

**Acceptability and effectiveness of a Multidisciplinary Team approach
involving Counselling for mesh-removal patients**

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Abstract

Patients with complications following mesh-removal risk a variety of symptoms, and can view medical-intervention negatively. This study explored patient-acceptability of a Multidisciplinary Team (MDT), and whether the presence of a Counsellor would be accepted and effective. Twenty consecutively-referred women, who had undergone mesh-removal but experienced complications, were interviewed about their experiences, and completed the Queensland scale for pelvic-floor symptoms, McGill Pain Questionnaire, and Hospital Anxiety and Depression Scales, before and after treatment. Patients had high levels of pelvic-floor symptoms, sensory and affective pain, anxiety, and depression. 70% reported a positive MDT-experience; predicted by higher anxiety, and lower depression. 60% elected to receive Counselling, which commenced within one week of referral, typically lasted 1-4 sessions, and reduced pelvic-floor symptoms, affective pain, anxiety, and depression. Results suggest that the MDT-approach is generally acceptable for this patient group, and that mesh-removal patients accept and benefit from input by a Counsellor.

Keywords: mesh-removal; mesh complications; Multidisciplinary Team (MDT); Counselling; treatment acceptability; symptoms.

Impact Statement

What is already known on this subject?

Concerns have been raised regarding safety of mesh-insertion. Multidisciplinary Teams (MDTs) are suggested to offer a strong approach to managing many women's health conditions, but no studies have examined mesh-removal patients, making generalisation difficult to the current patient group. Furthermore, it is unknown whether an MDT-approach, including a Counsellor, would be acceptable to mesh-removal patients.

What do the results of this study add?

Patients had high levels of pelvic-floor symptoms, pain, anxiety, and depression. 70% reported the MDT-experience as positive, predicted by higher anxiety, and lower depression. 60% elected to receive Counselling, which reduced pelvic-floor symptoms, affective pain, anxiety, and depression.

What are the implications of these findings for clinical practice and/or further research?

The Counselling provided as part of the MDT-approach was able to commence quickly, did not require many sessions, and reduced reported pelvic-floor symptoms, affective-pain, anxiety, and depression. These findings suggest that an MDT-approach involving Counselling is generally acceptable, and that mesh-removal patients accept and benefit from the input of a Counsellor, as part of their treatment.

Concerns have been raised regarding safety of mesh-insertion, which has a complication rate of 9% (Keltie, Elneil, Monga, et al., 2017), and re-operation rates of 3-4% (Jha, Hillard, Monga, & Duckett, 2019). As a result, the FDA reclassified mesh from Class II (simple device) to Class III (most complex device). Use of mesh was halted in the UK (Wise, 2018), leading to large numbers of patients requesting mesh-removal. However, mesh-removal can have negative consequences, involving multiple physical and psychological issues (Lee & Zimmern, 2019; Pandeva, Biers, Pradhan, et al., 2019). Treatment of mesh-removal patients often requires input from many health professions, presenting challenges for patient management (Lee & Zimmern, 2019). These challenges are exacerbated for patients who have negative perceptions of medical-interventions, due to mesh complications (AlMarzooqi, Petro, Tish, et al., 2020).

It has been suggested that Multidisciplinary Teams (MDTs) offer a strong approach to managing many women's health conditions, as single-specialty approaches mean that medical staff often do not have appropriate expertise spanning all necessary domains (Cook, McIntyre, Recoche, & Lee, 2019). The MDT-approach has enhanced outcomes in some areas of Urogynaecology (Mowat, Maher, Baessler, et al., 2018; Olsen, Smith, Bergstrom, et al., 1997; Pandeva et al., 2019). The composition of these MDTs varied widely (Cook et al., 2019; Pandeva et al., 2019), and none specifically examined mesh-removal patients, making generalisation difficult to the current patient group. Furthermore, it is unknown whether an MDT-approach would be acceptable to mesh-removal patients.

