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DESCONFORTO DO ASSOALHO PÉLVICO E VIA DE PARTO EM MULHERES NO PUERPÉRIO REMOTO

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Trabalho Conclusão do Curso de Graduação em Fisioterapia do Departamento de Ciências da Saúde da Universidade Federal de Santa Catarina como requisito para a obtenção do título de Bacharel em Fisioterapia

Orientador: Prof. Dra. Janeisa Franck Virtuoso

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DEDICATÓRIA

Dedico este trabalho à minha família e amigos.

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DESCONFORTO DO ASSOALHO PÉLVICO E VIA DE PARTO EM MULHERES NO PUERPÉRIO REMOTO

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RESUMO

Introdução: Os desconfortos do assoalho pélvico (DAP) tem inúmeros fatores de risco associados ao seu desenvolvimento, incluindo gravidez e via de parto. **Objetivo:** Analisar a presença de DAP em primíparas no puerpério remoto conforme a via de parto. **Métodos:** Estudo transversal, cuja amostra foi composta por mulheres primíparas residentes no sul de Santa Catarina, Brasil, com idade igual ou superior à 18 anos que estivessem no puerpério remoto. As participantes preencheram uma ficha de caracterização da amostra e o Pelvic Floor Distress Inventory (PFDI-20) para avaliar a presença de sintomas de DAP. Esses dados foram coletados por meio de um sitio eletrônico e foram analisados de forma descritiva e inferencial, com nível de significância de 5%. **Resultados:** Participaram do estudo 242 mulheres, sendo 64,9% puérperas de parto cesáreo e 35,1% puérperas de parto vaginal. Quanto às características da amostra, as puérperas de parto cesáreo possuíam uma maior tendência ao sobrepeso do que puérperas de parto vaginal. Observou-se que 87,2% das mulheres possuem algum DAP, havendo diferença significativa apenas nos sintomas urinários, em que, 60% das puérperas de parto vaginal apresentaram algum tipo desse sintoma. Os sintomas de prolapso de órgão pélvico (8,2%); incontinência urinária de urgência (25,9%); incontinência urinária de esforço (28,8%) e perda de urina em pequenas quantidades (34,1%) foram maiores entre as puérperas de parto vaginal. **Conclusão:** Somente as puérperas de parto vaginal tiveram associação com sintomas de DAP.

Palavras Chaves: Saúde da Mulher; Incontinência Urinária; Prolapso de Órgão Pélvico; Período Pós-Parto.

SUMÁRIO

INTRODUÇÃO

Os músculos do assoalho pélvico possuem um papel fundamental no suporte de órgãos pélvicos, continência anal e continência urinária [1]. Portanto, distúrbios desses músculos causam desconfortos dos músculos do assoalho pélvico (DAP), termo que inclui condições como prolapsos de órgãos pélvicos (POP), incontinência urinária (IU), incontinência anal (IA) e disfunção sexual [2].

A etiologia dos DAP é conhecida por ser multifatorial, mas frequentemente é relacionada à gravidez e à via de parto [3]. A respeito do parto vaginal, existem inúmeros fatores associados ao desenvolvimento de DAP, tornando-se difícil predizer qual é o mais importante. Dentre esses fatores de risco destacam-se: uso de ocitocina, prolongamento da segunda fase do trabalho de parto, a gravidade das lacerações perineais, episiotomia e o uso de vácuo ou fórceps [4]. Portanto, tendo em vista o grande número de fatores de risco, é bem estabelecido que o parto vaginal pode ocasionar danos aos músculos, nervos e ao tecido conjuntivo do assoalho pélvico [5]. Estudos associam o parto vaginal com o desenvolvimento de DAP, mas não há consenso sobre o papel protetor da cesariana [6]. No estudo realizado por Rocha e colaboradores (2017), com a participação de 237 mulheres no período de 3 três meses após o parto, 34,6% (n=82) apresentaram IU, sendo que 28,69% (n=68) haviam tido parto vaginal, enquanto 5,91% (n=14) haviam tido parto cesáreo [7].

