing* or well-being* or prevent* or rehabilitat* or weak* or hypertonic* or overactiv* or over activ* or over-activ*))):ti,ab,kw
#4	((pelvi* NEXT (dysfunction* or disorder* or fail* or impair* or incompeten* or insufficien* or dyssynerg* or symptom* or laxity or care* or health* or wellbeing* or well-being* or prevent* or rehabilitat* or weak* or hypertonic* or overactiv* or over activ* or over-activ*))):ti,ab,kw
#5	MeSH descriptor: [Urinary Incontinence] explode all trees
#6	MeSH descriptor: [Urinary Bladder, Overactive] this term only
#7	(((stress* or mix* or urg* or urin*) NEAR/5 incontinen*)):ti
#8	(((bladder* NEAR/5 (overactiv* or over activ* or over-activ* or instabilit* or hyper-reflex* or hyperreflex* or hyper reflex* or incontinen*)))):ti
#9	(((detrusor* NEAR/5 (overactiv* or over activ* or over-activ* or instabilit* or hyper-reflex* or hyperreflex* or hyper reflex*)))):ti
#10	((((urgency NEAR/2 frequency) or (frequency NEAR/2 urgency)))):ti
#11	((((urin* or bladder*) NEAR/2 (urg* or frequen*)))):ti
#12	(((SUI or OAB))):ti
#13	MeSH descriptor: [Pelvic Organ Prolapse] explode all trees
#14	MeSH descriptor: [Rectocele] this term only
#15	(((pelvic* NEAR/3 organ* NEAR/3 prolaps*))):ti
#16	(((urinary NEAR/3 bladder NEAR/3 prolaps*))):ti
#17	((((vagin* or urogenital* or genit* or uter* or viscer* or anterior* or posterior* or apical or pelvi* or vault* or urethr* or bladder* or cervi* or rectal or rectum) NEAR/3 prolaps*))):ti
#18	(((splanchnoptos* or visceroptos*))):ti
#19	(((hernia* NEAR/3 (pelvi* or vagin* or urogenital* or uter* or bladder* or urethr* or viscer*)))):ti
#20	(((urethroc?ele* or enteroc?ele* or sigmoidoc?ele* or proctoc?ele* or rectoc?ele* or cystoc?ele* or rectoenteroc?ele* or cystourethroc?ele*))):ti
#21	MeSH descriptor: [Fecal Incontinence] this term only
#22	((((faecal or fecal or faeces or feces or fecally or faecally or anal or anally or stool or stools or bowel or double or defecat* or defaecat*) NEAR/5 (incontinence or incontinent or urge* or leak or leaking or leakage or soiling or seeping or seepage or impacted or impaction)))):ti
#23	MeSH descriptor: [Urinary Retention] this term only
#24	(((urin* NEAR/3 (retention* or retain*)))):ti,ab,kw
#25	(((voiding NEXT (disorder* or dysfunction* or problem*)))):ti,ab,kw
#26	(((empty* NEXT disorder* NEAR/3 (bowel* or bladder* or vesical* or stool*)))):ti,ab,kw
#27	((((urogeni* or anorec* or ano-rec* or ano rec*) NEAR/3 dysfunction*))):ti,ab,kw
#28	MeSH descriptor: [Fecal Impaction] this term only
#29	((((difficult* or delay* or irregular* or infrequen* or pain*) NEAR/3 (defecat* or defaecat* or stool* or faecal or fecal or faeces or feces or fecally or faecally or bowel movement*)))):ti,ab,kw
#30	(((obstruct* NEAR/3 (defecat* or defaecat*)))):ti,ab,kw
#31	((((defecat* or defaecat* or evacuat*) NEAR/3 (disorder* or dysfunction*)))):ti,ab,kw
#32	((outlet* dysfunction* constipa*)):ti,ab,kw
#33	(((dys?ynerg* NEXT (defecat* or defaecat*)))):ti,ab,kw
#34	(((pelvi* NEAR/3 dyskines*))):ti,ab,kw
#35	((pelvi* outlet* obstruct*)):ti,ab,kw
#36	((anismus*)):ti,ab,kw
#37	((puborectal* contract*)):ti,ab,kw
#38	((((rectal or rectum) NEAR/3 urge*))):ti,ab,kw
#39	(((female NEXT sex* NEXT (dysfunct* or satisf* or problem* or symptom* or arous* or activit* or disorder*)))):ti,ab,kw
#40	(((obstruct* NEAR/3 intercourse))):ti,ab,kw
#41	(((vagin* NEAR/3 laxity*))):ti,ab,kw
#42	(((vagin* NEXT wind))):ti,ab,kw
#43	MeSH descriptor: [Vaginismus] this term only
#44	((vaginismus*)):ti,ab,kw
#45	(((vagin* NEXT penetrat* NEXT disorder*))):ti,ab,kw
#46	#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25 OR #26 OR #27 OR #28 OR #29 OR #30 OR #31 OR #32 OR #33 OR #34 OR #35 OR #36 OR #37 OR #38 OR #39 OR #40 OR #41 OR #42 OR #43 OR #44 OR #45
#47	MeSH descriptor: [Interdisciplinary Communication] this term only
#48	MeSH descriptor: [Physician-Patient Relations] this term only
#49	MeSH descriptor: [Interprofessional Relations] this term only
#50	MeSH descriptor: [Health Services Accessibility] this term only
#51	MeSH descriptor: [Delivery of Health Care] this term only
#52	MeSH descriptor: [Delivery of Health Care, Integrated] this term only
#53	MeSH descriptor: [Total Quality Management] this term only
#54	MeSH descriptor: [Comprehensive Health Care] this term only
#55	MeSH descriptor: [Continuity of Patient Care] this term only
#56	MeSH descriptor: [Primary Health Care] this term only
#57	MeSH descriptor: [Community Health Services] this term only
#58	MeSH descriptor: [Family Practice] this term only
#59	MeSH descriptor: [Referral and Consultation] this term only
#60	MeSH descriptor: [Health Personnel] this term only
#61	MeSH descriptor: [Patient Care Team] this term only

#	Searches
#62	MeSH descriptor: [Nursing, Team] this term only
#63	MeSH descriptor: [Nurse Clinicians] this term only
#64	MeSH descriptor: [Community Health Nursing] this term only
#65	MeSH descriptor: [Public Health Nursing] this term only
#66	MeSH descriptor: [Nursing Care] this term only
#67	MeSH descriptor: [Nurse's Role] this term only
#68	MeSH descriptor: [Models, Nursing] this term only
#69	MeSH descriptor: [Models, Organizational] this term only
#70	(((multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) NEAR/3 communicat*)):ti,ab,kw
#71	((integrat* NEXT (clinic* or unit or service* or care or therap* or management or approach* or treat* or system* or model*))):ti,ab,kw
#72	(((communitybase* or community-base* or "community base*") NEAR/3 (clinic* or center* or centre* or service* or team* or group* or meeting or staff* or care or therap* or management or approach* or strateg* or plan or role or cooperat* or co-operat* or treat* or panel* or program* or system* or setting* or unit or training or examination* or relationship* or network*))):ti,ab,kw
#73	((refer* NEXT (pattern* or pathway*))):ti,ab,kw
#74	((peer NEXT network*)):ti,ab,kw
#75	((((patient* or medical or health) NEAR/1 care team*) or healthcare team*)):ti,ab,kw
#76	((teamwork* or team-work* or “team work*” or teambased* or team-based* or “team based*”)):ti,ab,kw
#77	((team NEXT approach)):ti,ab,kw
#78	((collaborat* NEAR/3 (care or approach* or management or treatment or therapy or protocol or model or team* or working or patientcentre* or patient-centre* or patientfocus* or patient-focus* or multiple or multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin* or stake-holder* or stakeholder*))):ti,ab,kw
#79	((speciali* NEAR/3 (continence or nurs*))):ti,ab,kw
#80	(((multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) NEXT (clinic* or center* or centre* or service* or team* or group* or meeting or staff* or care or therap* or management or approach* or strateg* or plan or role or cooperat* or co-operat* or treat* or panel* or program* or system* or setting* or unit or training or examination* or relationship* or network* or responsibility* or consensus*))):ti,ab,kw
#81	(((multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) NEAR/3 “management plan*”)):ti,ab,kw
#82	((MDT* or MDM or MDMs)):ti,ab,kw
#83	(((communit* or specialist* or multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) NEAR/4 (continence or incontinence) NEXT (clinic or clinics))):ti,ab,kw
#84	((continence NEAR/3 (service* or team*))):ti,ab,kw
#85	((continence NEXT care)):ti
#86	(((multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) NEAR/3 (pelvi* care or continence care or pelvi* floor))):ti,ab,kw
#87	(("pelvic floor" NEAR/3 (clinic or clinics or team*))):ti,ab,kw
#88	(((multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) NEXT pain)):ti,ab,kw
#89	(pessar* NEXT (clinic or clinics or service or services)):ti,ab,kw
#90	((“pelvi* pain” NEAR/3 (clinic or clinics or service or services or team or teams))):ti,ab,kw
#91	#47 OR #48 OR #49 OR #50 OR #51 OR #52 OR #53 OR #54 OR #55 OR #56 OR #57 OR #58 OR #59 OR #60 OR #61 OR #62 OR #63 OR #64 OR #65 OR #66 OR #67 OR #68 OR #69 OR #70 OR #71 OR #72 OR #73 OR #74 OR #75 OR #76 OR #77 OR #78 OR #79 OR #80 OR #81 OR #82 OR #83 OR #84 OR #85 OR #86 OR #87 OR #88 OR #89 OR #90
#92	#46 AND #91

Database(s): Database of Abstracts of Reviews of Effects (DARE); HTA Database – CRD interface

Date of last search: 6 May 2020

#	Searches
1	MeSH DESCRIPTOR Pelvic Floor IN DARE,HTA
2	MeSH DESCRIPTOR Pelvic Floor Disorders IN DARE,HTA
3	((pelvi* NEXT (floor* or diaphragm*) NEAR3 (dysfunction* or disorder* or fail* or impair* or incompeten* or insufficien* or dyssynerg* or symptom* or laxity or change* or care* or health* or wellbeing* or well-being* or prevent* or rehabilitat* or weak* or hypertonic* or overactiv* or over activ* or over-activ*))) IN DARE, HTA
4	((pelvi* NEXT (dysfunction* or disorder* or fail* or impair* or incompeten* or insufficien* or dyssynerg* or symptom* or laxity or care* or health* or wellbeing* or well-being* or prevent* or rehabilitat* or weak* or hypertonic* or overactiv* or over activ* or over-activ*))) IN DARE, HTA
5	MeSH DESCRIPTOR Urinary Incontinence EXPLODE ALL TREES IN DARE,HTA
6	MeSH DESCRIPTOR Urinary Bladder, Overactive IN DARE,HTA
7	(((stress* or mix* or urg* or urin*) NEAR5 incontinen*)) IN DARE, HTA