For the current MDT, patients were able to discuss their health issues with a variety of specialists present at one time. The MDT included Urogynaecologists, Gynaecologists, Anaesthetics, Continence Nurses, Physiotherapists, and a Psychotherapeutic Counsellor. This range of staff was suggested by previous MDT studies (Cook et al., 2019; Pandeva et al., 2019), but tailored for the particular issues presented by mesh-removal patients. Perceptions

of mesh-removal patients, faced with such a large group of medical professionals, after what can be a traumatic experience, especially for those with surgery-related complications (AlMarzooqi et al., 2020), is unknown, and a prime aim was to elicit patient-views of their MDT-experiences.

Pelvic-floor dysfunction is connected with high rates of psychological problems (Khan, Whittal, Mansol, Osborne, Reed, & Emery, 2013), which negatively impact clinical-adherence and outcomes (Osborne, Whittall, Edwards, Emanuel, Emery, & Reed, 2016). Nevertheless, fewer than 5% of MDTs, studied in previous reports, included Psychologists or Counsellors (Pandeva et al., 2019; Reed, Osborne, & Mann, 2020). It is unknown what psychological issues mesh-removal (especially after surgery-related trauma) might produce, but it is reported that anxiety and pain are common (Lee & Zimmern, 2019). Thus, another aim was to provide indication of the types of issues presenting with mesh-removal, and the extent to which a Counsellor might address these issues.

A potential issue raised by the presence of a Counsellor on an MDT is that patients, who perceive themselves to have a purely physical problem stemming from mesh (AlMarzooqi et al., 2020), may object to any implication that their symptoms are psychological, as has been noted for other patient groups (Salmon, Peters, & Stanley, 1999). Negative reactions may be exacerbated by negative perceptions of medical-treatment held by some mesh-removal patients. A final aim of the study was to establish the likely acceptability of a Counsellor in the MDT.

Method

Multidisciplinary Team

The MDT met face-to-face approximately once a month. It comprised a Consultant Urogynaecologist, Consultant Urologist, Consultant Gynaecologist, Consultant Anaesthetist,

Registrar in Obstetrics and Gynaecology, Continence Nurse Specialist, and Psychotherapeutic Counsellor. These members were not always present at every meeting, but regularly attended. MDT-clinics were scheduled to last 3-4 hours, and saw between 3-5 patients on an individual basis (although patients could bring partners/spouses/relatives to MDT-meetings). Each patient was seen for approximately 40min. Patients were re-invited, if necessary, every three months.

During each consultation, patients were initially asked about their condition by MDT-members, and the MDT received information and updates. At this point, patients were given the opportunity of a physical-examination, in another room, with appropriate MDT-members. Afterwards, patients could ask questions of the MDT. Finally, patients were seen by the Counsellor, on a one-to-one basis, outside the MDT, and could ask further questions.

Patients

Twenty consecutively-referred women, attending one of five MDT-clinics, during 2019 and early 2020, participated. All gave informed consent (no patients declined). The study follows the principles of the Declaration of Helsinki. Patients were aged 38-69 years (mean=54.90; SD±8.91). Ethical approval was obtained from the University Psychology Ethics Committee. All patients had a variety of pelvic-floor dysfunctions, including stress urinary incontinence, faecal incontinence, and prolapse. All had mesh fitted between 3-7 years, previously. Patients were referred to the MDT from several centres, and access to full records was not always possible. Patients had undergone a variety of mesh procedures, including TVT, TVT-O, and vaginal-wall repairs. All patients reported complications from mesh, 2-4 years previously; all had mesh-removal (full or partial), 1-3 years previously.

Measures

Queensland Pelvic Floor Questionnaire (Baessler et al., 2008) is a self-administered female pelvic-floor questionnaire. Sections relate to bladder, bowel, prolapse, and sexual, dysfunction, each scoring 0–10, summing to an overall pelvic-floor dysfunction (0–40). The mean overall score in a non-clinical sample was 3.4 (0–15), and in an urogynaecological sample was 8.3 (0–24). The internal reliability (Cronbach α) ranges between .72 and .95 (Baessler et al., 2010).

