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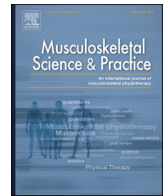
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Original article

Barriers and facilitators to ask for lower urinary tract symptoms in people with low back pain and pelvic girdle pain. A qualitative study

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ABSTRACT

Background: Lower urinary tract symptoms (LUTS) may be a relevant comorbidity when managing people with low back or pelvic girdle pain. It is unknown how often physiotherapists inquire about LUTS, and what the potential barriers and facilitators are to inquire about LUTS in this patient population.

Objective: To explore the frequency of inquiring about LUTS, and to identify the barriers and facilitators among physiotherapists with and without additional pelvic health training to ask for LUTS in people with low back or pelvic girdle pain.

Design: A qualitative study using thematic analysis.

Methods: Through purposeful sampling, 29 primary care physiotherapists were interviewed (16 physiotherapists and 13 physiotherapists with additional pelvic health training). Thematic analysis was performed to identify themes regarding facilitators and barriers.

Findings: The frequency of inquiring about LUTS was: 'never': 10%, 'sometimes': 38%, and 'always': 52%. Four barriers were identified: (1) lack of knowledge of the physiotherapist, (2) a standardised assessment approach which did not include LUTS, (3) patient expectations assumed by the physiotherapist, and (4) social, cultural and personal barriers. Three facilitators were identified: (1) communication skills and experience of the physiotherapist, (2) education and knowledge, and (3) interprofessional consultation and referral.

Conclusion: The majority of physiotherapists surveyed in this study regularly asked for LUTS in people with low back or pelvic pain. For when not asked, the identified barriers seem modifiable with adequate training, knowledge and skill acquisition, and sound clinical reasoning.

1. Background

Low back and pelvic girdle pain may be accompanied by lower urinary tract symptoms (LUTS) (Cassidy et al., 2017; Dufour et al., 2018). Although low back and pelvic girdle pain appear similar, the latter may be specifically characterized by pain in the vicinity of the sacroiliac joint and may radiate to the symphysis or posterior thigh (Vleeming et al., 2008). The International Continence Society defines LUTS as problems with voiding, post-voiding or storage of urine (D'Ancona et al., 2019). Physiotherapists with or without additional pelvic health training

commonly manage people with low back and pelvic girdle pain, with or without LUTS (Scheele et al., 2014).

The conservative management of LUTS, including pelvic floor muscle training and promotion of life-style changes such as weight loss, is highly effective (Dumoulin et al., 2018). This treatment may be provided by a men's and women's health, or, pelvic health physiotherapist. If present, it is however important that LUTS is identified in people with low back and pelvic girdle pain. The presence of LUTS increases the risk to develop chronic low back pain (Cassidy et al., 2017; Eliasson et al., 2008). Patients with LUTS are also at increased risk of experiencing

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anxiety, depression, reduced quality of life and reduced physical health (Haltbakk et al., 2005; Huang et al., 2017). These factors may further lead to delayed recovery from low back and pelvic girdle pain (Bjelland et al., 2013; Gregg et al., 2014).

Although LUTS may be an important comorbidity in people with low back pain, guidelines do not specifically describe LUTS as a possible comorbidity (Oliveira et al., 2018; Qaseem et al., 2017). The guidelines on pelvic girdle pain acknowledge the relevance of LUTS, but do not indicate how to account for LUTS in the diagnosis or management of patients with pelvic girdle pain (Vleeming et al., 2008). In order to provide adequate treatment, the patient interview should include a urological history. To our knowledge, no study has reported whether physiotherapists (with or without additional pelvic health training) ask people with back pain about the presence or impact of LUTS. Subsequently, no knowledge exists on what barriers possibly withhold them from doing so and what could facilitate physiotherapists to overcome these barriers. Therefore, the aim of this qualitative study was to explore the frequency of inquiring about LUTS, and to identify the barriers and facilitators among physiotherapists with and without additional pelvic health training to ask for LUTS in people with low back pain or pelvic girdle pain.