#	Searches
8	((bladder* NEAR5 (overactiv* or over activ* or over-activ* or instabilit* or hyper-reflex* or hyperreflex* or hyper reflex* or incontinen*))) IN DARE, HTA
9	((detrusor* NEAR5 (overactiv* or over activ* or over-activ* or instabilit* or hyper-reflex* or hyperreflex* or hyper reflex*))) IN DARE, HTA
10	(((urgency NEAR2 frequency) or (frequency NEAR2 urgency))) IN DARE, HTA
11	(((urin* or bladder*) NEAR2 (urg* or frequen*))) IN DARE, HTA
12	((SUI or OAB)) IN DARE, HTA
13	MeSH DESCRIPTOR Pelvic Organ Prolapse EXPLODE ALL TREES IN DARE,HTA
14	MeSH DESCRIPTOR Rectocele IN DARE,HTA
15	((pelvic* NEAR3 organ* NEAR3 prolaps*)) IN DARE, HTA
16	((urinary NEAR3 bladder NEAR3 prolaps*)) IN DARE, HTA
17	(((vagin* or urogenital* or genit* or uter* or viscer* or anterior* or posterior* or apical or pelvi* or vault* or urethr* or bladder* or cervi* or rectal or rectum) NEAR3 prolaps*)) IN DARE, HTA
18	((splanchnoptos* or visceroptos*)) IN DARE, HTA
19	((hernia* NEAR3 (pelvi* or vagin* or urogenital* or uter* or bladder* or urethr* or viscer*))) IN DARE, HTA
20	((urethroc?ele* or enteroc?ele* or sigmoidoc?ele* or proctoc?ele* or rectoc?ele* or cystoc?ele* or rectoenteroc?ele* or cystourethroc?ele*)) IN DARE, HTA
21	MeSH DESCRIPTOR Fecal Incontinence IN DARE,HTA
22	(((faecal or fecal or faeces or feces or fecally or faecally or anal or anally or stool or stools or bowel or double or defecat* or defaecat*) NEAR5 (incontinence or incontinent or urge* or leak or leaking or leakage or soiling or seeping or seepage or impacted or impaction))) IN DARE, HTA
23	MeSH DESCRIPTOR Urinary Retention IN DARE,HTA
24	((urin* NEAR3 (retention* or retain*))) IN DARE, HTA
25	((voiding NEXT (disorder* or dysfunction* or problem*))) IN DARE, HTA
26	((empty* NEXT disorder* NEAR3 (bowel* or bladder* or vesical* or stool*))) IN DARE, HTA
27	(((urogeni* or anorec* or ano-rec* or ano rec*) NEAR3 dysfunction*)) IN DARE, HTA
28	MeSH DESCRIPTOR Fecal Impaction IN DARE,HTA
29	(((difficult* or delay* or irregular* or infrequen* or pain*) NEAR3 (defecat* or defaecat* or stool* or faecal or fecal or faeces or feces or fecally or faecally or bowel movement*))) IN DARE, HTA
30	((obstruct* NEAR3 (defecat* or defaecat*))) IN DARE, HTA
31	(((defecat* or defaecat* or evacuat*) NEAR3 (disorder* or dysfunction*))) IN DARE, HTA
32	(((outlet* NEXT dysfunction* NEXT constipa*))) IN DARE, HTA
33	((dys?ynerg* NEXT (defecat* or defaecat*))) IN DARE, HTA
34	((pelvi* NEAR3 dyskines*)) IN DARE, HTA
35	((pelvi* NEXT outlet* NEXT obstruct*)) IN DARE, HTA
36	((anismus*)) IN DARE, HTA
37	((puborectal* NEXT contract*)) IN DARE, HTA
38	(((rectal or rectum) NEAR3 urge*)) IN DARE, HTA
39	((female NEXT sex* NEXT (dysfunct* or satisf* or problem* or symptom* or arous* or activit* or disorder*))) IN DARE, HTA
40	((obstruct* NEAR3 intercourse)) IN DARE, HTA
41	((vagin* NEAR3 laxity*)) IN DARE, HTA
42	((vagin* NEXT wind)) IN DARE, HTA
43	MeSH DESCRIPTOR Vaginismus IN DARE,HTA
44	((vaginismus*)) IN DARE, HTA
45	((vagin* NEXT penetrat* NEXT disorder*)) IN DARE, HTA
46	#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25 OR #26 OR #27 OR #28 OR #29 OR #30 OR #31 OR #32 OR #33 OR #34 OR #35 OR #36 OR #37 OR #38 OR #39 OR #40 OR #41 OR #42 OR #43 OR #44 OR #45
47	MeSH DESCRIPTOR Interdisciplinary Communication IN DARE,HTA
48	MeSH DESCRIPTOR Physician-Patient Relations IN DARE,HTA
49	MeSH DESCRIPTOR Interprofessional Relations IN DARE,HTA
50	MeSH DESCRIPTOR Health Services Accessibility IN DARE,HTA
51	MeSH DESCRIPTOR Delivery of Health Care IN DARE,HTA
52	MeSH DESCRIPTOR Total Quality Management IN DARE,HTA
53	MeSH DESCRIPTOR Comprehensive Health Care IN DARE,HTA
54	MeSH DESCRIPTOR Delivery of Health Care, Integrated IN DARE,HTA
55	MeSH DESCRIPTOR Continuity of Patient Care IN DARE,HTA
56	MeSH DESCRIPTOR Primary Health Care IN DARE,HTA
57	MeSH DESCRIPTOR Community Health Services IN DARE,HTA
58	MeSH DESCRIPTOR Family Practice IN DARE,HTA
59	MeSH DESCRIPTOR Referral and Consultation IN DARE,HTA
60	MeSH DESCRIPTOR Health Personnel IN DARE,HTA
61	MeSH DESCRIPTOR Patient Care Team IN DARE,HTA
62	MeSH DESCRIPTOR Nursing, Team IN DARE,HTA
63	MeSH DESCRIPTOR Nurse Clinicians IN DARE,HTA
64	MeSH DESCRIPTOR Community Health Nursing IN DARE,HTA
65	MeSH DESCRIPTOR Public Health Nursing IN DARE,HTA
66	MeSH DESCRIPTOR Nursing Care IN DARE,HTA
67	MeSH DESCRIPTOR Nurse's Role EXPLODE ALL TREES

#	Searches
68	MeSH DESCRIPTOR Models, Nursing IN DARE,HTA
69	MeSH DESCRIPTOR Models, Organizational IN DARE,HTA
70	(((multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) NEAR3 communicat*)) IN DARE, HTA
71	((integrat* NEXT (clinic* or unit or service* or care or therap* or management or approach* or treat* or system* or model*))) IN DARE, HTA
72	(((communitybase* or community-base* or "community base*") NEAR3 (clinic* or center* or centre* or service* or team* or group* or meeting or staff* or care or therap* or management or approach* or strateg* or plan or role or cooperat* or co-operat* or treat* or panel* or program* or system* or setting* or unit or training or examination* or relationship* or network*))) IN DARE, HTA
73	((refer* NEXT (pattern* or pathway*))) IN DARE, HTA
74	((peer NEXT network*)) IN DARE, HTA
75	((teamwork* or team-work* or team work* or teambased* or team-based* or team based*)) IN DARE, HTA
76	(((patient* or medical or health) NEAR1 care team*) or healthcare team*) IN DARE, HTA
77	(team NEXT approach) IN DARE, HTA
78	((collaborat* NEAR3 (care or approach* or management or treatment or therapy or protocol or model or team* or working or patientcentre* or patient-centre* or patientfocus* or patient-focus* or multiple or multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin* or stake-holder* or stakeholder*))) IN DARE, HTA
79	((speciali* NEAR3 (continence or nurs*))) IN DARE, HTA
80	(((multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) NEXT (clinic* or center* or centre* or service* or team* or group* or meeting or staff* or care or therap* or management or approach* or strateg* or plan or role or cooperat* or co-operat* or treat* or panel* or program* or system* or setting* or unit or training or examination* or relationship* or network* or responsibility* or consensus*))) IN DARE, HTA
81	(((multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) NEAR3 management plan*)) IN DARE, HTA
82	((MDT* or MDM or MDMs)) IN DARE, HTA
83	(((communit* or specialist* or multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) NEAR4 (continence or incontinence) NEXT (clinic or clinics))) IN DARE, HTA
84	((continence NEAR3 (service* or team*))) IN DARE, HTA
85	((continence NEXT care)) IN DARE, HTA
86	(((multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) NEAR3 (pelvi* care or continence care or pelvi* floor))) IN DARE, HTA
87	((pelvic floor NEAR3 (clinic or clinics or team*))) IN DARE, HTA
88	(((multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) NEXT pain)) IN DARE, HTA
89	((pessar* NEXT (clinic or clinics or service or services))) IN DARE, HTA
90	((pelvi* pain NEAR3 (clinic or clinics or service or services or team or teams))) IN DARE, HTA
91	#47 OR #48 OR #49 OR #50 OR #51 OR #52 OR #53 OR #54 OR #55 OR #56 OR #57 OR #58 OR #59 OR #60 OR #61 OR #62 OR #63 OR #64 OR #65 OR #66 OR #67 OR #68 OR #69 OR #70 OR #71 OR #72 OR #73 OR #74 OR #75 OR #76 OR #77 OR #78 OR #79 OR #80 OR #81 OR #82 OR #83 OR #84 OR #85 OR #86 OR #87 OR #88 OR #89 OR #90
92	#46 AND #91