As taxas de realização de partos cesáreos aumentam a cada ano, chegando a 24,5% na Europa Ocidental, 32% na américa do Norte e 41% na América do Sul [8]. No estudo de Blomquist e colaboradores (2018), participaram 1.528 mulheres, que foram divididas em 3 grupos: mulheres que tiveram parto cesáreo (n= 778), mulheres que tiveram parto vaginal (n= 565) e mulheres que tiveram parto vaginal com uso de fórceps ou vácuo (n= 185). Entre as mulheres que tiveram parto cesáreo, 13% apresentaram incontinência urinária de esforço (IUE)

e 19% IA; entre as mulheres que tiveram parto vaginal, 26,4% apresentaram IUE e 22,8% IA; e entre as mulheres que tiveram parto vaginal com uso de fórceps ou vácuo 30,3% apresentaram IUE e 31,4% IA [9].

Diante da literatura pesquisada, a gravidez e o tipo de parto são fatores de risco para o desenvolvimento de DAP. O conhecimento acerca da prevalência e dos fatores que contribuem para o surgimento desses desconfortos com relação à via de parto vaginal e via de parto cesáreo poderá auxiliar na prática clínica fisioterapêutica, já que, por meio de orientações e intervenções é possível reduzir a incidência de DAP nessa população. Além disso, a promoção desse conhecimento gera autonomia nas gestantes para a escolha da via para a concepção. Portanto, o objetivo deste estudo foi analisar a presença de DAP em primíparas no puerpério remoto, conforme a via de parto.

METODOLOGIA

O presente estudo é parte de um projeto guarda-chuva intitulado “Estudo DAPSUL” que avalia os DAP em mulheres adultas da região sul do Brasil, tendo parecer de aprovação ética (CEP/UFSC: 3.357.956). Trata-se de um estudo observacional do tipo transversal, conduzido entre fevereiro e outubro de 2020, em que a população foi composta de mulheres adultas primíparas durante o puerpério remoto e residentes do sul catarinense, Brasil.

Para a seleção da amostra foram considerados critérios de inclusão mulheres primíparas com idade igual ou superior a 18 anos que estivessem no período de puerpério remoto (a partir do 43° dia pós parto até 12 meses pós parto). Além desses critérios, as participantes também deveriam falar e compreender o idioma português brasileiro.

Foram excluídas mulheres com histórico de aborto em idade gestacional superior a 12 semanas, sem relações sexuais nas últimas 4 semanas, histórico de cirurgia uroginecológica nos últimos 3 anos, sinais ou sintomas sugestivos de Infecção do Trato Urinário (ITU) (disúria, ardência, poliúria) auto relatado nas últimas quatro semanas, grávidas, a gestação ter sido múltipla e/ou o recém-nascido/filho ter histórico de internação hospitalar nas últimas quatro semanas.

Para caracterização da amostra, foram coletados, por meio de uma ficha dados sociodemográficos (idade, estado civil, escolaridade, raça, renda familiar), clínicos (doenças pregressas e prática de atividade), dados antropométricos (peso em kg, altura em cm e índice de massa corporal), obstétricos (histórico de aborto), via de parto no nascimento (vaginal, cesárea) e tempo de puerpério (meses).

Para avaliar os desconfortos do assoalho pélvico foi utilizado o Pelvic Floor Distress Inventory (PFDI-20). Baseado na versão elaborada por Barber et al (2001), o Pelvic Floor Distress Inventory foi adaptado por Barber, Walters e Bump (2005) [10], sendo validado no

Brasil recentemente por Arouca et al (2016) [11]. Trata-se de um instrumento utilizado para avaliação do desconforto gerado pelas DMAP, onde aplica-se três diferentes escalas: Urinary Distress Inventory - UDI-6 que avalia os sintomas urinários; Colorectal-Anal Distress Inventory - CRADI-8 que avalia o sintomas anorretais e Pelvic Organ Prolapse Distress Inventory - POPDI-6 que avalia os sintomas pélvicos [10].