2. Methods

A qualitative study was performed and designed in accordance with the consolidated criteria for reporting research (COREQ) recommendations (Tong et al., 2007).

2.1. Qualitative approach

Semi-structured interviews were used to identify themes that describe barriers or facilitators to perform history taking of LUTS in people with back pain or pelvic girdle pain. If the physiotherapist did not ask for LUTS, the interview was directed towards getting an understanding why LUTS were not discussed. A selection of pelvic health physiotherapists was asked similar questions, to find out what barriers they experienced in the past and how they overcame such barriers during their career.

2.2. Research team and reflexivity

The two interviewers (TV, MSc, male and AE, BSc, female) are primary care physiotherapists who commonly treat people with back pain. The other authors (SR, PhD; AP, PhD and MC, PhD), are experienced musculoskeletal physiotherapists and researchers with experience in qualitative research. AP has advanced pelvic health clinical and research expertise.

2.3. Study design

A purposeful sampling strategy was used to gather information from physiotherapists based on their expertise treating low back pain and/or LUTS, either with or without a musculoskeletal or pelvic health specialisation (Miles et al., 2014). Recruitment of primary care

physiotherapists in The Netherlands was performed via email and at a science network meeting for pelvic health physiotherapists.

Participants were interviewed at their workplace, in a quiet and private room, to ensure physiotherapists could speak freely. The interview was performed based on an interview-guide, built on an a-priori designed topic list (Kallio et al., 2016). The interview commenced with a basic vignette about an adult patient (no sex was described) with non-specific low back pain, without the presence of neurological signs or symptoms or red flags. The vignette was followed by the first question whether the participant would ask about LUTS. To practice the interview, a pilot interview was conducted with a randomly selected physiotherapy student with extensive internship experience in her final year. The pilot interview did not result in any changes of the interview procedure.

2.4. Ethical considerations

Ethical approval was obtained from the ethical committee of the Vrije Universiteit Amsterdam (VCWE-2019-141). All physiotherapists were informed about the study before the interview would take place and signed an informed consent form.

2.5. Data collection procedure

Before the interview started, participants' characteristics were noted. Characteristics included gender, age, specialisation through post-graduate courses, years working as a physiotherapist. All data were collected between November 2018 and June 2019. All interviews were recorded and transcribed verbatim. The transcription of the audio files was anonymized.

2.6. Analysis procedure

Thematic analysis was conducted on written transcript files of the interviews (Braun and Clarke, 2006). This involved a hybrid process of inductive and deductive thematic analyses to obtain codes and themes (Fereday and Muir-Cochrane, 2017).

AE coded the first 16 interviews. TV then structured the codes into an initial theme list and coded the remaining 13 interviews accordingly until saturation was reached. To enhance the validity of the themes, SR independently coded four interviews, to search for differences in coding. In the construction phase, the code structures were then discussed between TV and SR until agreement was achieved. Since similar words in coding were used by TV and SR, high agreement was already obtained. After consensus was found, the codes were then organised to generate a definitive code structure. In case of disagreement, MC and AP acted as a third party and reviewed the final code structure in the rectification phase. Only small changes were made to the final code structure. The codes were then stabilised by fitting quotations from the participants (Vaismoradi et al., 2016).

To perform the thematic analysis, MAXQDA Analytics Pro 2018 (VERBI Software, Berlin, Germany, 2017) was used. Analysis of participants' characteristics was performed with IBM SPSS 25 (IBM Corp, Armonk, NY, 2017).

Table 1
Participants' characteristics.

Characteristics	Physiotherapist (n = 16)	Pelvic health physiotherapist (n = 13)	Total (n = 29)
Gender, female	3 (19%)	13 (100%)	16 (55%)
Age (mean [sd])	45.1 (15.0)	46.9 (14.7)	45.9 (14.6)
Clinical experience in years (mean [sd])	21.9 (14.4)	24.5 (14.6)	23.1 (14.3)
Postgraduate courses			
None	9 (56%)	0 (0%)	9 (31%)
MSK specialist	7 (44%)	0 (0%)	7 (24%)
Pelvic Health Physiotherapy	0 (0%)	13 (100%)	13 (45%)

NA: Not applicable, n: frequency, sd: standard deviation, MSK: musculoskeletal specialisation.