Database(s): Cinahl Plus – EBSCOhost interface

Date of last search: 6 May 2020

#	Searches
S86	S84 NOT S85 Limiters - English Language;
S85	PT anecdote or PT audiovisual or PT bibliography or PT biography or PT book or PT book review or PT brief item or PT cartoon or PT commentary or PT computer program or PT editorial or PT games or PT glossary or PT historical material or PT interview or PT letter or PT listservs or PT masters thesis or PT obituary or PT pamphlet or PT pamphlet chapter or PT pictorial or PT poetry or PT proceedings or PT “questions and answers” or PT response or PT software or PT teaching materials or PT website
S84	S45 AND S83
S83	S46 OR S47 OR S48 OR S49 OR S50 OR S51 OR S52 OR S53 OR S54 OR S55 OR S56 OR S57 OR S58 OR S59 OR S60 OR S61 OR S62 OR S63 OR S64 OR S65 OR S66 OR S67 OR S68 OR S69 OR S70 OR S71 OR S72 OR S73 OR S74 OR S75 OR S76 OR S77 OR S78 OR S79 OR S80 OR S81 OR S82
S82	TI (“pelvi* pain” N3 (clinic or clinics or service or services or team or teams)) OR AB (“pelvi* pain” N3 (clinic or clinics or service or services or team or teams))
S81	TI ((multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) N1 pain) OR AB ((multiprofess* or multi-profess* or interprofess* or inter-profess*

#	Searches
	or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) N1 pain)
S80	TI (pessar* N1 (clinic or clinics or service or services)) OR AB (pessar* N1 (clinic or clinics or service or services))
S79	TI (pelvic floor N3 (clinic or clinics or team*)) OR AB (pelvic floor N3 (clinic or clinics or team*))
S78	TI ((multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) N3 (pelvi* care or continence care or pelvi* floor)) OR AB ((multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) N3 (pelvi* care or continence care or pelvi* floor))
S77	TI ("continence care")
S76	TI (continence N3 (service* or team*)) OR AB (continence N3 (service* or team*))
S75	TI ((communit* or specialist* or multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) N4 (continence or incontinence) N1 (clinic or clinics)) OR AB ((communit* or specialist* or multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) N4 (continence or incontinence) N1 (clinic or clinics))
S74	TI (MDT* or MDM or MDMs) OR AB (MDT* or MDM or MDMs)
S73	TI ((multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) N3 “management plan*”) OR AB ((multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) N3 “management plan*”)
S72	TI ((multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) N1 (clinic* or center* or centre* or service* or team* or group* or meeting or staff* or care or therap* or management or approach* or strateg* or plan or role or cooperat* or co-operat* or treat* or panel* or program* or system* or setting* or unit or training or examination* or relationship* or network* or responsibility* or consensus*)) OR AB ((multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) N1 (clinic* or center* or centre* or service* or team* or group* or meeting or staff* or care or therap* or management or approach* or strateg* or plan or role or cooperat* or co-operat* or treat* or panel* or program* or system* or setting* or unit or training or examination* or relationship* or network* or responsibility* or consensus*))
S71	TI (speciali* N3 (continence or nurs*)) OR AB (speciali* N3 (continence or nurs*))
S70	TI (collaborat* N3 (care or approach* or management or treatment or therapy or protocol or model or team* or working or patientcentre* or patient-centre* or patientfocus* or patient-focus* or multiple or multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin* or stake-holder* or stakeholder*)) OR AB (collaborat* N3 (care or approach* or management or treatment or therapy or protocol or model or team* or working or patientcentre* or patient-centre* or patientfocus* or patient-focus* or multiple or multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin* or stake-holder* or stakeholder*))
S69	TI (“team approach”) OR AB (“team approach”)
S68	TI (teamwork* or team-work* or team work* or teambased* or team-based* or team based*) OR AB (teamwork* or team-work* or team work* or teambased* or team-based* or team based*)
S67	TI (((patient* or medical or health) N1 care team*) or healthcare team*) OR AB (((patient* or medical or health) N1 care team*) or healthcare team*)
S66	TI (peer N1 network*) OR AB (peer N1 network*)
S65	TI (refer* N1 (pattern* or pathway*)) OR AB (refer* N1 (pattern* or pathway*))
S64	TI ((communitybase* or community-base* or community base*) N3 (clinic* or center* or centre* or service* or team* or group* or meeting or staff* or care or therap* or management or approach* or strateg* or plan or role or cooperat* or co-operat* or treat* or panel* or program* or system* or setting* or unit or training or examination* or relationship* or network*)) OR AB ((communitybase* or community-base* or community base*) N3 (clinic* or center* or centre* or service* or team* or group* or meeting or staff* or care or therap* or management or approach* or strateg* or plan or role or cooperat* or co-operat* or treat* or panel* or program* or system* or setting* or unit or training or examination* or relationship* or network*))
S63	TI (integrat* N1 (clinic* or unit or service* or care or therap* or management or approach* or treat* or system* or model*)) OR AB (integrat* N1 (clinic* or unit or service* or care or therap* or management or approach* or treat* or system* or model*))
S62	TI ((multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) N3 communicat*) OR AB ((multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) N3 communicat*)
S61	(MH "Multidisciplinary Care Team")
S60	(MH "Community Health Nursing")
S59	(MM "Clinical Nurse Specialists")
S58	(MM "Nursing Role") OR (MH "Nursing Models, Theoretical") OR (MH "Nursing Care")
S57	(MH "Health Personnel")
S56	(MM "Referral and Consultation")
S55	(MM "Family Practice")

#	Searches
S54	(MH "Community Health Services")
S53	(MH "Primary Health Care")
S52	(MH "Continuity of Patient Care")
S51	(MH "Quality Improvement")
S50	(MH "Integrative Medicine")
S49	(MH "Health Care Delivery") OR (MH "Health Care Delivery, Integrated")
S48	(MH "Health Services Accessibility")
S47	(MH "Interprofessional Relations")
S46	(MH "Physician-Patient Relations") OR (MH "Nurse-Patient Relations")
S45	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19 OR S20 OR S21 OR S22 OR S23 OR S24 OR S25 OR S26 OR S27 OR S28 OR S29 OR S30 OR S31 OR S32 OR S33 OR S34 OR S35 OR S36 OR S37 OR S38 OR S39 OR S40 OR S41 OR S42 OR S43 OR S44
S44	TI (vagin* penetrat* disorder*) OR AB (vagin* penetrat* disorder*)
S43	TI vaginism* OR AB vaginism*
S42	TI (vagin* N1 wind) OR AB (vagin* N1 wind)
S41	TI (vagin* N3 laxity*) OR AB (vagin* N3 laxity*)
S40	TI (obstruct* N3 intercourse) OR AB (obstruct* N3 intercourse)
S39	TI (obstruct* N3 intercourse) OR AB (obstruct* N3 intercourse)
S38	TI (female N1 sex* N (dysfunct* or satisf* or problem* or symptom* or arous* or activit* or disorder*)) OR AB (female N1 sex* N (dysfunct* or satisf* or problem* or symptom* or arous* or activit* or disorder*))
S37	(MH "Sexual Dysfunction, Female")
S36	TI ((rectal or rectum) N3 urge*) OR AB ((rectal or rectum) N3 urge*)
S35	TI puborectal* contract* OR AB puborectal* contract*
S34	TI anismus* OR AB anismus*
S33	TI pelvi* outlet* obstruct* OR AB pelvi* outlet* obstruct*
S32	TI (pelvi* N3 dyskines*) OR AB (pelvi* N3 dyskines*)
S31	TI (pelvi* N3 dyskines*) OR AB (pelvi* N3 dyskines*)
S30	TI (dys?ynerg* N1 (defecat* or defaecat*)) OR AB (dys?ynerg* N1 (defecat* or defaecat*))
S29	TI outlet* dysfunction* constipa* OR AB outlet* dysfunction* constipa*
S28	TI ((defecat* or defaecat* or evacuat*) N3 (disorder* or dysfunction*)) OR AB ((defecat* or defaecat* or evacuat*) N3 (disorder* or dysfunction*))
S27	TI (obstruct* N3 (defecat* or defaecat*)) OR AB (obstruct* N3 (defecat* or defaecat*))
S26	TI ((difficult* or delay* or irregular* or infrequen* or pain*) N3 (defecat* or defaecat* or stool* or faeces or feces or bowel movement*)) OR AB ((difficult* or delay* or irregular* or infrequen* or pain*) N3 (defecat* or defaecat* or stool* or faeces or feces or bowel movement*))
S25	(MH "Feces, Impacted")
S24	TI ((urogeni* or anorec* or ano-rec* or ano rec*) N3 dysfunction*) OR AB ((urogeni* or anorec* or ano-rec* or ano rec*) N3 dysfunction*)
S23	TI (empty* N1 disorder* N3 (bowel* or bladder* or vesical* or stool*)) OR AB (empty* N1 disorder* N3 (bowel* or bladder* or vesical* or stool*))
S22	TI (voiding N1 (disorder* or dysfunction* or problem*)) OR AB (voiding N1 (disorder* or dysfunction* or problem*))
S21	TI (urin* N3 (retention* or retain*)) OR AB (urin* N3 (retention* or retain*))
S20	(MH "Urinary Retention")
S19	TI ((faecal or fecal or faeces or feces or fecally or faecally or anal or anally or stool or stools or bowel or double or defecat* or defaecat*) N5 (incontinence or incontinent or urge* or leak or leaking or leakage or soiling or seeping or seepage or impacted or impaction))
S18	(MM "Fecal Incontinence")
S17	TI (urethroc?ele* or enteroc?ele* or sigmoidoc?ele* or proctoc?ele* or rectoc?ele* or cystoc?ele* or rectoenteroc?ele* or cystourethroc?ele*)
S16	TI (hernia* N3 (pelvi* or vagin* or urogenital* or uter* or bladder* or urethr* or viscer*))
S15	TI (splanchnoptos* or visceroptos*)
S14	TI ((vagin* or urogenital* or genit* or uter* or viscer* or anterior* or posterior* or apical or pelvi* or vault* or urethr* or bladder* or cervi* or rectal or rectum) N3 prolaps*)
S13	TI (urinary N3 bladder N3 prolaps*)
S12	TI (pelvic* N3 organ* N3 prolaps*)
S11	(MM "Pelvic Organ Prolapse+") OR (MM "Rectocele")
S10	TI (SUI or OAB)
S9	TI ((urin* or bladder*) N2 (urg* or frequen*))
S8	TI ((urgency N2 frequency) or (frequency N2 urgency))
S7	TI (detrusor* N5 (overactiv* or over activ* or over-activ* or instabilit* or hyper-reflex* or hyperreflex* or hyper reflex*))
S6	TI (bladder* N5 (overactiv* or over activ* or over-activ* or instabilit* or hyper-reflex* or hyperreflex* or hyper reflex* or incontinen*))
S5	TI ((stress* or mix* or urg* or urin*) N5 incontinen*)
S4	(MM "Urinary Incontinence+") OR (MM "Overactive Bladder")
S3	TI (pelvi* N1 (dysfunction* or disorder* or fail* or impair* or incompeten* or insufficien* or dyssynerg* or symptom* or laxity or care* or health* or wellbeing* or well-being* or prevent* or rehabilitat* or weak* or hypertonic* or overactiv* or over activ* or over-activ*)) OR AB (pelvi* N1 (dysfunction* or disorder* or fail* or impair* or incompeten* or insufficien* or dyssynerg* or symptom* or laxity or care* or health* or wellbeing* or well-being* or prevent* or rehabilitat* or weak* or hypertonic* or overactiv* or over activ* or over-activ*))
S2	TI (pelvi* N1 (floor* or diaphragm*) N33 (dysfunction* or disorder* or fail* or impair* or incompeten* or insufficien* or dyssynerg* or symptom* or laxity or change* or care* or health* or wellbeing* or well-being* or prevent* or