O instrumento é formado por 20 questões pontuadas entre zero para nenhum sintoma e quatro para sintomas presentes e incômodos, o valor correspondente as questões de cada subescala gera uma média que deve ser multiplicada por 25 totalizando uma pontuação entre 0 (nenhum desconforto) a 100 (máximo desconforto) para cada escala. Desse modo, a pontuação do PFDI-20 pode totalizar até 300 pontos sendo que quanto maior a pontuação pior é o desconforto do assoalho pélvico [10].

Nesse estudo, foi verificada a presença / ausência de desconfortos do assoalho pélvico (escore total de PFDI-20), sintomas pélvicos, sintomas anorretais e sintomas urinários. Além disso, foi avaliada a presença / ausência de cada um dos 20 sintomas analisados pelo instrumento.

Para a coleta de dados as mulheres foram convidadas por pesquisadores treinados a participar de um estudo *online* através de plataformas digitais como *Instagram* e *Facebook*, sendo o recrutamento de forma intencional. Ao acessar a pesquisa (link), na página inicial, as participantes receberam orientações relacionadas ao objetivo do estudo, critérios de elegibilidade, tempo estimado para aplicação dos instrumentos e acesso ao termo de consentimento livre e esclarecido. Ainda na página inicial, foi questionado sobre o aceite e concordância com os termos da pesquisa. Para aquelas que aceitaram, data e horário do aceite foram registrados e as participantes foram direcionadas para avaliação da elegibilidade. Mulheres que se adequaram aos critérios de seleção terão acesso aos instrumentos da pesquisa.

Os instrumentos foram organizados em sessões com perguntas que poderiam ser respondidas no formato discursivo, múltipla escolha e/ou em de caixas de seleção.

Para formulação do banco de dados e análise estatística, foi montada inicialmente uma planilha eletrônica no programa Microsoft Excel® com informações relativas aos dados coletados. Cada participante recebeu um número de controle.

As variáveis foram analisadas descritivamente por meio de frequência (variáveis categóricas) e medidas de posição e dispersão (variáveis numéricas). Para comparação entre grupos foi utilizado o teste de qui quadrado de Pearson ou teste exato de Fisher, conforme indicado. As variáveis quantitativas foram apresentadas em média ± desvio padrão ou mediana e amplitude interquartil (AIQ). Para as comparações das variáveis quantitativas entre grupos foi utilizado teste t de Student ou U de Mann-Whitney Rank-sum, precedidos de teste de Kolmogorov Smirnov. Para todas as análises estatísticas foi adotado o valor de $p < 0,05$ para indicar diferença estatisticamente significativa entre os grupos. As analises foram realizadas no software estatístico SPSS – Statistical Package for Social Sciences (versão 22.0 IBM®).