3. Findings

The interviews were held with 13 pelvic health physiotherapists (PH-PT) and 16 physiotherapists (PT). Table 1 shows the characteristics of the participants. The analysis yielded a code structure derived from all 29 participant interviews as presented in Table 2. TV added brackets in the quotations of participants to add clarifications.

3.1. Frequency of asking about LUTS (N)

Participants were categorised in three groups regarding the frequency of asking about LUTS: ‘never’, ‘sometimes’ or ‘always’. The category ‘sometimes’ included participants who would ask for LUTS only if particular patient characteristics or symptoms would be present (e.g., neurological signs or women after childbirth). The findings are presented in Table 3.

3.2. Barrier: Lack of knowledge of the physiotherapist (B.1)

For some participants, the relationship between back pain and LUTS was unknown. Twelve physiotherapists mentioned lack of knowledge as

an important reason why they would not ask for LUTS in people with back pain. One physiotherapist said:

[PT-3] “It is unknown to me, the presence of LUTS in male patients. I would think that they would be the only ones in The Netherlands! And to be honest, the combination of having both non-specific low back pain and LUTS don’t seem...[thinks] well... if someone had neurological symptoms, then I would think sooner about it [LUTS], instead of someone with non-specific low back pain.”

Seven pelvic health physiotherapists mentioned that lack of knowledge before their post-graduate specialisation was an important barrier.

3.3. Barrier: Standardised assessment approach which did not include LUTS (B.2)

Some of the participants stated that, asking for LUTS, is not a part of their standardised assessment approach of people with low back pain. Only when certain aspects were present in the patient’s story, they would incorporate LUTS in their history taking.

Table 2
Code structure.

Theme	Code
N	Frequency
	N.1.1 Never.
	N.1.2 Sometimes.
	N.1.3 Always.
B	Barriers
B.1	Lack of knowledge of the physiotherapist.
B.2	Standardised assessment approach which did not include LUTS.
B.3	Patient expectations assumed by the physiotherapist.
B.4	Social, cultural and personal barriers.
F	Facilitators
F.1	Communication skills and experience of the physiotherapist.
	F.1.2 Experience of the physiotherapist.
	F.1.3 Introducing the subject to patients.
F.2	Education and knowledge.
F.3	Interprofessional consultation and referral.

N: frequency, B: barriers, F: facilitators.

Table 3
Frequency of asking about LUTS in patients with low back pain.

Category n (%)	Female n (%)	Median age (min-max)	Specialisation n	Quotes from participants
Never 3 (10%)	0 (0%)	55 (29-57)	None: 2 MSK: 1 PH-PT: 0	[PT-5] “No [...] because that’s not the complaint a patient would visit me for.”
Sometimes 11 (38%)	3 (19%)	38 (27-65)	None: 6 MSK: 4 PH-PT: 1	[PT-3] “It is unknown to me, the presence of LUTS in male patients. I would think that they would be the only ones in The Netherlands!” [PT-11] “...if someone has low back pain for two years, and already, for example, has seen other.... [health professionals], then I would look at it from a broader perspective.”
Always 15 (52%)	13 (81%)	52 (26-69)	None: 1 MSK: 2 PH-PT: 12	[PT-4] “Yes [...] for example in a woman with three children and chronic low back pain” [PT-6] “Only if certain symptoms are present that would lead to the hypothesis, like a herniated disk” [PT-7] “Yes, but not right away [...] if there is distress, for example, if someone is able to take the time to go to the toilet at work or the mental aspects of it” [PT-13] “If it is about low back pain, and I have to define it as nonspecific low back pain, then I have to be sure no urogenital complaints are present [...] then I would ask... always” [PT-8] “Yes, I would, it’s more widely accepted than it was in the past” [PH-PT-4] “Yes, always...” [when asked why] “because there is scientific evidence that patients with low back pain may have LUTS”

n: frequency, MSK: musculoskeletal specialisation, PT: physiotherapist, PH-PT: pelvic health physiotherapist.