#	Searches
	rehabilitat* or weak* or hypertonic* or overactiv* or over activ* or over-activ*)) OR AB (pelvi* N1 (floor* or diaphragm*) N33 (dysfunction* or disorder* or fail* or impair* or incompeten* or insufficien* or dyssynerg* or symptom* or laxity or change* or care* or health* or wellbeing* or well-being* or prevent* or rehabilitat* or weak* or hypertonic* or overactiv* or over activ* or over-activ*))
S1	(MH "Pelvic Floor Disorders") OR (MH "Pelvic Floor Muscles")

Economic Search

One global search was conducted for economic evidence across the guideline.

Database(s): NHS Economic Evaluation Database (NHS EED); HTA Database – CRD interface

Date of last search: 3 February 2021

#	Searches
1	MeSH DESCRIPTOR Pelvic Floor IN NHSEED,HTA
2	MeSH DESCRIPTOR Pelvic Floor Disorders IN NHSEED,HTA
3	MeSH DESCRIPTOR Urinary Bladder, Overactive IN NHSEED,HTA
4	(((pelvi* NEXT (floor* or diaphragm*) NEAR3 (dysfunction* or disorder* or fail* or impair* or incompeten* or insufficien* or dyssynerg* or symptom* or laxity or change* or care* or health* or wellbeing* or well-being* or prevent* or rehabilitat* or weak* or hypertonic* or overactiv* or over activ* or over-activ*)))) IN NHSEED, HTA
5	MeSH DESCRIPTOR Urinary Incontinence EXPLODE ALL TREES IN NHSEED,HTA
6	MeSH DESCRIPTOR Urinary Bladder, Overactive IN NHSEED,HTA
7	((((stress* or mix* or urg* or urin*) NEAR5 incontinen*))) IN NHSEED, HTA
8	(((bladder* NEAR5 (overactiv* or over activ* or over-activ* or instabilit* or hyper-reflex* or hyperreflex* or hyper reflex* or incontinen*)))) IN NHSEED, HTA
9	(((detrusor* NEAR5 (overactiv* or over activ* or over-activ* or instabilit* or hyper-reflex* or hyperreflex* or hyper reflex*)))) IN NHSEED, HTA
10	((((urgency NEAR2 frequency) or (frequency NEAR2 urgency)))) IN NHSEED, HTA
11	((((urin* or bladder*) NEAR2 (urg* or frequen*)))) IN NHSEED, HTA
12	(((SUI or OAB))) IN NHSEED, HTA
13	MeSH DESCRIPTOR Pelvic Organ Prolapse EXPLODE ALL TREES IN NHSEED,HTA
14	MeSH DESCRIPTOR Rectocele IN NHSEED,HTA
15	(((pelvic* NEAR3 organ* NEAR3 prolaps*))) IN NHSEED, HTA
16	(((urinary NEAR3 bladder NEAR3 prolaps*))) IN NHSEED, HTA
17	((((vagin* or urogenital* or genit* or uter* or viscer* or anterior* or posterior* or apical or pelvi* or vault* or urethr* or bladder* or cervi* or rectal or rectum) NEAR3 prolaps*))) IN NHSEED, HTA
18	(((splanchnoptos* or visceroptos*))) IN NHSEED, HTA
19	(((hernia* NEAR3 (pelvi* or vagin* or urogenital* or uter* or bladder* or urethr* or viscer*)))) IN NHSEED, HTA
20	(((urethroc?ele* or enteroc?ele* or sigmoidoc?ele* or proctoc?ele* or rectoc?ele* or cystoc?ele* or rectoenteroc?ele* or cystourethroc?ele*))) IN NHSEED, HTA
21	MeSH DESCRIPTOR Fecal Incontinence IN NHSEED,HTA
22	((((faecal or fecal or faeces or feces or fecally or faecally or anal or anally or stool or stools or bowel or double or defecat* or defaecat*) NEAR5 (incontinence or incontinent or urge* or leak or leaking or leakage or soiling or seeping or seepage or impacted or impaction)))) IN NHSEED, HTA
23	MeSH DESCRIPTOR Urinary Retention IN NHSEED,HTA
24	(((urin* NEAR3 (retention* or retain*)))) IN NHSEED, HTA
25	(((voiding NEXT (disorder* or dysfunction* or problem*)))) IN NHSEED, HTA
26	(((empty* NEXT disorder* NEAR3 (bowel* or bladder* or vesical* or stool*)))) IN NHSEED, HTA
27	((((urogeni* or anorec* or ano-rec* or ano rec*) NEAR3 dysfunction*))) IN NHSEED, HTA
28	MeSH DESCRIPTOR Fecal Impaction IN NHSEED,HTA
29	((((difficult* or delay* or irregular* or infrequen* or pain*) NEAR3 (defecat* or defaecat* or stool* or faecal or fecal or faeces or feces or fecally or faecally or bowel movement*)))) IN NHSEED, HTA
30	(((obstruct* NEAR3 (defecat* or defaecat*)))) IN NHSEED, HTA
31	((((defecat* or defaecat* or evacuat*) NEAR3 (disorder* or dysfunction*)))) IN NHSEED, HTA
32	((((outlet* NEXT dysfunction* NEXT constipa*)))) IN NHSEED, HTA
33	(((dys?ynerg* NEXT (defecat* or defaecat*)))) IN NHSEED, HTA
34	(((pelvi* NEAR3 dyskines*))) IN NHSEED, HTA
35	(((pelvi* NEXT outlet* NEXT obstruct*))) IN NHSEED, HTA
36	(((anismus*))) IN NHSEED, HTA
37	(((puborectal* NEXT contract*))) IN NHSEED, HTA
38	((((rectal or rectum) NEAR3 urge*))) IN NHSEED, HTA
39	(((female NEXT sex* NEXT (dysfunct* or satisf* or problem* or symptom* or arous* or activit* or disorder*)))) IN NHSEED, HTA
40	(((obstruct* NEAR3 intercourse))) IN NHSEED, HTA
41	(((vagin* NEAR3 laxity*))) IN NHSEED, HTA
42	(((vagin* NEXT wind))) IN NHSEED, HTA
43	MeSH DESCRIPTOR Vaginismus IN NHSEED,HTA
44	(((vaginismus*))) IN NHSEED, HTA
45	(((vagin* NEXT penetrat* NEXT disorder*))) IN NHSEED, HTA

#	Searches
46	(#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25 OR #26 OR #27 OR #28 OR #29 OR #30 OR #31 OR #32 OR #33 OR #34 OR #35 OR #36 OR #37 OR #38 OR #39 OR #40 OR #41 OR #42 OR #43 OR #44 OR #45) IN NHSEED, HTA

Database(s): Medline & Embase (Multifile) – OVID interface
Embase Classic+Embase 1947 to 2021 February 01; **Ovid MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily** 1946 to February 01, 2021
Date of last search: 3 February 2021

Multifile database codes: emczd = Embase Classic+Embase; ppez= MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily