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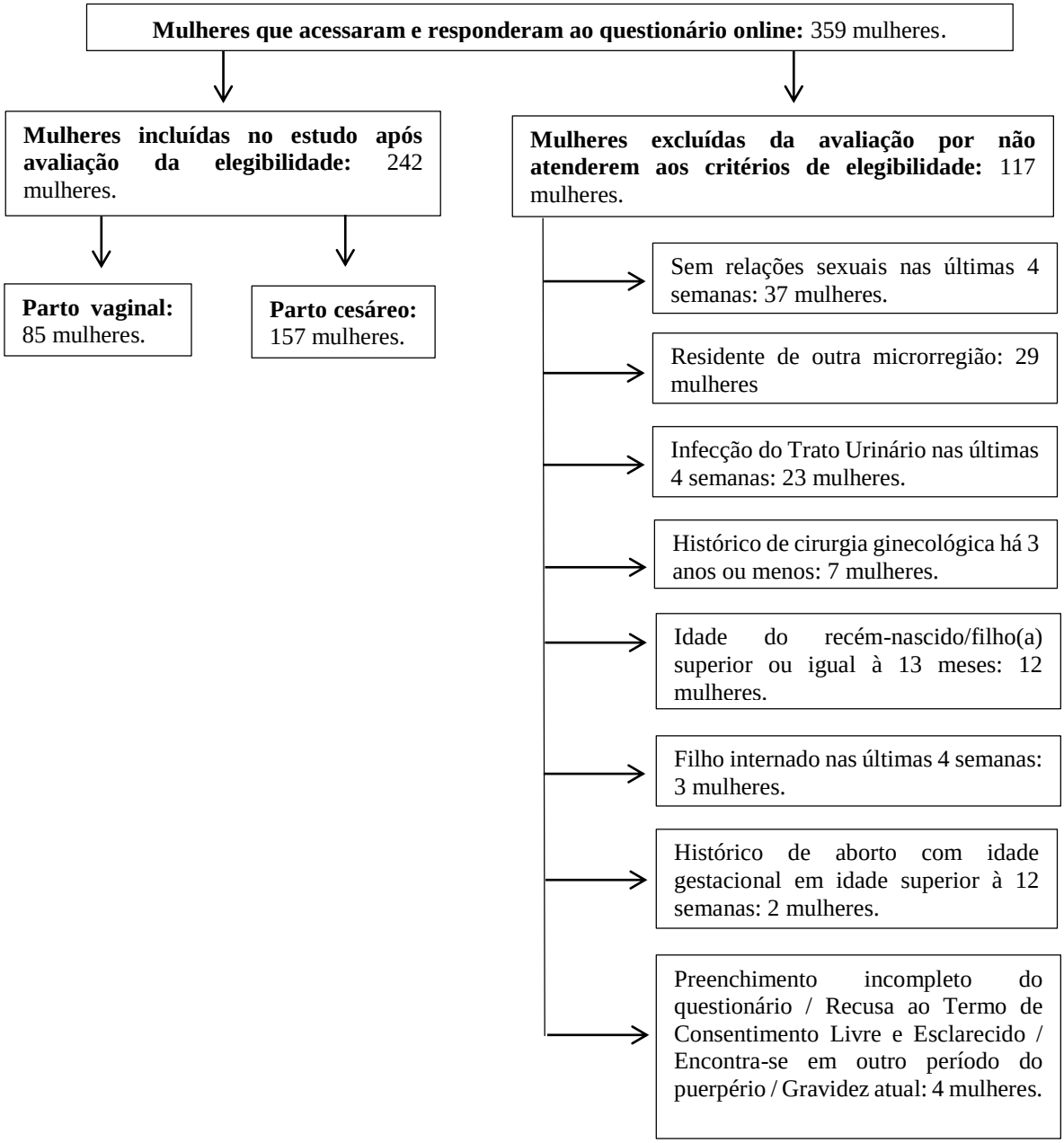
RESULTADOS

Participaram do estudo um total de 359 mulheres, sendo incluídas na análise 242 mulheres com média de idade de 27,28 ± 4,81 anos que concordaram com os termos de pesquisa e atenderam aos critérios de elegibilidade. Dessa forma, foram excluídas do estudo 117 mulheres com média de idade de 25,20 ± 5,57 anos devido à ausência de relações sexuais nas últimas quatro semanas (31,62%), morar em regiões distintas a área de interesse do estudo (24,78%), sinais clínicos de infecção urinária nas últimas quatro semanas (19,65%) e histórico de cirurgia ginecológica nos últimos três anos (5,98%) (Figura 1).

Com relação à via de parto, 64,9% (n=157) mulheres eram puérperas de parto cesáreo e 35,1% (n=85) eram puérperas de parto vaginal. O tempo médio de puerpério das mulheres que participaram do estudo foi de 5,91 ± 3,21 meses. Quanto às características sociodemográficas 94,6% (n=229) eram casadas ou estavam em uma união estável, 55% (n=133) possuíam nível superior completo e 70,6% (n=171) tinham uma renda familiar maior que dois salários mínimos.

Figura 1- Fluxograma das participantes incluídas e excluídas do estudo com justificativa.



Fonte: Dados da Pesquisa, 2022.

Na associação entre os fatores associados aos desconfortos do assoalho pélvico e a via de parto (Tabela 1), observou-se que as puérperas de parto cesáreo apresentavam uma maior tendência ao sobrepeso (50,3%), segundo a classificação do IMC, em relação às puérperas de parto vaginal (27,1%).

Tabela 1- Associação entre fatores associados aos desconfortos do assoalho pélvico e a via de parto cesáreo (n=157) e parto vaginal (n=85).

