Joint Terminology Report on Female Lower Urinary Tract and Pelvic Floor Dysfunction

Introduction

Standardization of terminology is essential for communication between clinical providers, learners, researchers and patients. The most recent comprehensive terminology document for female lower urinary tract symptoms (LUTS) and pelvic floor dysfunction (PFD), a joint report from the International Continence Society (ICS) and the International Urogynecological Association (IUGA)(1), was published in 2010. Since then, several peer-reviewed terminology publications on these topics have been published by different associations and societies of gynecological and urological specialties.(2-15) These smaller, more focused terminology papers have brought progress, but, at times, they also have introduced contradictory terms. To address this and to keep up with advances in clinical science and practice, an update to the comprehensive 2010 document is overdue. This joint project of ICS, IUGA, the Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction (SUFU), and The American Urogynecologic Society (AUGS) was launched in January 2020 to standardize terminology in female LUTS and PFD. All stakeholders aimed to produce an updated core report on female LUTS and PFD which would incorporate changes in terminology developed since 2010 and streamline the content of the available reports. Since the beginning of the project, our global community faced a calamitous pandemic caused by the COVID-19 virus. Clinical and research efforts were diverted from this project to more urgent clinical and research needs. When the pandemic crisis ended, committee terms for some project leaders had ended, and other writing group members had new, competing roles. The overarching commitment to this document, however, remained strong. This paper is the work of persistently committed stakeholders who ensured that each term was considered thoroughly and achieved expert consensus.

Methods

ICS, the sponsoring society for this project, produced a scoping document defining the aims and objectives of the project and clarifying the need for regular terminology updates in LUTS and PFD including urinary disorders, pelvic organ prolapse (POP), anorectal dysfunction, and sexual health. A joint committee

was established with representatives of the four societies. The working group chair was nominated by ICS as the sponsoring organization. One deputy chair was nominated by each additional organization (AUGS, IUGA and SUFU) which then held open calls for volunteers. All 4 organizations selected 4 writing group members for a total of 16. Please see the Acknowledgements section for their names. They represent different geographical areas including Europe, the Americas, Asia, Australia, New Zealand, Africa, and the Middle East.

During the virtual kickoff meeting, 4 main sections to the document were proposed: LUTS, POP and PFD, anorectal dysfunction and sexual dysfunction. Each of the four topics was allocated to a working subgroup, which then selected a subgroup chair based on individual expertise. A first draft of the revised terminology was produced and reviewed over several years until agreement was achieved over a final version. Care was taken to preserve definitions in use by stakeholders outside of clinical practice or academic work in women's pelvic health. Therefore, the writing groups agreed to introduce only substantive changes prompted by meaningful concerns. Minor wording changes to improve clarity or to match analogous terms were made rarely. This document is relevant to pelvic floor disorders in women. It is not a comprehensive compilation of all pelvic health terminology, and specifically male pelvic floor terms are not presented here. However, where appropriate and practical, gendered terms have been eliminated to eliminate redundant terms and promote inclusivity.

Results

Below are the terms established during the project organized into 4 main sections: The Lower Urinary Tract (LUT), Pelvic Organ Prolapse, Anorectal, and Sexual Function and Dysfunction. Urodynamic observations, conditions, and definitions are excluded from this list. Each term is signified as unchanged, changed, or new. If the term is unchanged or changed, it will be referenced with the most recent preceding terminology document in which it appears. Please note that several terms appear more than once in the document because the same word can indicate either a symptom or a sign, depending upon context. However, we took care to present each sign and symptom in only 1 document section to avoid redundancy, even though some terms are relevant to more than one section. For example, terms pertaining to sexual

urinary and anorectal signs and symptoms appear in the Sexual Function and Dysfunction section and not in the LUT or Anorectal sections.

TERMINOLOGY REPORT

General Definitions

Symptom: NEW Any manifestation of a pathological condition subjectively perceived (felt) by a patient as abnormal.

Sign: **UNCHANGED** Any abnormality indicative of disease or health problem, discoverable on examination of the patient; an objective indication of disease or health problem.(13)

THE LOWER URINARY TRACT (LUT)

The terms presented in this section are drawn primarily from Haylen, et al(1); D'Ancona, et al(3); and Hashim, et al(8), each of which provides additional detail on specific topics not included here. Urodynamic terminology is not included here and is outside the scope of this section.