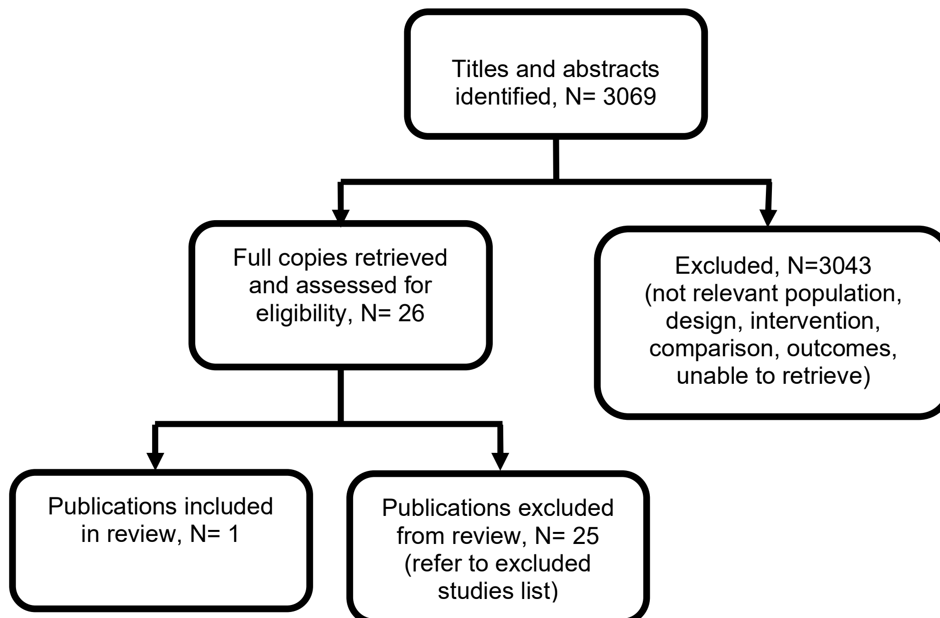
#	Searches
1	Pelvic Floor/ use ppez
2	Pelvic Floor Disorders/ use ppez
3	pelvis floor/ use emczd
4	pelvic floor disorder/ use emczd
5	(pelvi$ adj (floor$ or diaphragm$) adj3 (dysfunction$ or disorder$ or fail$ or impair$ or incompeten$ or insufficien$ or dyssynerg$ or symptom$ or laxity or change$ or care$ or health$ or wellbeing$ or well-being$ or prevent$ or rehabilitat$ or weak$ or hypertonic$ or overactiv$ or over activ$ or over-activ$)).tw.
6	(pelvi$ adj (dysfunction$ or disorder$ or fail$ or impair$ or incompeten$ or insufficien$ or dyssynerg$ or symptom$ or laxity or care$ or health$ or wellbeing$ or well-being$ or prevent$ or rehabilitat$ or weak$ or hypertonic$ or overactiv$ or over activ$ or over-activ$)).tw.
7	or/1-6
8	exp *Urinary Incontinence/ use ppez
9	*Urinary Bladder, Overactive/ use ppez
10	exp *urine incontinence/ use emczd
11	*overactive bladder/ use emczd
12	*bladder instability/ use emczd
13	((stress$ or mix$ or urg$ or urin$) adj5 incontinen$).ti.
14	(bladder$ adj5 (overactiv$ or over activ$ or over-activ$ or instabilit$ or hyper-reflex$ or hyperreflex$ or hyper reflex$ or incontinen$)).ti.
15	(detrusor$ adj5 (overactiv$ or over activ$ or over-activ$ or instabilit$ or hyper-reflex$ or hyperreflex$ or hyper reflex$)).ti.
16	((urgency adj2 frequency) or (frequency adj2 urgency)).ti.
17	((urin$ or bladder$) adj2 (urg$ or frequen$)).ti.
18	(SUI or OAB).ti.
19	or/8-18
20	exp *Pelvic Organ Prolapse/ use ppez
21	exp *pelvic organ prolapse/ use emczd
22	*Rectocele/ use ppez
23	*rectocele/ use emczd
24	(pelvic$ adj3 organ$ adj3 prolaps$).ti.
25	(urinary adj3 bladder adj3 prolaps$).ti.
26	((vagin$ or urogenital$ or genit$ or uter$ or viscer$ or anterior$ or posterior$ or apical or pelvi$ or vault$ or urethr$ or bladder$ or cervi$ or rectal or rectum) adj3 prolaps$).ti.
27	(splanchnoptos$ or visceroptos$).ti.
28	(hernia$ adj3 (pelvi$ or vagin$ or urogenital$ or uter$ or bladder$ or urethr$ or viscer$)).ti.
29	(urethroc?ele$ or enteroc?ele$ or sigmoidoc?ele$ or proctoc?ele$ or rectoc?ele$ or cystoc?ele$ or rectoenteroc?ele$ or cystourethroc?ele$).ti.
30	or/20-29
31	*Fecal Incontinence/ use ppez
32	*feces incontinence/ use emczd
33	((faecal or fecal or faeces or feces or fecally or faecally or anal or anally or stool or stools or bowel or double or defecat$ or defaecat$) adj5 (incontinence or incontinent or urge$ or leak or leaking or leakage or soiling or seeping or seepage or impacted or impaction)).ti.
34	or/31-33
35	Urinary Retention/ use ppez
36	urine retention/ use emczd
37	(urin$ adj3 (retention$ or retain$)).tw.
38	(voiding adj (disorder$ or dysfunction$ or problem$)).tw.
39	(empty$ adj disorder$ adj3 (bowel$ or bladder$ or vesical$ or stool$)).tw.
40	((urogeni$ or anorec$ or ano-rec$ or ano rec$) adj3 dysfunction$).tw.
41	defecation disorder/ use emczd
42	Fecal Impaction/ use ppez
43	Feces Impaction/ use emczd
44	((difficult$ or delay$ or irregular$ or infrequen$ or pain$) adj3 (defecat$ or defaecat$ or stool$ or faeces or feces or bowel movement$)).tw.
45	(obstruct$ adj3 (defecat$ or defaecat$)).tw.

#	Searches
46	((defecat$ or defaecat$ or evacuat$) adj3 (disorder$ or dysfunction$)).tw.
47	outlet$ dysfunction$ constipa$.tw.
48	(dys?ynerg$ adj (defecat$ or defaecat$)).tw.
49	(pelvi$ adj3 dyskines$).tw.
50	pelvi$ outlet$ obstruct$.tw.
51	anismus$.tw.
52	puborectal$ contract$.tw.
53	((rectal or rectum) adj3 urge$).tw.
54	or/35-53
55	female sexual dysfunction/ use emczd
56	(female adj sex$ adj (dysfunct$ or satisf$ or problem$ or symptom$ or arous$ or activit$ or disorder$)).tw.
57	(obstruct$ adj3 intercourse).tw.
58	(vagin$ adj3 laxity$).tw.
59	(vagin$ adj wind).tw.
60	Vaginismus/ use ppez
61	vaginism/ use emczd
62	vaginismus$.tw.
63	(vagin$ adj penetrat$ adj disorder$).tw.
64	or/55-63
65	7 or 19 or 30 or 34 or 54 or 64
66	Economics/ use ppez
67	Value of life/ use ppez
68	exp "Costs and Cost Analysis"/ use ppez
69	exp Economics, Hospital/ use ppez
70	exp Economics, Medical/ use ppez
71	Economics, Nursing/ use ppez
72	Economics, Pharmaceutical/ use ppez
73	exp "Fees and Charges"/ use ppez
74	exp Budgets/ use ppez
75	health economics/ use emczd
76	exp economic evaluation/ use emczd
77	exp health care cost/ use emczd
78	exp fee/ use emczd
79	budget/ use emczd
80	funding/ use emczd
81	budget*.ti,ab.
82	cost*.ti.
83	(economic* or pharmaco?economic*).ti.
84	(price* or pricing*).ti,ab.
85	(cost* adj2 (effective* or utilit* or benefit* or minimi* or unit* or estimat* or variable*)).ab.
86	(financ* or fee or fees).ti,ab.
87	(value adj2 (money or monetary)).ti,ab.
88	or/66-87
89	65 and 88
90	limit 89 to english language

Appendix C – Clinical evidence study selection

Study selection for: What competencies should be involved in a community-based multidisciplinary team for the management of symptoms associated with pelvic floor dysfunction?

Figure 1: Study selection flow chart



Appendix D – Evidence tables

Evidence tables for review question: What competencies should be involved in a community-based multidisciplinary team for the management of symptoms associated with pelvic floor dysfunction?

Table 4: Evidence tables

Study details	Participants	Interventions	Methods	Outcomes	Comments
Full citation Du Moulin, M. F., Hamers, J. P., Paulus, A., Berendsen, C. L., Halfens, R., Effects of introducing a specialized nurse in the care of community-dwelling women suffering from urinary incontinence: a randomized controlled trial, Journal of wound, ostomy, and continence nursing : official publication of the wound, ostomy and continence nurses society, 34, 631-640, 2007 **Ref Id** 1232491 **Country/ies where the study was carried out** Netherlands **Study type** RCT	**Sample size** N= 101 GPs; n=50 intervention group GPs and n=51 control group GPs Community-dwelling women visiting their GP for complaints of UI Intervention group n=35 Control group n=10 **Characteristics** Age (years); mean, (SD): Intervention group: 51 (13); Control group: 54 (10) BMI (kg/m2); mean, (SD): Intervention group: 27 (5); Control group: 27 (4) Number of births (n); mean: Intervention group: 2; Control group: 2 Duration of complaint (less than 3 years); n (%): Intervention group: 14 (42); Control group: 5 (55) Duration of complaint (more than 3 years); n (%): Intervention group: 19 (58); Control group: 4 (45)	**Interventions** Intervention Women met with a registered nurse who specialised in the care of incontinent patients. The nurse advised and guided patients and provided an assessment using history-taking and postvoid residual (PVR) urine measurement. Bladder diaries and quality of life questionnaires were completed by subjects and results were reviewed at subsequent visits. After assessment, the continence nurse advised the patient about treatment options guided by a protocol written by a multidisciplinary team comprising a GP, urologist, physiotherapist, and continence nurse. Additional caregivers treating the women, such as the physiotherapist, were asked to report findings and progress to the nurse, who acted as a	**Details** • The number of incontinent episodes, assessed by a 3-day bladder diary recording the frequency and volume (a few drops, moderate loss, or severe loss) of incontinent episodes throughout the day and night. • Numbers of pads use, measured by the 3-day bladder diary. • The Incontinence Impact Questionnaire (IIQ): consist of 30 items covering 5 subscales (mobility, emotional functioning, physical activity, social functioning, and embarrassment). Patients rate the extent to which urine leakage affects their functioning (from “1 = not at all” to “4 = very much”). The mean of responses is transformed to a score ranging from 0 to 100	**Results** Incontinence episodes Total loss at 6 months; mean (SD): Intervention 5.3 (7.4); Control 9.6 (7.7) Total loss at 12 months; mean (SD): Intervention 4.8 (7.5); Control 8.6 (5.6) Pad use Total use at 6 months; mean (SD): Intervention 5.0 (3.8); Control 6.4 (3.9) Total use at 12 months; mean (SD): Intervention 4.2 (4.2); Control 5.8 (4.1) IIQ scores Mobility at 6 months; mean (SD): Intervention 21.0 (25.3); Control 17.6 (20.4) Mobility 12 months; mean (SD): Intervention 18.4 (25.0); Control 14.7 (18.4) Emotional at 6 months; mean (SD): Intervention 13.9 (25.1); Control 14.0 (17.9) Emotional 12 months; mean (SD): Intervention	**Limitations** Cochrane risk of bias (Version 2.0) **Domain 1: Randomisation:** High risk 1.1: Yes, says that a random number table was used 1.2: No information, patient might know the allocation of the GP 1.3: Probably Yes, no significant differences reported, however difference between types of incontinence is large (stress incontinence 15 vs 78%; urge incontinence 3 vs 11%; mixed UI 82 vs 11%) **Domain 2: Deviations from intended interventions:** Some risk 2.1: Yes, participants not blinded 2.2: Yes, carers and people delivering the