Variáveis	Parto cesáreo (n=157) n (%)	Parto vaginal (n=85) n (%)	Total (n=242)	p
Atividade física no puerpério				0,511
Sim	33 (21,0)	21 (24,7)	54 (22,3)	
Não	124 (79,0)	64 (75,3)	188 (77,7)	
Índice de massa corporal				<0,001*
Com sobrepeso	79 (50,3)	23 (27,1)	102 (42,1)	
Peso normal	78 (49,7)	62 (72,9)	140 (57,9)	
Raça				0,777
Branca	148 (94,3)	80 (94,1)	228 (94,2)	
Negra	2 (1,3)	2 (2,4)	4 (1,7)	
Parda	7 (4,5)	3 (3,5)	10 (4,1)	
Tempo de puerpério				0,553
1 a 6 meses	93 (59,2)	47 (55,3)	140 (57,9)	
7 a 12 meses	64 (40,8)	38 (44,7)	102 (42,1)	

Fonte: Dados da pesquisa, 2022.

Legenda: f: frequência simples, %: porcentagem, p: nível de significância, *p≤0,05.

Na associação entre a presença de desconfortos do assoalho pélvico e a via de parto (Tabela 2), observou-se que 87,2% (n=211) das mulheres tinham algum desconforto, sendo que houve associação apenas nos sintomas urinários, nas quais as puérperas de parto vaginal (60%) tiveram maiores prevalências de sintomas urinários em relação às puérperas de parto cesáreo (40,1%).

Tabela 2- Associação entre o PFDI-20 e suas subescalas e a via de parto cesáreo (n= 157) e parto vaginal (n= 85).

PFDI-20 e subescalas	**Parto cesáreo f (%)**	**Parto vaginal f (%)**	**Total f (%)**	**p**
PFDI-20				
Sim	135 (86,0)	76 (89,4)	211 (87,2)	0,447
Não	22 (14,0)	9 (10,6)	31 (12,8)	
Pelvic Organ Prolapse Distress Inventory				
Sim	81 (51,6)	42 (49,9)	123 (50,8)	0,746
Não	76 (48,4)	43 (50,6)	119 (49,2)	
Colorectal-Anal Distress Inventory				
Sim	118 (75,2)	67 (78,8)	185 (76,4)	0,521
Não	39 (24,8)	18 (21,2)	57 (23,6)	
Urinary Distress Inventory				
Sim	63 (40,1)	**51 (60,0)¥**	114 (47,1)	**0,003***
Não	94 (59,9)	34 (40,0)	128 (52,9)	

Fonte: Dados da pesquisa, 2021.

Legenda: PFDI-20: Pelvic Floor Distress Inventory, Pelvic Organ Prolapse Distress Inventory: Inventário de Sofrimento de Prolapso de Órgãos Pélvicos, Colorectal-Anal Distress Inventory: Inventário de sofrimento colorretal-anal, Urinary Distress Inventory: Inventário de Desconforto Urinário, f: frequência simples; %: porcentagem; p: nível de significância; ¥: Ajuste residual ≥ 2,0; * p≤0,05.

Na associação entre os 20 sintomas de desconfortos do assoalho pélvico e a via de parto (Tabela 3) observa-se que, entre as puérperas de parto vaginal houve associação nos sintomas “Ver ou sentir “bola” na vagina” (8,2%); “Perde urina durante sensação de urgência” (25,9%), “Perde urina durante esforços” (28,8%) e “Perde urina em pequenas quantidades (34,1%).

Tabela 3- Associação entre itens do PFDI-20 segundo a via de parto. (n=242).