Short-Form McGill Pain Questionnaire (SFM; Melzack, 1978) assesses pain-experience along 15-descriptors, ranging from 0 (none) to 3 (severe), representing sensory (11 items) and affective (4 items) pain-experience. This gives a score-range of 0-33 for sensory-pain, and 0-12 for affective-pain. Mean sensory-pain for a range of disorders was noted as 13.9, and the affective-pain mean was 3.3. This tool has a Cronbach α range of .73 to .89 (Burckhardt & Bjelle, 1994).

Hospital Anxiety and Depression Scales (HADS; Zigmond & Snaith, 1983) consists of 14 questions: 7 anxiety, 7 depression, each scoring 0-3 (normal = 0-7, mild = 8-10, moderate = 11-14, severe = 15-21). This measure is widely used, with strong test-retest reliability and validity (Zigmond & Snaith, 1983).

Procedure

While a patient waited in the waiting-area, prior to their MDT-consultation, they were given psychometric questionnaires to complete: Queensland (pelvic-floor function), McGill (pain), and HADS (anxiety, depression). Patients then entered the MDT-clinic, and participated in the consultation (and optional examination), for approximately 40-60min. Following MDT-consultation, the Psychotherapeutic Counsellor accompanied patients into another room to follow up, where it was checked whether patients had completed the

questionnaires, and whether they needed help with them. Patients were asked whether there were any outstanding issues that they needed to raise regarding their MDT-consultation. If so, the appropriate MDT-member was asked to advise. Subsequently, patients were asked whether they would like an appointment with the Counsellor. They did not have to reveal reasons, at this point, but, following their MDT-visit, patients received a telephone call from the Counsellor, usually during the week following their MDT-clinic, when they could discuss reasons, and any outstanding issues.

During the follow-up telephone call, patients were given a short (approximately 5min) semi-structured interview, asking: “*We would like to know how you found the whole experience?*”; “*What, if anything, was helpful about the process?*”; and “*What could be improved about the process?*”. Responses were subjected to thematic content analysis (Vaughn et al., 1996), in line with previous procedures within health-contexts (Osborne & Reed, 2008). Responses were examined by two researchers to identify key-themes, and ensure reliability. Individual ‘units-of-information’, contained within each transcript, were highlighted. A ‘unit’ is any piece of text relating to an identified theme, that can be interpreted on its own to provide meaningful and informative comment. From reading the unitised comments, initial themes were refined, so that all ‘units’ could be categorised according to those themes. Coding of ‘units’ into themes was conducted independently by two researchers, and a Cohen’s Kappa of .85 was obtained regarding inter-coder agreement.

If patients requested Counselling, their reasons were noted, as was the time-period from the MDT-clinic to the first Counselling session. In addition, patients attending MDT-clinics could be referred by MDT-members to the Counsellor, and reasons were noted. For patients requesting Counselling, the number of Counselling sessions, as well as their psychometric scores (Queensland, SFM, HADS) at discharge, were noted.

Results

 Table 1

Table 1 shows presenting characteristics of the sample, along with correlations between these variables. Pelvic-floor symptoms (total Queensland) were high, relative to previously-established norms: 19/20 (95%) patients exceeded the normed mean for urogynaecological patients not having mesh-removal; 14/20 (60%) patients exceeded the highest point in the range for those patients (cf. Baessler et al., 2009). The mean for both sensory-pain and affective-pain (SFM) exceeded the reported average for pain across a variety of disorders: 15/20 (75%) patients exceeded this mean for sensory-pain; 18/20 (90%) patients exceeded this mean for affective-pain. The mean anxiety score (HADS-A) was 11.40 (± 2.81 ; range=5–17), which is in the moderate range: 1 patient = no anxiety; 5 = mild; 10 = moderate; 3 = severe. The mean depression score (HADS-D) was 15.60 (± 3.48 ; range=3–48), which is in the severe range: 0 patients = no depression; 2 = mild; 4 = moderate; 14 = severe.