Study details	Participants	Interventions	Methods	Outcomes	Comments
Aim of the study To investigate the short-term and long-term effect of introducing a continence nurse to the care of community-dwelling patients suffering from UI. **Study dates** Not reported **Source of funding** None reported	**Inclusion criteria** • Community-dwelling women • Aged 18 years and older • Seeing their GP for the first time with complaints of stress, urge, or mixed incontinence **Exclusion criteria** • urine tested positive for bacteria • had a PVR of 100 mL or more • had given birth within 3 months preceding recruitment • suffered from bladder cancer, renal disease, or uterine prolapse past the introitus.	coordinator. The nurse provided lifestyle and behavioural interventions tailored to the individual woman as well as information about pad use. All patients returned at 3, 6, and 12 months for follow-up including review of bladder diaries and questionnaires. When patients expressed dissatisfaction with their progress, treatment was reviewed and, if indicated, the nurse recommended referral to a urologist. After each visit, the nurse reported her findings to the subject's GP, who remained responsible for their overall care. <u>Control group</u> Usual care delivered by the GP also allowed access to health care workers in the field of continence care, such as a physiotherapist or urologist. In most cases pelvic floor muscle exercises were completed under the direction of a physiotherapist. Follow-up was at 3, 6 and 12 months.	with a higher score indicating greater impact on daily life. • Urogenital Distress Inventory (UDI): consists of 19 items covering 5 subscales (discomfort/pain, urinary incontinence, overactive bladder, genital prolapse, and obstructive micturition); each item assesses 2 aspects: whether or not a symptom is present and the amount of bother it causes (measured on a 4-point Likert scale ranging from "1 = not at all" to "4 = greatly"). The mean of responses is transformed to a score ranging from 0 to 100 with a higher score indicating greater impact on daily life. • The EuroQol (EQ-5D), was used to assess general health related quality of life. It defines health in terms of 5 dimensions: mobility, self-care, usual activities, pain/discomfort, and anxiety/ depression. Each dimension is assessed at 3 levels, representing "no problem," "some problem," and "extreme problem." The EQ-5D	12.4 (20.7); Control 12.9 (12.7) Social at 6 months; mean (SD): Intervention 9.8 (18.8); Control 3.7 (7.9) Social 12 months; mean (SD): Intervention 7.8 (21.8); Control 5.6 (9.4) Embarrassment at 6 months; mean (SD): Intervention 17.9 (26.5); Control 17.6 (23.0) Embarrassment 12 months; mean (SD): Intervention 15.4 (26.6); Control 13.3 (16.3) Physical at 6 months; mean (SD): Intervention 13.5 (21.6); Control 11.7 (17.7) Physical 12 months; mean (SD): Intervention 10.4 (19.5); Control 9.3 (12.4) <u>UDI scores</u> Incontinence at 6 months; mean (SD): Intervention 25.3 (23.6); Control 22.8 (13.1) Incontinence 12 months; mean (SD): Intervention 19.6 (20.1); Control 22.8 (12.6) Obstructive micturition at 6 months; mean (SD): Intervention 17.7 (25.3); Control 8.3 (11.8) Obstructive micturition 12 months; mean (SD): Intervention 13.6 (25.8); Control 3.3 (10.5)	interventions not blinded 2.3: No information whether there were any deviations from the intended intervention **Domain 3: Missing outcome data:** Some risk 3.1: No, 92% of the intervention group and 77% of the control group completed the post-intervention questionnaires 3.2: No, no correction for dropout bias or sensitivity analysis conducted 3.3: Probably no, unlikely missingness in the outcome data was influenced by true value **Domain 4: Measurement of the outcome:** Some risk 4.1: No, questionnaire used which is asked appropriate questions 4.2: No, questionnaire used which would not differ between treatment arms 4.3: Probably yes, questionnaire is self report so outcome assessors are the participants who were not blinded 4.4: Probably yes, women aware of the intervention

Study details	Participants	Interventions	Methods	Outcomes	Comments
			questionnaire also includes a 20 cm visual analogue scale (EQ-5Dvas) ranging from 0 (indicating worst imaginable health state) to 100 (indicating best imaginable health state). • Patient satisfaction with care was measured on a 10-point scale ranging from "very poor" (1) to "excellent" (10).	Pain/discomfort at 6 months; mean (SD): Intervention 11.3 (16.9); Control 11.7 (14.0) Pain/discomfort 12 months; mean (SD): Intervention 9.9 (14.7); Control 10.0 (9.0) Overactive bladder at 6 months; mean (SD): Intervention 18.2 (24.8); Control 26.7 (20.4) Overactive bladder 12 months; mean (SD): Intervention 17.8 (21.7); Control 23.3 (22.5) Prolapse at 6 months; mean (SD): Intervention 4.3 (9.3); Control 9.3 (12.1) Prolapse 12 months; mean (SD): Intervention 3.5 (17.62); Control 6.7 (8.6) EQ-5D EQ-5D at 12 months; mean (SD): Intervention 73.5 (18.3); Control 71.5 (8.1) Satisfaction Satisfaction at 6 months; mean (SD): Intervention 8.2 (1.2); Control 7.4 (1.1) Satisfaction at 12 months; mean (SD): Intervention 8.7 (1.0); Control 7.5 (1.0)	which could influence patient reported outcomes 4.5: Probably no, knowledge of intervention status is unlikely to influence outcome assessment **Domain 5: Selection of the reported result:** Some concerns 5.1: No, no pre-panned analysis or protocol available 5.2: No, descriptive data presented 5.3: No, data presented as expected **Domain 6: Overall judgement of bias:** High risk

BMI, body mass index; EQ-5D, EuroQol; IIQ, incontinence impact questionnaire; PVD, postvoid residual; SD, standard deviation; UDI, urogenital distress inventory; UI, urinary incontinence

Appendix E – Forest plots

Forest plots for review question: What competencies should be involved in a community-based multidisciplinary team for the management of symptoms associated with pelvic floor dysfunction?

No meta-analysis was conducted for this review question and so there are no forest plots.

Appendix F – GRADE tables

GRADE tables for review question: What competencies should be involved in a community-based multidisciplinary team for the management of symptoms associated with pelvic floor dysfunction?

Table 5: Clinical evidence profile for comparison of continence nurse to GP

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intervention (continence nurse)	Control (GP)	Relative (95% CI)	Absolute		
Incontinence episodes - Total loss at 6 months (Better indicated by lower values)												
Du Moulin 2007	randomised trials	very serious[1]	no serious inconsistency	serious[2]	serious[3]	none	35	10	-	MD 4.3 lower (9.67 lower to 1.07 higher)	VERY LOW	IMPORTANT
Incontinence episodes - Total loss at 12 months (Better indicated by lower values)												
Du Moulin 2007	randomised trials	very serious[1]	no serious inconsistency	serious[2]	serious[3]	none	35	10	-	MD 3.8 lower (8.07 lower to 0.47 higher)	VERY LOW	IMPORTANT
Pads used - Total use at 6 months (Better indicated by lower values)												
Du Moulin 2007	randomised trials	very serious[1]	no serious inconsistency	serious[2]	serious[4]	none	35	10	-	MD 1.4 lower (4.13 lower to 1.33 higher)	VERY LOW	IMPORTANT
Pads used - Total use at 12 months (Better indicated by lower values)												
Du Moulin 2007	randomised trials	very serious[1]	no serious inconsistency	serious[2]	serious[4]	none	35	10	-	MD 1.6 lower (4.5 lower to 1.3 higher)	VERY LOW	IMPORTANT
IIQ - Mobility at 6 months (Better indicated by higher values)												
Du Moulin 2007	randomised trials	very serious[1]	no serious inconsistency	serious[2]	very serious[5]	none	35	10	-	MD 3.4 higher (11.77 lower to 18.57 higher)	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Intervention (continence nurse)**	**Control (GP)**	**Relative (95% CI)**	**Absolute**		
IIQ - Mobility at 12 months (Better indicated by higher values)												
Du Moulin 2007	randomised trials	very serious[1]	no serious inconsistency	serious[2]	serious[6]	none	35	10	-	MD 3.7 higher (10.39 lower to 17.79 higher)	VERY LOW	IMPORTANT
IIQ - Emotional at 6 months (Better indicated by higher values)												
Du Moulin 2007	randomised trials	very serious[1]	no serious inconsistency	serious[2]	very serious[7]	none	35	10	-	MD 0.1 lower (13.96 lower to 13.76 higher)	VERY LOW	IMPORTANT
IIQ - Emotional at 12 months (Better indicated by higher values)												
Du Moulin 2007	randomised trials	very serious[1]	no serious inconsistency	serious[2]	very serious[7]	none	35	10	-	MD 0.5 lower (10.94 lower to 9.94 higher)	VERY LOW	IMPORTANT
IIQ - Social at 6 months (Better indicated by higher values)												
Du Moulin 2007	randomised trials	very serious[1]	no serious inconsistency	serious[2]	serious[8]	none	35	10	-	MD 6.1 higher (1.82 lower to 14.02 higher)	VERY LOW	IMPORTANT
IIQ - Social at 12 months (Better indicated by higher values)												
Du Moulin 2007	randomised trials	very serious[1]	no serious inconsistency	serious[2]	very serious[9]	none	35	10	-	MD 2.2 higher (7.08 lower to 11.48 higher)	VERY LOW	IMPORTANT
IIQ - Embarrassment at 6 months (Better indicated by higher values)												
Du Moulin 2007	randomised trials	very serious[1]	no serious inconsistency	serious[2]	very serious[10]	none	35	10	-	MD 0.3 higher (16.44 lower to 17.04 higher)	VERY LOW	IMPORTANT
IIQ - Embarrassment at 12 months (Better indicated by higher values)												
Du Moulin 2007	randomised trials	very serious[1]	no serious inconsistency	serious[2]	very serious[10]	none	35	10	-	MD 2.1 higher (11.31 lower to 15.51 higher)	VERY LOW	IMPORTANT
IIQ - Physical at 6 months (Better indicated by higher values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intervention (continence nurse)	Control (GP)	Relative (95% CI)	Absolute		
Du Moulin 2007	randomised trials	very serious[1]	no serious inconsistency	serious[2]	very serious[11]	none	35	10	-	MD 1.8 higher (11.3 lower to 14.9 higher)	VERY LOW	IMPORTANT
IIQ - Physical at 12 months (Better indicated by higher values)												
Du Moulin 2007	randomised trials	very serious[1]	no serious inconsistency	serious[2]	very serious[11]	none	35	10	-	MD 1.1 higher (8.94 lower to 11.14 higher)	VERY LOW	IMPORTANT
UDI - Incontinence at 6 months (Better indicated by lower values)												
Du Moulin 2007	randomised trials	very serious[1]	no serious inconsistency	serious[2]	very serious[12]	none	35	10	-	MD 2.5 higher (8.77 lower to 13.77 higher)	VERY LOW	IMPORTANT
UDI - Incontinence at 12 months (Better indicated by lower values)												
Du Moulin 2007	randomised trials	very serious[1]	no serious inconsistency	serious[2]	serious[13]	none	35	10	-	MD 3.2 lower (13.46 lower to 7.06 higher)	VERY LOW	IMPORTANT
UDI - Obstructive micturition at 6 months (Better indicated by lower values)												
Du Moulin 2007	randomised trials	very serious[1]	no serious inconsistency	serious[2]	serious[14]	none	35	10	-	MD 9.4 higher (1.72 lower to 20.52 higher)	VERY LOW	IMPORTANT
UDI - Obstructive micturition at 12 months (Better indicated by lower values)												
Du Moulin 2007	randomised trials	very serious[1]	no serious inconsistency	serious[2]	serious[14]	none	35	10	-	MD 10.3 higher (0.44 lower to 21.04 higher)	VERY LOW	IMPORTANT
UDI - Pain/discomfort at 6 months (Better indicated by lower values)												
Du Moulin 2007	randomised trials	very serious[1]	no serious inconsistency	serious[2]	very serious[15]	none	35	10	-	MD 0.4 lower (10.73 lower to 9.93 higher)	VERY LOW	IMPORTANT
UDI - Pain/discomfort at 12 months (Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Intervention (continence nurse)**	**Control (GP)**	**Relative (95% CI)**	**Absolute**		
Du Moulin 2007	randomised trials	very serious[1]	no serious inconsistency	serious[2]	very serious[15]	none	35	10	-	MD 0.1 lower (7.5 lower to 7.3 higher)	VERY LOW	IMPORTANT
UDI - Overactive bladder at 6 months (Better indicated by lower values)												
Du Moulin 2007	randomised trials	very serious[1]	no serious inconsistency	serious[2]	serious[16]	none	35	10	-	MD 8.5 lower (23.58 lower to 6.58 higher)	VERY LOW	IMPORTANT
UDI - Overactive bladder at 12 months (Better indicated by lower values)												
Du Moulin 2007	randomised trials	very serious[1]	no serious inconsistency	serious[2]	serious[16]	none	35	10	-	MD 5.5 lower (21.19 lower to 10.19 higher)	VERY LOW	IMPORTANT
UDI - Prolapse at 6 months (Better indicated by lower values)												
Du Moulin 2007	randomised trials	very serious[1]	no serious inconsistency	serious[2]	serious[17]	none	35	10	-	MD 5 lower (13.11 lower to 3.11 higher)	VERY LOW	IMPORTANT
UDI - Prolapse at 12 months (Better indicated by lower values)												
Du Moulin 2007	randomised trials	very serious[1]	no serious inconsistency	serious[2]	serious[17]	none	35	10	-	MD 3.2 lower (11.1 lower to 4.7 higher)	VERY LOW	IMPORTANT
EQ-5D - At 12 months (Better indicated by higher values)												
Du Moulin 2007	randomised trials	very serious[1]	no serious inconsistency	serious[2]	very serious[18]	none	35	10	-	MD 2 higher (5.87 lower to 9.87 higher)	VERY LOW	CRITICAL
Satisfaction - At 6 months (Better indicated by higher values, score range 0 to 10)												
Du Moulin 2007	randomised trials	very serious[1]	no serious inconsistency	serious[2]	serious[19]	none	35	10	-	MD 0.8 higher (0.01 to 1.59 higher)	VERY LOW	CRITICAL
Satisfaction - At 12 months (Better indicated by higher values, score range 0 to 10)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intervention (continence nurse)	Control (GP)	Relative (95% CI)	Absolute		
Du Moulin 2007	randomised trials	very serious[1]	no serious inconsistency	serious[2]	serious[19]	none	35	10	-	MD 1.2 higher (0.5 to 1.9 higher)	VERY LOW	CRITICAL