I. LUT Symptoms

a. Storage Symptoms: UNCHANGED Lower urinary tract symptoms (LUTS) occurring during the bladder storage phase (of micturition cycle).(3)

Increased Urinary Frequency -- **UNCHANGED** Complaint that voiding occurs more frequently than deemed normal by the individual (or caregivers).[1]

Increased Daytime[2] Urinary Frequency (IDF) – **CHANGED**: Complaint that voiding occurs more frequently than deemed normal during the main awake period by the individual (or caregiver). Number of voids in a 24-hour period should be quantified and dated by intake/voiding diary[4].(1)

[1]Quantifying the number of voids and amount of fluid intake in a 24-hour period in diary format is recommended.

[2] The word "daytime" has a formal definition of "the time between sunrise and sunset." However, the writing group felt it would be more relevant to refer to the "main awake period" for all definitions including the word "daytime." A similar change was previously made for "nocturnal" symptoms.8. Hashim H, Blanker MH, Drake MJ, Djurhuus JC, Meijlink J, Morris V, et al. International Continence Society (ICS) report on the terminology for nocturia and nocturnal lower urinary tract function. Neurourol Urodyn. 2019;38(2):499-508.

Nocturia - CHANGED: Complaint of interruption of sleep because of the need to micturate. Each void is preceded and followed by sleep.(8)

Polyuria -- CHANGED Complaint that volume of urine voided in one 24-hour period is noticeably larger than previously experienced[3].

Diurnal Polyuria -- CHANGED Complaint that the volume of urine voided during the main awake period is noticeably larger than previously experienced[4].(3).

Nocturnal Polyuria – CHANGED: Complaint of passing large volumes of urine during the main sleep period[7].(8)

b. **Bladder Filling (Sensory) Symptoms[5] – CHANGED:** Complaint of early, decreased, or increased awareness of the normal sensations of bladder filling, or abnormal sensations during bladder filling.(3)

Urge – NEW: The normal sensation of a need to pass urine that may be deferred.

Urgency[6] -- UNCHANGED Complaint of a sudden, compelling desire to pass urine which is difficult to defer.(1)

Reduced Bladder Filling Sensation - CHANGED Complaint that the sensation of bladder filling is less intense or occurs later in filling than previously experienced.(1)

Absent Bladder Filling Sensation -- CHANGED Complaint of both the absence of the sensation of bladder (filling) fullness and a definite desire to void.(1)

Non-Specific (Atypical) Bladder Filling Sensation (Bladder Dysesthesia) – **CHANGED** Complaint of abnormal bladder filling sensation such as the perception of vague abdominal

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[3] Quantifying the current and previous amounts of fluid intake and volumes of urine voided in a 24-hour period in diary format is recommended.

[4] Quantifying the current and previous volume of urine voided during the waking hours should with a voiding diary is recommended.

[5] The original definition referenced "abnormal sensations experienced during bladder filling," but bladder filling sensations could also be normal. Patients could have hyper awareness of normal sensations or early awareness of normal sensations. The definition was changed to reflect that observation.

[6] The writing group felt it important to identify that fear of urinary leakage could refer to specific subtype of urgency. They ultimately agreed that "fear of leakage" could be added when this subtype is implied.

bloating, vegetative symptoms (nausea, vomiting, faintness), or spasticity. It differs from normal bladder filling sensation or pain, pressure, or discomfort of the bladder.(6)

Urinary Incontinence – **UNCHANGED** Complaint of involuntary loss of urine.(1)

Urgency Urinary Incontinence (UUI) -- UNCHANGED Complaint of involuntary loss of urine associated with urgency.(1)

Stress Urinary Incontinence (SUI) – **UNCHANGED** Complaint of involuntary loss of urine on effort or physical exertion including sporting activities, or on sneezing or coughing.(1)

Mixed Urinary Incontinence (MUI) – **CHANGED** Complaints of both stress and urgency urinary incontinence, that is, with effort or physical exertion including sporting activities or on sneezing or coughing (stress) as well as involuntary loss of urine associated with urgency.(1)