[PH-PT3] "Well, because it wasn't in my usual pattern of history taking. That's mostly it. When I treated patients with non-specific low back pain, I didn't think of the pelvic floor as a relevant region. Now, [as pelvic health physiotherapist], it is where my clinical reasoning starts at."

[PT-6] "To me, LUTS belongs to my extended clinical reasoning and would not fit my standard assessment approach. I wouldn't have any reason to ask for problems with urinating, to me, it's only a relevant question in case neurological symptoms exist".

3.4. Barrier: Patient expectations assumed by the physiotherapist (B.3)

Some participants considered the assumed patients' expectations to be a possible barrier to discuss LUTS. They assumed their patients to see them as a health professional to solely discuss musculoskeletal problems with.

[PT-14] "Patients expect, when they consult a physiotherapist, to primarily talk about the musculoskeletal system. If you would additionally ask such questions [on LUTS] that wouldn't be a problem. However, if the first, second or third question would be: 'do you have problems with urinating', then they would think: 'what's going on?'"

When asked about different groups of patients and their expectations, this participant stated:

[PT-14] "Young adults wouldn't have it [LUTS], and if they would have it, I think it would be the last thing they would discuss"

Some of them also expect their patients not able to relate low back pain to LUTS, which could be another reason not to discuss LUTS with them.

[PH-PT-5] "No, I think they would never do that [bring up LUTS]. [...] I don't expect a 'regular' patient with low back pain to relate their complaints to LUTS"

[PH-PT-6] "Maybe if they [patients] would really understand the relationship... but I think that really a lot of people do not understand it, and see it as two separate entities, and that they would think: 'that is not a part of my back [problem]'."

3.5. Barrier: Social, cultural and personal barriers (B.4)

Social, cultural and personal barriers were experienced by some participants. Social and cultural restraints influence how freely the participants would talk about LUTS with different groups of patients, considering for example ethnicity or gender. Personal restraints describe a barrier due to participants feeling uncomfortable to talk about LUTS. Social, cultural and personal restraints appeared to be closely interwoven.

On the social and cultural restraints, a physiotherapist said:

[PT-9] "It appears that some patients don't feel like they could talk about it, it's not something you throw out in the open. I think that elderly people have the idea, that they are the only one [with LUTS], but they are definitely not. I think that's what makes it so hard to talk about."

[PT-4] "I would definitely feel a barrier [to talk about LUTS], with an Arabian woman, who is less proficient in Dutch and clothed in a long robe."

When asked what reasons lead to these barriers, this participant stated:

[PT-4] "It's language barriers..."

However, also personal restraints were present:

[PT-4] "To be able to express myself and tell patients why it was relevant".

Similar remarks were made by a physiotherapist who described it as a part of one's career and refers to his own early career experiences:

[PT-12] "I think I would not have done that [asking for LUTS], you are not really aware, I think. You are really just trying to discover how to get along with all sorts of people. I think I would be ashamed and think 'that it [LUTS] is a private matter, I don't need that information'."

3.6. Facilitator: Communication skills and experience of the physiotherapist (F.1)

Communication skills and experience can facilitate talking about potential sensitive issues such as LUTS. Two subthemes were identified: 'experience of the physiotherapist' and 'introducing the subject to patients' as a skill that could ease the conversation.

Many of the physiotherapists mentioned it to be easier once they gain more experience on asking about the presence of LUTS. A pelvic health physiotherapist stated:

[PH-PT-13] "It will grow on you to talk about urinating, pooping and having sex. I can see why patients would find that hard at first as well... eh... And now, I would talk quite easily about urinating, because it is something you do all the time."