Patients' Perceptions of MDT-clinic

We would like to know how you found the whole experience?: Analysis of participants' responses, regarding how they found the whole MDT-experience, produced 29 'units-of-information', forming 4 themes. The most positive theme, '**Helpful**', was the most common, with 14 (48%) 'units' coded as belonging to this theme (e.g., "*Really good way of doing it*"; "*Helpful*"; "*The whole NHS should be run like that*"; "*Always very helpful*"). There were 6 (21%) 'units' indicating '**Relief**' (e.g., "*Didn't feel it was scary*"; "*Not so bad*"). A slightly greater number of 'units', 7 (24%), suggested the MDT was '**Daunting**' (e.g.,

“Daunting”; “Daunting when first went in”; “Daunting at start”). Only 2 (6%) ‘units’ reported a ‘**Negative Reaction**’ to the MDT (“Never want to do that again”; “The team talked among themselves”).

Of the participants, 11 (55%) found the MDT ‘helpful’, 3 (15%) were ‘relieved’ after the MDT, 5 (25%) found the process ‘daunting’, and 1 (5%) had a ‘negative reaction’ to the process. These suggest that 14 (70%) had positive views (‘helpful’ or ‘relief’), and 6 (30%) had negative views (‘daunting’ or ‘negative’), about the MDT. A logistic regression conducted on these binary outcome data (negative = 0; positive = 1), using age, pelvic-floor symptoms (Queensland), sensory-pain and affective-pain (SFM), and anxiety and depression (HADS), as predictors, revealed these patient-characteristics marginally significantly predicted their responses, $2LL=12.49$, $X^2(6)=11.94$, $p=.063$, with anxiety associated with positive reactions ($\beta=1.545$, $p=.051$, $OR=4.689$), and depression associated with negative reactions ($\beta=-.811$, $p=.060$, $OR=.444$), but age ($\beta=.200$, $p=.103$, $OR=1.222$), pelvic-floor symptoms ($\beta=-.376$, $p=.101$, $OR=.687$), sensory-pain ($\beta=.247$, $p=.107$, $OR=1.293$), or affective-pain ($\beta=-.077$, $p=.806$, $OR=.962$), did not predict responses.

What, if anything, was helpful about the process?: There were 23 ‘units’ coded in response to this question, made by 14 participants. These fell into two main themes: 16 (70%) ‘units’ noted the ease of ‘**Access to Professionals**’ (e.g., “Lots of people helpful”; “As there were lots of options”; “The whole team made it quicker, easier, and better”; “Really good to have the whole team at once”; “Avoids multiple journeys”). A smaller set of ‘units’, 7 (30%), referred to feeling ‘**Being Listened to**’ (e.g., “Felt people paid attention”; “Listening, hearing me”; “Rather have all information, than none at all – which is what you normally get”).

What could be improved about the process?: There were 15 ‘units’ made in response to this question, by 7 participants. There were two aspects patients felt could be improved.

The main theme concerned the amount of ‘**Information Received**’ (10 ‘units’, 66%; e.g., “*Lot of information at once*”; “*Step-by-step might be better*”; “*Maybe write it down*”). A second theme concerned ‘**Prior Information**’ about what to expect (5 ‘units’, 33%; e.g., “*Letter was very helpful*”).

Counselling Sessions

Of the 20 patients, 12 (60%) requested Counselling. The characteristics of patients who did, and did not, request Counselling are shown in Table 2. There were no statistically significant differences between the two sets of patients, although there were medium effect sizes for all contrasts, and the group not requesting Counselling tended to have more-severe symptoms. A multivariate analysis of variance conducted between the groups, using all variables as dependent variables, revealed no statistically significant difference, but produced a large effect size, *Pillai’s Trace*=.991, $F(6,13)=2.30$, $p=.098$, $\eta^2_p=.515$.

 Table 2

Initial reasons given for requesting Counselling were varied: 6/12 (50%) anxiety; 2/12 (16%) unresolved loss/grief; 2/12 (16%) chronic-pain; 2/12 (16%) abuse. Mean time-period from MDT-clinic to initial Counselling-session was 7 days (range=2–18). 6/12 patients (50%) felt they only required a single session; 4/12 (33%) patients required 3-4 sessions; and 2/12 (16%) were long-term (more than 6 sessions, both involving chronic-pain).