Enuresis[7] (Nocturnal) – **CHANGED** Complaint of urinary incontinence which occurs during the main sleep period. This can be **primary** (has been present lifelong) or **acquired** (occurs following an established period of nighttime continence).(1)

Continuous Urinary Incontinence -- UNCHANGED Complaint of continuous involuntary loss of urine.(1, 6)

Insensible Urinary Incontinence -- CHANGED Complaint of urinary incontinence where the individual is aware of urine leakage but unaware of how or when it occurred.(1)

Postural Urinary Incontinence – CHANGED: Complaint of urinary incontinence during change of posture or position (e.g., from supine or seated to standing), but not from other forms of physical exertion (including sporting activities, or after sneezing or coughing).(1)

[7] Acquired enuresis has been eliminated and incorporated into the definition of Enuresis.

Functional Urinary Incontinence- NEW Urinary incontinence due to cognitive impairment, or severe physical disability of immobility.[8], [9]

Overflow Incontinence – **UNCHANGED** Complaint of urinary incontinence in the presence of an excessively (over-) full bladder (no cause identified).(3)

Sexual activity incontinence (See Sexual Dysfunction Symptoms)

Situational Urinary Incontinence (Other) – NEW: Complaint of urinary incontinence during situations not described previously (e.g., giggle incontinence, prolonged holding, incontinence associated with epileptic seizures, sphincter denervation in cauda equina).

Overactive Bladder Syndrome (OAB) -- UNCHANGED Urinary urgency, usually accompanied by frequency and nocturia, with or without urgency urinary incontinence, in the absence of urinary tract infection or other obvious pathology.(1)

Underactive Bladder Syndrome (UAB) – UNCHANGED: Slow urinary stream, hesitancy, and straining to void, with or without a feeling of incomplete bladder emptying, sometimes with storage symptoms.(2)

c. **Voiding Symptoms – NEW** LUTS experienced during micturition (voiding).

Hesitancy -- UNCHANGED -- Complaint of a delay in initiating micturition.(1)

Bashful (Shy) Bladder) – **CHANGED** Complaint of the inability to initiate voiding in public (i.e., voiding in the presence of other persons) despite there being no difficulty in private.(3)

[8] Term as defined in International Classification of Diseases (ICD) 11. (16. International Classification of Diseases, Eleventh Revision (ICD-11). Geneva: World Health Organization; 2025.

[9] The terms Impaired Cognition Urinary Incontinence, Impaired Mobility Urinary Incontinence and Disability Associated Incontinence have been incorporated into the term Functional Urinary Incontinence.

Episodic Inability to Void -- **UNCHANGED** Complaint of occasional inability to initiate voiding despite relaxation and/or an intensive effort (by abdominal straining, Valsalva maneuver or suprapubic pressure).(3)

Straining to Void[10] – UNCHANGED Complaint of the need to make an intensive effort (by abdominal straining, Valsalva, or suprapubic pressure) to either initiate, maintain, or improve the urinary stream.(1)

Slow (Urinary) Stream -- UNCHANGED Complaint of a urinary stream perceived as slower compared to previous performance or in comparison with others.(1)

Intermittency -- **UNCHANGED** Complaint of urine flow that stops and starts on one or more occasions during one voiding episode.(1)

Terminal Dribbling – **UNCHANGED** Complaint that during the final part of voiding there is noticeable slowing of the flow to drops or a trickling stream.(3)

Spraying (Splitting) of Urinary Stream[11] – UNCHANGED: Complaint that the urine passage is a spray or split rather than a single discrete stream.(1)

Position-Dependent Voiding -- UNCHANGED Complaint of having to adopt specific positions to be able to void spontaneously or to improve bladder emptying, for example, needing to void in a seated position.(3)

Dysuria[12] -- CHANGED Complaint of pain, burning, other discomfort, or difficulty during voiding. Discomfort may be intrinsic to the lower urinary tract (e.g., bladder or urethra), external (vulvar), or referred from other adjacent similarly innervated structures, for example, lower ureter[13].(3)

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[10] This term has been defined differently by D'Ancona, et al, 2019 and Haylen, et al, 2010. The writing group felt that the Haylen definition to be more descriptive.