Another therapist, compared the situation before and after graduating as a pelvic health physiotherapist:

[PH-PT-6] "Maybe it was a bridge too far, it was tough for me [to talk about LUTS]. But not anymore, because it became daily business".

Some pelvic health physiotherapists stated that questioning the patient about LUTS was facilitated simply by providing an explanation in advance why they need to discuss this topic.

[PT-12] "The funny thing is, if you approach it calmly, but direct, as long as you introduce it... eh... you have to explain, why you ask questions in that direction [on LUTS], and... eh... the same goes for sexual functions, just make it clear, like "I'm going to ask you some questions, because I need to know if..." [...] I notice that people accept it very well and give a straightforward answer to the question."

[PH-PT-4] "If you would explain why you ask, then the patient opens up. If a patient denies, or hesitates, just paraphrase and ask several different questions on the topic, just to make sure that the answer is really true"

3.7. Facilitator: Education and knowledge (F.2)

Participants reported that it would have facilitated them if they learned more about LUTS during the initial training as a physiotherapist. In particular they mentioned education and knowledge about the pelvic region or LUTS in general, the relationship between LUTS and low back pain, and knowing what possible care pathways exist for these patients. One participant put it as:

[PT-10] "During the initial study of physiotherapy, we did not spend much time on adequate history taking, especially on urogenital or bowel movement subjects [...] I got used to asking this [LUTS] once I started with the post-graduate course orthopaedic manual therapy [musculoskeletal specialisation]"

Another physiotherapist described that it would change one's choices for therapy and referred to the effects a post-graduate course had on the students:

[PT-16] *“In the post-graduate course orthopaedic manual therapy [musculoskeletal specialisation], we have one or two thematic days. For one of those, the subject is pelvic therapy [...] you can see them [students] start to see the pattern [relationship between LUTS and low back pain] [...] My colleague, a pelvic health physiotherapist, got three to four patient referrals from these students the following days [...] probably, just a little information is all that is needed.”*

Not only knowledge on the relationship between LUTS and low back pain would help them, some participants also mentioned that they needed to know about possible care pathways. They were interested to learn about interventions they could provide themselves, or when to refer a patient to another healthcare professional. One participant said:

[PT-3] *“[If LUTS are present] ... I am not going to treat those patients. No. I will refer them to a colleague with a three-year post-graduate course, and 20 years of experience, who is much better at it [treating] than I am. [...] I really would not know how to treat someone with pelvic problems or LUTS.”*

[PT-1] *“It could be that we don't know enough [on LUTS] and that it would be a really important factor to keep in mind. However, it is quite interesting, if a patient reports such complaints, that I would know what to do about it”.*

Knowledge about possible care pathways also appears to influence the clinical reasoning and facilitates making appropriate choices in diagnosis, prognosis and treatment options.

[PT-7] *“...if someone says ‘yes, I have pain when starting to urinate’, then, I would not know how to help someone with that [...] I can ask if they have seen a general practitioner or think along with them a little, but it is not something I learned during my initial study.”*

3.8. Facilitator: Interprofessional consultation and referral (F.3)

Interprofessional consultation with a nearby pelvic health physiotherapist could be a way to obtain more knowledge on LUTS as a more indirect method, compared to explicit learning through education. This could help to address and improve the knowledge of colleagues on a daily basis:

[PH-PT-10] *“I think that it's important [on: having a pelvic health physiotherapist nearby], as we have a lot of knowledge, in other practices they don't, so how will you get the knowledge there?”*

Not only a pelvic health physiotherapist colleague as a source of knowledge is of importance, but the possibility to discuss LUTS and refer patients to a pelvic health physiotherapist in the same area was also mentioned to be useful:

[PH-PT-1] *“I think that all physiotherapists, eh... should be aware that it [LUTS] could play a role, even if they have the slightest suspicion. They could ask really easy questions [...] and conclude ‘well, maybe I should have a look at it with a colleague who is a pelvic health physiotherapist and see if we can solve the problem together’.”*

It seems that such actions are shared by different pelvic health physiotherapists, as another stated in a comparable manner:

[PH-PT2] *“I expect them [physiotherapists] to take LUTS and incorporate it in their clinical reasoning and build a pelvic-related hypothesis, even if they could not test to confirm a hypothesis in the pelvic region, as long as they refer to a pelvic health physiotherapist”.*

4. Discussion

This study aimed to explore the frequency of inquiring about LUTS,

and to identify the barriers and facilitators among physiotherapists with or without additional pelvic health training to ask for LUTS in people with low back or pelvic girdle pain.