 Figure 1

Figure 1 displays mean scores (standard errors) before and after Counselling for the 12 patients, for pelvic-floor symptoms (Queensland), sensory-pain (SFM_S), affective-pain (SFM_A), anxiety (HADS_A), and depression (HADS_D). Inspection of these data shows all symptoms decreased (improved) after Counselling.

Mean pelvic-floor symptoms score (Queensland) at start of treatment was 26.58 (± 4.77), and after completing Counselling was 22.91 (± 2.87). This reduction was statistically significant, $t(11)=3.57$, $p=.004$, $d=1.03$. Of these patients, 5/12 (42%) demonstrated a clinically-reliable decrease in pelvic-floor symptoms, and none demonstrated a reliable increase in symptoms (Jacobson et al., 1984).

Mean sensory-pain was 20.08 (± 7.17) before, and 19.83 (± 6.10) after, Counselling, $t < 1$, $d = .05$; 1/12 (8%) patients demonstrated a clinically-reliable decrease in sensory-pain, but 1/12 (8%) demonstrated a reliable increase. Mean affective-pain score was 9.08 (± 3.60) before, and 7.50 (± 2.97), after Counselling, $t(11)=1.431$, $p=.179$, $d=.41$; 6/12 (50%) patients demonstrated a clinically-reliable decrease in affective-pain, and none demonstrated a reliable increase in symptoms.

Mean anxiety was 11.75 (± 2.26) before, and 8.33 (± 3.67) after, Counselling. This was statistically significant, $t(11)=4.03$, $p=.002$, $d=1.16$. Of these patients, 7/12 (58%) demonstrated a clinically-reliable decrease in anxiety, and none demonstrated a reliable increase. Mean depression was 14.58 (± 3.84) before, and 9.58 (± 3.34) after, Counselling. This was statistically significant, $t(11)=4.02$, $p=.002$, $d=1.16$. Of these patients, 8/12 (66%) demonstrated a clinically-reliable decrease in depression, and none demonstrated a reliable increase.

Discussion

Patients had high levels of pelvic-floor dysfunction, pain, and psychological distress. Nevertheless, 70% of patients found the MDT-clinic acceptable, with 60% opting to receive Counselling. Following Counselling, there were significantly reduced levels of pelvic-floor symptoms, anxiety, and depression, with affective-pain also showing reduction.

The majority of patients were positive about their MDT-experience, believing it helpful, or feeling relieved after the process. The main facets of the MDT-approach thought useful were access to multiple professionals, simultaneously, and feeling listened to. That most patients, from a group previously associated with negative views of medical-treatment around mesh (AlMarzooqi et al., 2020), expressed positive views is encouraging, and these views resonate with those of other patient groups asked about similar MDTs (Taylor, Finnegan-John, & Green, 2014). Nevertheless, around one third of patients expressed less-positive views. Their suggestions for MDT improvement involved the large amount of information being presented to them (cf. Osborne & Reed, 2008), and wanting greater explanation about what to expect at the MDT-clinic.

Although caution should be taken interpreting results from a relatively-small sample, the positive association between higher-anxiety and positive views of MDTs might be explained by anxious individuals feeling relief after MDT-clinics. That those with higher levels of depression did not find the MDT-experience as positive, might reflect a general reduction in their ability to engage, and perhaps encode information (Khan et al., 2013).

A majority of patients requested Counselling, suggesting this addition to the MDT was acceptable (Lee & Zimmern, 2019). Waiting times to see the integrated Counsellor were three-times shorter than mean waiting times for external psychological-services (mean=20 days; range=4–61 days; Baker, 2020). Analyses of impacts of Counselling demonstrated improvement in pelvic-floor symptoms, affective-pain, anxiety, and depression. Caution is

needed in attributing such improvements to Counselling, alone, although improvements occurred rapidly after Counselling commenced. These effects of Counselling are similar to those reported in a randomised-study of Counselling with a pelvic-floor dysfunction group (Osborne, Whittall, Emery, et al., 2021). It may be that Counselling-induced improvements in psychological symptoms allow more-positive perception of physical functioning (Reed, Osborne, Whittall, et al., 2021). One aspect of these data deserving further analysis is that those with more-severe symptoms were less likely to request Counselling. Those engaging in Counselling did so for a wide variety of stated reasons, not always necessarily related to mesh-removal (e.g., abuse, loss/grief), but which possibly related to their perceptions of treatment-effectiveness (Reed et al., 2021).