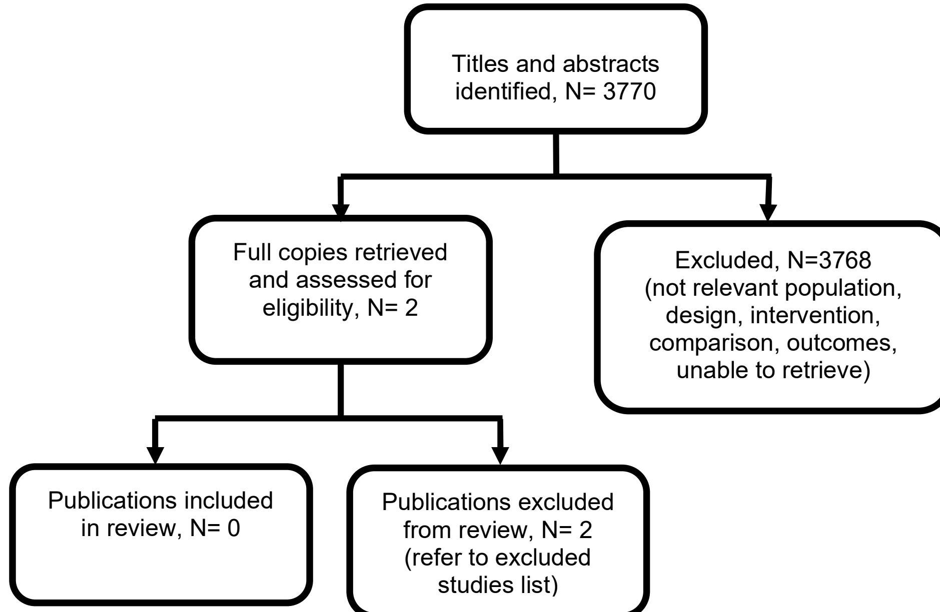
CI: confidence interval; EQ-5D. EuroQol; IIQ, incontinence impact questionnaire; MD: mean difference; UDI, urogenital distress inventory
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 Intervention is indirect as study is not comparing a team, as such, but a nurse to a GP
3 95% CI crosses 1 MID (0.5 x SD control at baseline, 3.6)
4 95% CI crosses 1 MID (0.5 x SD control at baseline, 2.6)
5 95% CI crosses 2 MIDs (0.5 x SD control at baseline, 10.9)
6 95% CI crosses 1 MID (0.5 x SD control at baseline, 10.9)
7 95% CI crosses 2 MIDs (0.5 x SD control at baseline, 10.4)
8 95% CI crosses 1 MID (0.5 x SD control at baseline, 6.7)
9 95% CI crosses 2 MIDs (0.5 x SD control at baseline, 6.7)
10 95% CI crosses 2 MIDs (0.5 x SD control at baseline, 9.3)
11 95% CI crosses 2 MIDs (0.5 x SD control at baseline, 8.3)
12 95% CI crosses 2 MIDs (0.5 x SD control at baseline, 8.2)
13 95% CI crosses 2 MIDs (0.5 x SD control at baseline, 8.2)
14 95% CI crosses 1 MID (0.5 x SD control at baseline, 8.1)
15 95% CI crosses 2 MIDs (0.5 x SD control at baseline, 6.1)
16 95% CI crosses 1 MID (0.5 x SD control at baseline, 12.9)
17 95% CI crosses 1 MID (0.5 x SD control at baseline, 5.9)
18 95% CI crosses 2 MIDs (0.5 x SD control at baseline, 5.2)
19 95% CI crosses 1 MID (0.5 x SD control at 6-months follow-up – baseline data not reported, 0.6)

Appendix G – Economic evidence study selection

Economic evidence study selection for review question: What competencies should be involved in a community-based multidisciplinary team for the management of symptoms associated with pelvic floor dysfunction?

No economic evidence was identified which was applicable to this review question.

Figure 2: Study selection flow chart



Appendix H – Economic evidence tables

Economic evidence tables for review question: What competencies should be involved in a community-based multidisciplinary team for the management of symptoms associated with pelvic floor dysfunction?

No evidence was identified which was applicable to this review question.

Appendix I – Economic evidence profiles

Economic evidence profiles for review question: What competencies should be involved in a community-based multidisciplinary team for the management of symptoms associated with pelvic floor dysfunction?

No economic evidence was identified which was applicable to this review question.

Appendix J – Economic analysis

Economic evidence analysis for review question: What competencies should be involved in a community-based multidisciplinary team for the management of symptoms associated with pelvic floor dysfunction?

No economic analysis was conducted for this review question.

Appendix K – Excluded studies

Excluded studies for review question: What competencies should be involved in a community-based multidisciplinary team for the management of symptoms associated with pelvic floor dysfunction?

Clinical studies

Table 6: Excluded studies and reasons for their exclusion

Study	Reason for exclusion
Albers-Heitner, P. C., Lagro-Janssen, T. A., Joore, M. M., Berghmans, B. L., Nieman, F. F., Venema, P. P., Severens, J. J., Winkens, R. R., Effectiveness of involving a nurse specialist for patients with urinary incontinence in primary care: results of a pragmatic multicentre randomised controlled trial, International Journal of Clinical Practice, 65, 705â 712, 2011	Population includes males with no separate analysis
Albers-Heitner, P., Berghmans, B., Joore, M., Lagro-Janssen, T., Severens, J., Nieman, F., Winkens, R., The effects of involving a nurse practitioner in primary care for adult patients with urinary incontinence: the PromoCon study (Promoting Continence), BMC Health Services Research, 8, 84, 2008	Protocol
Albers-Heitner, P., Winkens, R., Berghmans, B., Joore, M., Nieman, F., Severens, J., Lagro-Janssen, T., Consumer satisfaction among patients and their general practitioners about involving nurse specialists in primary care for patients with urinary incontinence, Scandinavian Journal of Caring Sciences, 27, 253-259, 2013	Population includes males with no separate analysis
Badger, F. J., Drummond, M. F., Isaacs, B., Some issues in the clinical, social and economic evaluation of new nursing services... a new nursing post, that of the adviser on incontinence, Journal of Advanced Nursing (Wiley-Blackwell), 8, 487-494, 1983	Population includes males with no separate analysis
Borrie, M. J., Bawden, M., Speechley, M., Kloseck, M., Interventions led by nurse continence advisers in the management of urinary incontinence: A randomized controlled trial, Cmaj, 166, 1267-1273, 2002	Population includes males with no separate analysis
Bradley, S., Moran, R., Better continence care through use of research in clinical practice, Nursing Times, 94, 52-53, 1998	Review
Chin, Weng Yee, Choi, Edmond P. H., Wan, Eric Y. F., Chan, Anca K. C., Chan, Karina H. Y., Lam, Cindy L K., Evaluation of the outcomes of care of nurse-led continence care clinics for Chinese patients with lower urinary tract symptoms, a 2-year prospective longitudinal study, Journal of Advanced Nursing (John Wiley & Sons, Inc.), 73, 1158-1171, 2017	Population includes males with no separate analysis
Choi, E. P., Chin, W. Y., Lam, C. L., Wan, E. Y., Chan, A. K., Chan, K. H. Evaluation of the effectiveness of nurse-led continence care treatments for Chinese primary care patients with lower urinary tract symptoms. PloS one, 10(6), e0129875, 2015.	Not an RCT
Divine, K., McVey, L. W., Snyder, C., Could Pelvic Floor Dysfunction Be the Missing Link? Collaboration in the Physical Therapy Clinic to Treat Chronic Buttock and Hip Pain, Journal of Women's Health Physical Therapy, 42, 40-40, 2018	Abstract
Du Moulin, M. F., Hamers, J. P., Paulus, A., Berendsen, C., Halfens, R., The role of the nurse in community continence care: a systematic review, International journal of nursing studies, 42, 479-92, 2005	Systematic Review - included studies checked for relevance
Eustice, S., Reversing deterioration in continence services, Nursing Times, 109, 18-19, 2013	Review