Itens PFDI	**Parto cesáreo f(%)**	**Parto Vaginal f (%)**	**p**
Sensação de pressão em baixo ventre	47 (29,9)	17 (20,0)	0,094
Endurecimento/frouxidão em baixo ventre	32 (20,4)	18 (21,2)	0,884
Ver ou sentir "bola" na vagina	4 (2,5)	**7 (8,2)** ¥	**0,043***
Empurrar algo com os dedos para evacuar	16 (10,2)	8 (9,4)	0,846
Sensação de esvaziamento incompleto da bexiga	30 (19,1)	15 (17,6)	0,780
Empurrar algo com os dedos para urinar	1 (0,6)	0 (0,0)	0,461
Força para evacuar	62 (39,5)	35 (41,2)	0,798
Sensação de esvaziamento incompleto do intestino	59 (37,6)	30 (35,3)	0,725
Perde fezes sólidas	16 (10,2)	7 (8,2)	0,620
Perde fezes líquidas	9 (5,7)	2 (2,4)	0,228
Elimina flatos involuntariamente	52 (33,1)	27 (31,8)	0,830
Dor ao evacuar	56 (35,7)	32 (37,6)	0,760
Forte sensação de urgência para evacuar	79 (50,3)	32 (37,6)	0,059
"Bola" na região genital depois de evacuar	6 (3,8)	7 (8,2)	0,146
Aumento da frequência urinária	26 (16,6)	17 (20,0)	0,504
Perde urina durante sensação de urgência	24 (15,3) ¥	**22 (25,9)** ¥	**0,045***
Perde urina durante esforços	17 (10,8) ¥	**24 (28,8)** ¥	**0,001***
Perde urina em pequenas quantidades (gotas)	20 (12,7) ¥	**29 (34,1)** ¥	**<0,001***
Dificuldade em esvaziar a bexiga	20 (12,7)	6 (7,1)	0,173
Dor/desconforto em baixo ventre ou região genital	21 (13,4)	10 (11,8)	0,720

Fonte: Dados da pesquisa, 2021.

Legenda: f: frequência simples; %: porcentagem; p: nível de significância; ¥: Ajuste residual ≥ 2,0; * p≤0,05.

DISCUSSÃO

Ao avaliar a presença de DAP apenas os sintomas urinários apresentaram uma diferença significativa entre os grupos de puérperas de parto cesáreo e puérperas de parto vaginal, sendo mais prevalente no último grupo. Além disso, ao avaliar a associação entre os 20 sintomas de DAP e a via de parto houve uma maior ocorrência dos sintomas de POP e sintomas urinários entre as puérperas de parto vaginal em relação ao parto cesáreo.

O aumento do IMC leva a prejuízos na função dos músculos do assoalho pélvico por inúmeras razões que incluem o aumento crônico da pressão intra-abdominal, danos a musculatura pélvica, danos aos nervos e comorbidades relacionadas ao sobrepeso e obesidade [12]. O estudo de Lamerton e colaboradores (2018) mostrou que mulheres com excesso de peso aumentaram em um terço (35%) a chance de desenvolver IU e mulheres obesas dobraram essas chances (95%) [13]. Apesar de estudos relacionarem o aumento do IMC com o surgimento DAP [12, 13, 14], no presente estudo a população com maior porcentagem de DAP não estava no grupo com tendências ao sobrepeso, o que indica que outros fatores de risco presentes nessa população podem explicar esses desconfortos.

Quanto à maior prevalência de sintomas de POP nas mulheres que tiveram parto vaginal, o estudo de Reimers e colaboradores (2018) mostrou resultado similar. Realizado com 284 mulheres seis semanas após o parto, apontou que 9% (n=25) tinham POP no estágio 2 ou mais, sendo que do grupo com 25 mulheres, 24 tiveram parto vaginal e 1 parto cesáreo [15]. No estudo de Zhang e colaboradores (2021) os autores explicam que o parto vaginal está correlacionado com uma maior taxa de lesão do músculo elevador do ânus, aumento da área hiatal e mobilidade do colo vesical. Com relação ao músculo elevador do ânus, durante o parto vaginal, ocorre expansão de 2,5% a 24,5% durante a coroação e casos de POP foram relatados como decorrentes de lesão no músculo elevador do ânus [16].