[11] The writing group preferred the term "discrete" from Haylen, et al 2010 over "directional," used in D'Ancona, et al. 2019.

[12] In medical parlance, dysuria refers to difficult or painful discharge of urine. The committee felt it was important to keep that clinical intent in the definition. Hence, "difficult voiding" has been added to the definition. Also, "vulvar dysuria," a term included in a previous definition, has been added back to the current definition. The term "stranguria," implying a spasmodic "drop by drop" sensation, has been retired, but it's concept can be referred to as the more general "dysuria."

Hematuria – **UNCHANGED** Complaint of passage of visible blood mixed with urine. This may be initial (at the beginning), terminal (at the end) or total (throughout bladder emptying).(3)

Pneumaturia -- UNCHANGED Complaint of the passage of gas (or air) from the urethra during or after voiding.(3)

Fecaluria – UNCHANGED Complaint of passage of feces (per urethra) in the urine.(3)

Chyluria (Albiduria) – **UNCHANGED** Complaint of passage of chyle (pale or white, milky cloudy) in the urine.(3)

Urinary Retention[14] – CHANGED: Complaint of the inability to empty the bladder requiring the use of a catheter. May may be due to anatomical or functional bladder outlet obstruction, detrusor underactivity, or both. There are 3 subtypes of urinary retention.(3)

Acute urinary retention - complaint of a rapid onset, usually painful suprapubic sensation (from a full bladder) due to inability to void (non-episodic), despite persistent intensive effort

Chronic urinary retention - complaint of a long-standing or repeated inability to empty the bladder, with or without the ability to pass some urine. This may result in the frequent passage of small amounts of urine or urinary incontinence and a distended bladder**,**

A**cute on chronic urinary retention - NEW-** complaint of a rapid onset, usually painful suprapubic sensation (from a full bladder) due to inability to void from a patient with chronic urinary retention, despite the ability to previously pass some urine.

d. <u>Post-Voiding (Post-Micturition) Symptoms- UNCHANGED</u> <u>LUTS experienced after voiding has ceased.(3)</u>

Feeling of Incomplete (Bladder) Emptying -- UNCHANGED Complaint that the bladder does not feel empty after voiding has ceased.(3)

[14] The terms <u>Complete Urinary Retention</u> and <u>Incomplete Urinary Retention</u> have been eliminated. <u>Acute Urinary Retention</u>, <u>Chronic Urinary Retention</u>, and <u>Acute on Chronic Urinary Retention</u> have been included as subtypes of Urinary Retention.

Need to Immediately Re-Void ("Encore" or "Double" Voiding) – **UNCHANGED** Complaint that further voiding is necessary soon after passing urine (cessation of flow).(3)

Post-Voiding incontinence[15] – CHANGED Complaint of urinary incontinence or dribbling immediately after completion of passing urine, usually after leaving the toilet or after rising from the toilet.(1)

Post-Micturition Urgency -- UNCHANGED Complaint of persistent urgency post-voiding.(3)

e. Lower Urinary Tract Pain

Bladder Pain – UNCHANGED Complaint of suprapubic or retropubic pain, pressure or discomfort related to the bladder and usually associated with bladder filling. It may persist or be relieved after voiding.(3).

Urethral Pain – **CHANGED** Complaint of pain, pressure or discomfort felt in the urethra before, during and/or after voiding and the patient indicates the urethra as the site.(3)

f. Bladder Sensation

Normal Sensation – UNCHANGED Awareness of bladder filling and increasing sensation up to a strong desire to void.(7)

Abnormal Sensation – NEW: Complaint of an atypical sensation in the bladder, urethra or pelvis that is different from normal bladder filling and emptying sensation.

g. Additional Terms

Female Bladder Pain Syndrome[16] – UNCHANGED Complaint of persistent or recurrent chronic pelvic pain, pressure, or discomfort perceived to be increased with urinary bladder filling and accompanied by at least one other urinary symptom such as urinary urgency or frequency.(10)

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[15] Post-Micturition Leakage and Post-Micturition Dribble have been eliminated and incorporated into Post-Void Incontinence.