Only few of the interviewed participants (10%) never ask about LUTS, while some (38%) only do if certain symptoms or characteristics are present, and others (52%) always ask. Of the 15 participants who reported to always ask about LUTS, 12 had specialised in pelvic health physiotherapy.

Barriers to discuss LUTS with patients with back or pelvic girdle pain included lack of knowledge of the physiotherapist, standardised assessment approach that did not include LUTS, assumptions of patient expectations, and social and personal limitations. It was often difficult to make a clear distinction between social and personal limitations. This was especially the case if participants gave patient examples. It remained sometimes unclear whether such examples reflected personal hesitance or really described social or cultural restraints. Other research showed difficulty discussing less somatic topics due to the gender of the health professional (Bertakis et al., 1995; Christen et al., 2008). Although our study also identified these differences (i.e., more women reported to always ask for LUTS), interpretation is difficult because all therapists with additional pelvic training were women. Social barriers could also be caused due to differences in ethnicity and intercultural skills (Paternotte et al., 2016). However, we were unable to fully reveal the underlying constructs that cause these barriers. No facilitators could be identified specifically aimed at overcoming social, cultural or personal barriers.

The participants considered knowledge and practical skills as important facilitators to overcome before mentioned limitations. This included knowledge on the pelvic region; LUTS; its relationship with back or pelvic girdle pain or to be aware of possible healthcare pathways. This follows findings of other research where history taking was not complete due to lack of knowledge or lesser taught subjects in the initial education (Ohm et al., 2013). Other facilitators included referral to a pelvic health physiotherapist or to have the possibility for interprofessional consultation. This also follows findings from previous research, where similar factors were found to improve asking about social determinants and not solely the disease itself (Naz et al., 2016).

This qualitative study has several limitations. First, the interviews with the physiotherapists were scheduled during their lunch break or in-between appointments with patients. In the Netherlands, this is about 30 min. Therefore, some of the interviews may have been longer if more time would have been scheduled. Nonetheless, saturation was reached and meaningful themes emerged from the data. Second, each interview started with a vignette of an uncomplicated patient with low back pain scenario. This may have steered the physiotherapists to not think of LUTS immediately. However, consecutive questions were aimed to provide the physiotherapist with ample opportunity to talk about LUTS. Therefore, all possible ways towards representative answers were explored during the interview.

All identified themes will benefit from further exploration to provide an understanding how, and when these barriers originated, and what facilitators should be prioritised to improve history taking on LUTS in people with low back and pelvic girdle pain. To further validate the themes and increase generalisability, data-triangulation, for example through large surveys or focus groups, is needed (Carter et al., 2014).

5. Conclusion

This study identified that the frequency of inquiring about LUTS varied between never, sometimes or always among the physiotherapists with or without additional pelvic health training. Barriers to ask for LUTS in people with low back or pelvic girdle pain were lack of knowledge and patient expectations assumed by the physiotherapist, standardised assessment approach of patients which did not include LUTS and social, cultural and personal barriers. Possible facilitators could be education, to improve on introducing the subject and gain more

experience with asking about LUTS. These findings could help physiotherapists to address LUTS in patients with low back pain, although no facilitators or secondary factors for the social, cultural and personal barriers were found.

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Ethical considerations

Ethical approval was obtained from the ethical committee of the Vrije Universiteit Amsterdam (VCWE-2019-141). All physiotherapists were informed about the study before the interview would take place and signed an informed consent form.

Declaration of competing interest

None declared.

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