Em relação à maior prevalência de sintomas urinários no grupo de puérperas de parto vaginal, o estudo de Sigurdardottir e colaboradores (2021) demonstrou que as mulheres que tiveram parto vaginal foram mais propensas a sofrer de sintomas urinários do que as mulheres que tiveram parto cesáreo. Participaram do estudo 721 mulheres, em que, dessas, 601 tiveram parto vaginal e 120 tiveram parto cesáreo. Das mulheres que relataram ter IU, 52% estavam no grupo de parto vaginal e 27% no grupo de parto cesáreo, além disso, os sintomas de IUE e incontinência urinária de urgência (IUU) estavam mais prevalentes entre as mulheres de parto vaginal (40% e 32%, respectivamente). Ademais, o estudo trouxe como fator de risco para IU o IMC da gestante maior que 30 kg/m^2 (p=0,007) e a realização de episiotomia (p=0,003) e para IUU o alto peso do bebê ao nascimento (p=0,03) [17].

No estudo de Wesnes e colaboradores (2017), participaram 7561 mulheres, 85% (n=6441) tiveram parto vaginal e 15% (n=1120) parto cesáreo. Das mulheres que relataram ter sintomas de IUE 10% (n=614) passaram pelo parto vaginal e 3% (n=37) pelo parto cesáreo. Em relação a presença de sintomas de IUU, 7% (n= 440) estavam entre as mulheres de parto vaginal e 3% (n= 31) estavam entre as mulheres de parto cesáreo. Esse mesmo estudo trouxe que alto peso do recém-nascido ao nascer (OR= 1.4, IC95%, 1.2 -1.6 recém-nascido entre 3541 e 4180g e OR= 1.6, IC95% 1.2 -2.0 recém-nascido com mais de 4,180 g) e perímetro cefálico aumentado do recém-nascido (OR= 1.3, IC95%, 1.2 -1.5 recém-nascido com perímetro cefálico entre 35 e 37 cm) estão associados com risco aumentado de IU 6 meses pós-parto, além disso não foi encontrada associação significativa para fatores de risco relacionados ao parto ou fatores de risco neonatais e IU após qualquer cesariana. Os autores colocam que durante a passagem do feto pela vagina ocorrem traumas aos músculos, fáscias e tecido conjuntivo que afetam o assoalho pélvico e estão associados à IU, o que pode indicar que o risco do alto peso e o perímetro cefálico aumentado do recém-nascido passando pelo canal vaginal são fatores de risco maiores comparados ao peso do feto carregado durante a gestação [18].

Uma das limitações deste estudo foi a avaliação de mulheres durante a pandemia de SARSCOV-2. Sabe-se que em virtude às medidas restritivas e também ao impacto psicossocial causado pela pandemia, a avaliação dos DAP pode ter sido influenciada por esta condição. Outra limitação foi a avaliação de mulheres através de um sítio eletrônico o que infere que essas tinham uma condição socioeconômica mais alta para possuir equipamentos eletrônicos, como computadores e *smartphones*, e internet.

CONCLUSÃO

Neste estudo, os resultados indicaram apenas associação entre sintomas urinários e a via de parto, sendo mais prevalente no grupo de puérperas de parto vaginal, ademais, quando associados os 20 sintomas de DAP e a via de parto houve uma maior ocorrência dos sintomas de POP e sintomas urinários entre as puérperas de parto vaginal em relação às puérperas de parto cesáreo.

Diante dos resultados, reforçamos a importância do planejamento e aplicação de orientações e condutas para a prevenção e tratamento dos desconfortos do assoalho pélvico que ocorrem durante a gravidez e após o parto.

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- Haylen, B.T., de Ridder, D., Freeman, R.M., Swift, S.E. and Berghmans*, B. et al. (2010)* **An International Urogynecological Association (IUGA)/International Continence Society (ICS) joint report on the terminology for female pelvic floor dysfunction.** Int Urogynecol J 21: 5-26. doi: 10.1007/s00192-009-0976-9
- Bernard T. Haylen, B.T., Freeman, R.M., Lee, J., Swift, S.E. and Cosson*, M. et al.(2012)* **An International Urogynecological Association (IUGA)/International Continence Society (ICS)joint terminology and classification of the complications related to native tissue female pelvic floor surgery.** Int Urogynecol J 23: 515-526. doi: 10.1007/s00192-011-1659-x

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