Initially, the inclusion of a Counsellor in the MDT was thought to be a risk, given the possibility for negative perceptions of being offered psychological-support for what is perceived as wholly a physical problem by many patients (AlMarzooqi et al., 2020; Salmon et al., 1999). However, that the professional was identified (correctly) as a ‘Psychotherapeutic Counsellor’, not a ‘Psychologist’, may have helped overcome this issue. Counsellors may be perceived to have a broader role than Clinical Psychologists; dealing with life-style, relationships, and motivational issues, in addition to psychological problems.

This study was designed as an initial assessment of the feasibility of adopting one such MDT-approach for mesh-removal patients. As a result, caution is needed in over-interpreting and over-generalising from a small-scale study. Additional studies need to corroborate and further analyse the indicative findings pointing to the utility of this MDT-approach. Developing the analysis of impacts of MDTs on medical decision-making (Pandeva et al., 2019), and predicting which patients may benefit most from this approach, would be helpful. A wider range of assessment tools may be useful, and a controlled study would test the relative efficacy of this approach. Analysing the cost of providing an MDT, in

this manner, is essential; for example, is this multi-professional approach cost-effective, and are medical staff comfortable with this manner of working?

In summary, a majority of mesh-removal patients reported their MDT-experience as acceptable; positive views being associated with higher levels of anxiety, and lower levels of depression. The majority of patients elected to receive Counselling as part of their ongoing treatment. The Counselling provided as part of the MDT-approach was able to commence quickly, did not require many sessions, and reduced reported pelvic-floor symptoms, affective-pain, anxiety, and depression. These findings suggest an MDT-approach involving Counselling is generally acceptable, and that mesh-removal patients accept and benefit from the input of a Counsellor as part of their treatment.

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Disclosure of Interest

The authors report no conflict of interest.

Table 1: Mean age, pelvic-floor symptoms (Queensland), sensory-pain (SFM_S), affective-pain (SFM_A), anxiety (HADS_A), and depression (HADS_D), along with Pearson's correlations between variables.

	Mean (SD) Range	Pelvic- floor symptoms	Sensory- pain	Affective- pain	Anxiety	Depression
Age	54.90 (8.91) 38 – 69	-.224	.096	-.225	-.420	.014
Pelvic- floor symptoms	25.10 (7.83) 6 – 38		.391	.831***	.705**	.751**
Sensory- pain	21.30 (8.00) 6 – 32			.334	.223	.276
Affective- pain	8.50 (3.71) 1 – 12				.575**	.566**
Anxiety	11.40 (2.81) 5 – 17					.521*
Depression	15.60 (3.48) 8 – 20					

* $p < .05$; ** $p < .01$; *** $p < .001$

Table 2: Mean age, pelvic-floor symptoms (Queensland), sensory-pain (SFM_S), affective-pain (SFM_A), anxiety (HADS_A), and depression (HADS_D), for the patients who did and did not request a session with a Counsellor, along with the results of independent t-tests conducted between these groups on these variables.

	Counselling (<i>n</i> = 12)	No Counselling (<i>n</i> = 8)	<i>t</i>(18)	<i>d</i>
	Mean (SD)	Mean (SD)		
Age	53.00 (8.93)	57.75 (8.65)	1.19	.53
Pelvic-floor symptoms	26.58 (4.77)	22.87 (11.01)	1.03	.46
Sensory-pain	20.08 (7.17)	23.12 (9.29)	.82	.37
Affective-pain	9.08 (3.60)	7.63 (3.92)	.86	.57
Anxiety	11.75 (2.26)	10.88 (3.60)	.67	.41
Depression	14.58 (3.84)	17.12 (2.29)	1.67	.83

Figure 1: Mean scores before and after Counselling sessions for pelvic-floor symptoms (Queensland), sensory-pain (SFM_S), affective-pain (SFM_A), anxiety (HADS_A), and depression (HADS_D). Error bars = standard error.