Study	Reason for exclusion
Farrell, S. A., Scott, T. A., Farrell, K. D., Irving, L., Foren, J., Twohig, J. Two models for delivery of women's continence care: the step-wise continence team versus the traditional medical model. Journal of Obstetrics and Gynaecology Canada, 31(3), 247-253, 2009.	Not an RCT
Ganz, D. A., Koretz, B. K., Bail, J. K., McCreath, H. E., Wenger, N. S., Roth, C. P., Reuben, D. B., Nurse practitioner comanagement for patients in an academic geriatric practice, American Journal of Managed Care, 16, e343-55, 2010	Population includes males with no separate analysis
Ganz, D. A., Wenger, N. S., Roth, C. P., Kamberg, C. J., Chang, J. T., MacLean, C. H., Young, R. T., Solomon, D. H., Higashi, T., Min, L., Reuben, D. B., Shekelle, P. G., The effect of a quality improvement initiative on the quality of other aspects of health care: the law of unintended consequences?, Medical care, 45, 8-18, 2007	Population includes males with no separate analysis
Glazener, C. M., Herbison, G. P., MacArthur, C., Grant, A., Wilson, P. D., Randomised controlled trial of conservative management of postnatal urinary and faecal incontinence: six year follow up, BMJBmj, 330, 337, 2005	Does not involve a 'team', either active treatment or standard care
Glazener, C. M., MacArthur, C., Hagen, S., Elders, A., Lancashire, R., Herbison, G. P., Wilson, P. D., ProLong Study, Group, Twelve-year follow-up of conservative management of postnatal urinary and faecal incontinence and prolapse outcomes: randomised controlled trial, BJOG: An International Journal of Obstetrics & Gynaecology, 121, 112-20, 2014	Does not involve a 'team', either active treatment or standard care
Goodman, C., L. Davies S, Norton, C., Fader, M., Morris, J., Wells, M., Gage, H., Can district nurses and care home staff improve bowel care for older people using a clinical benchmarking tool?, British journal of community nursing, 18, 580-7, 2013	Population includes males with no separate analysis
Jha, S., Moran, P., Blackwell, A., Greenham, H., Integrated care pathways: the way forward for continence services?, European Journal of Obstetrics, Gynecology, & Reproductive BiologyEur J Obstet Gynecol Reprod Biol, 134, 120-5, 2007	Not community-based care
Karon, S., A team approach to bladder retraining: a pilot study, Urologic nursing, 25, 269-76, 2005	Population includes males with no separate analysis
McDowell, B. J., Engberg, S., Sereika, S., Donovan, N., Jubeck, M. E., Weber, E., Engberg, R., Effectiveness of behavioral therapy to treat incontinence in homebound older adults, Journal of the American Geriatrics Society, 47, 309-318, 1999	Population includes males with no separate analysis
McDowell, B. J., Silverman, M., Martin, D., Musa, D., Keane, C., Identification and intervention for urinary incontinence by community physicians and geriatric assessment teams, Journal of the American Geriatrics Society, 42, 501â 505, 1994	Population - outcomes not split for male and female
Prentice, A., Bazzi, A. A., Aslam, M. F., Treatment patterns of primary care physicians vs specialists prior to subspecialty urogynaecology referral for women suffering from pelvic floor disorders, World Journal of MethodologyWorld j, 9, 26-31, 2019	Does not involve a 'team'
Ribas, Y., Coll, M., Espina, A., Jimenez, C., Chicote, M., Torne, M., Modolell, I., Initiative to improve detection of faecal incontinence in primary care: The GIFT Project, Family Practice, 34, 175-179, 2017	Intervention - new screening tool added to detect FI
Wagg, A., Lowe, D., Peel, P., Potter, J., Do self-reported 'integrated' continence services provide high-quality continence care?, Age and Ageing, 38, 730-733, 2009	Not interventional study design / outcomes not relevant
Wenger, N. S., Roth, C. P., Hall, W. J., Ganz, D. A., Snow, V., Byrkit, J., Dzielak, E., Gullen, D. J., Loepfe, T. R., Sahler, C., Snooks, Q., Beckman, R., Adams, J., Rosen, M., Reuben, D. B., Practice redesign to improve care for falls and urinary incontinence: Primary	Population includes males with no separate analysis

Study	Reason for exclusion
care intervention for older patients, Archives of internal medicine, 170, 1765-1772, 2010	

FI: faecal incontinence; RCT: randomised controlled trial

Economic studies

Study	Reason for exclusion
Franken, M. G., Corro Ramos, I., Los, J., Al, M. J., The increasing importance of a continence nurse specialist to improve outcomes and save costs of urinary incontinence care: an analysis of future policy scenarios, BMC Family PracticeBMC Fam Pract, 19, 31, 2018	Population includes men and women and proportion of women cannot be determined.
Merguerian, P. A., Grady, R., Waldhausen, J., Libby, A., Murphy, W., Melzer, L., Avansino, J., Optimizing value utilizing Toyota Kata methodology in a multidisciplinary clinic, Journal of Pediatric Urology, 11, 228.e1-228.e6, 2015	The population is children

Appendix L – Research recommendations

Research recommendations for review question: What competencies should be represented in a community-based multidisciplinary team for the management of symptoms associated with pelvic floor dysfunction?

Research question

What roles are needed in a community-based multidisciplinary pelvic floor dysfunction team?

Why this is important?

Pelvic floor dysfunction, is a complex condition managed differently by differing professionals. It spans urology, gynaecology, colorectal and pain specialties. Currently, no evidence exists in supporting service managers / commissioners in the optimal mix of professionals to manage this complex condition in non-specialist settings.

Table 7: Research recommendation rationale

Research question	What roles are needed in a community-based multidisciplinary pelvic floor dysfunction team?
Why is this needed	
Importance to 'patients' or the population	Pelvic floor dysfunction results in symptoms relating to many different systems and its management involves numerous different modalities. Treatment frequently does not require input from secondary care and even if assessed in secondary care treatment is often delivered in the community. An effective integrated approach from a multidisciplinary team both in assessment and management is essential. The correct composition of that team is important to deliver effective care. Currently it is not known what roles/professionals are needed to provide optimal care for the treatment of pelvic floor dysfunction. Increased knowledge of the professional roles within a multidisciplinary team may lead to improving patient care, provide improved time to diagnosis and treatments within the community, in addition to reducing unnecessary interventions and ultimately improving patient safety.
Relevance to NICE guidance	The absence of evidence regarding this topic for UK practice currently restricts NICE guidance from making recommendations regarding the composition of a community based multidisciplinary team to manage pelvic floor dysfunction. The outcome of this research would allow such recommendations to be developed and become part of NICE guidance.
Relevance to the NHS	Effective community-based management of pelvic floor dysfunction will reduce costs for the NHS compared with referral into secondary care
National priorities	The NHS long term plan (2019) states "We will ensure that women have access to multidisciplinary pelvic health clinics and pathways across England via referral".
Current evidence base	None for the United Kingdom
Equality	Effective community based multidisciplinary teams will allow care to be delivered close to a woman or child's home which will benefit all but particularly vulnerable groups who might otherwise not be blae to access assistance
Feasibility	Setting up these teams is very feasible as the individual members already work in most communities and the only innovation would be structured team working focussing on pelvic floor dysfunction
Other comments	None

Table 8: Research recommendation modified PICO table

Criterion	Explanation
Population	Professionals who provide conservative management for pelvic floor dysfunction and users of pelvic floor dysfunction services.
Intervention	A mixed method action research study, using a collaborative leadership approach to service redesign. This intervention would be led by the local professionals and service users who are currently involved in the treatment of pelvic floor dysfunction.
Comparator	Current service model (for example. continence service, previous years' data).
Outcomes	Key performance indicators for a service based on service parameters, patient improvement, patient reported cure rate and referral on for surgical procedures. Financial costs of the service.
Study design	Qualitative action research with service user and team involvement.
Timeframe	2 year intervention period for services.
Additional information	The participants: The team themselves would be the population assessing if they can provide a cost-effective model of care with an optimal service for patients from a quality and customer focus. The local experts including allied health professionals, medical and nursing colleagues would be consulted alongside the service users and commissioners to create a preferred service model. Utilizing quality improvement methodology such as process mapping a local approach to managing the problems for patients with pelvic floor dysfunction would be addressed. The action research would follow with implementation of the service design and review. After a 6 month period, adjustments to be made as necessary to team roles, functions and the service model. As no research currently exists this mixed methods approach is needed to gain depth and insights into problems associated for service users and medical professionals. The focus on the collaborative leadership approach is necessary to ensure the balance of all views is taken into consideration prior to the design intervention. How can this be applied across the population? Further research may be needed to establish whether the problems that exist in the local area, are also applicable in other areas around the UK. This smaller study may be able to provide further understanding of saturation and impact around the UK.