[16] The terms Hypersensitive Bladder Symptoms, Bladder Pain Syndrome, and IC with Hunner Lesions have been eliminated. Female Bladder Pain Syndrome (FBPS) includes these concepts.

Urologic Chronic Pelvic Pain Syndrome (UCPPS) – **UNCHANGED** Complaint of pain attributable to GU tract, including IC/BPS and chronic prostatitis/chronic pelvic pain syndrome (CP/CPPS).(4)

II. LUT Signs

a. Urinary Incontinence Signs[17]

Urinary Incontinence -- UNCHANGED Observation of involuntary loss of urine on examination.(1)

Stress Urinary Incontinence (SUI, Clinical Stress Leakage) -- UNCHANGED Observation of involuntary leakage from the urethra synchronous with effort or physical exertion, or on sneezing or coughing.(1)

Urgency Urinary Incontinence (UUI) – UNCHANGED Observation of involuntary leakage from the urethra synchronous with the sensation of a sudden, compelling desire to void that is difficult to defer.(1)

Extra-Urethral Incontinence – **UNCHANGED** Observation of urine leakage through channels other than the urethral meatus, e.g., fistula.(1)

Stress Incontinence on Prolapse Reduction (occult or latent stress incontinence) – **UNCHANGED** Stress incontinence only observed after the reduction of co-existent prolapse (1)

b. Storage Signs

Daytime (Urinary) Frequency -- UNCHANGED Number of voids during the main awake period (including first void after waking up from sleep and last void before sleep).(17)

24-hour (Urinary) Frequency – **UNCHANGED** Total number of voids during a specified 24-hour period.(17)

24-Hour Urine Volume – **CHANGED** Summation of all urine volumes during a specified 24-hour period. The first void after rising is discarded and the 24-hour period begins at the

[17] All examinations for the evaluation of urinary incontinence are best performed with the individual's bladder comfortably full.

time of the next void. It is completed by the following day and includes the first void after rising.(17)

Maximum Voided Volume – **NEW** Highest voided volume recorded during the assessment period. This usually equals bladder capacity.

Average Voided Volume – NEW Summation of volumes voided divided by the number of voids during the assessment period.

24-Hour Polyuria – UNCHANGED Excessive excretion of urine resulting in profuse and frequent micturition. It has been defined as over 40 mL/kg body weight during 24 h or 2.8 L urine for an individual weighing 70 kg.(8)

Polyuria -- NEW Excessive production of urine.

c. <u>Nocturnal Signs</u>

Nocturia --CHANGED The number of times an individual passes urine during their main sleep period, from the time they have fallen asleep up to the intention to rise from that period. This is derived from the bladder diary.(8)[18]

Nocturnal (Night-Time) Polyuria (NP) – **UNCHANGED** Excessive[19] production of urine during the individual's main sleep period.(8)

Nocturnal polyuria index (NPi)* -- (nocturnal urine volume/ 24-h voided volume) based on nocturnal urine volume as part of total 24-h urine volume. It is age dependent; however the age groups have not been clearly defined: a. 33% in elderly, for example, >65; b. >20% in younger individuals; c. 20–33% in "middle age."(8)

[18] A previous term, Night-time (Urinary) Frequency, has been eliminated due to redundancy with this term.

[19] The definition used by the health-care provider to quantify "excessive" will need to be highlighted in both clinical and research settings and should be derived from a bladder diary

*While not signs, NPI and Nocturia index are calculations that can be used to define the sign "Nocturnal Polyuria."

Nocturia index* – **CHANGED** A value calculated as (nocturnal urine volume) / (maximum voided volume)[20].(8)

Enuresis – CHANGED Urinary incontinence ("wetting") that occurs during periods of sleep (while asleep).(8)

Nocturnal Urine Volume -- CHANGED Total volume of urine produced during the main sleep period. Volume measurement begins after last void preceding sleep and concludes after the first void of the normal waking period (when the individual decides to no longer attempt to sleep).(8)

d. Additional signs

Urethral prolapse – CHANGED Circumferential extrusion of urethral mucosa beyond the urethral meatus.(14)

Urethral caruncle – CHANGED Extrusion of urethral mucosa beyond the urethral meatus that is not circumferential.(14)

PELVIC ORGAN PROLAPSE

The preponderance of terms listed in this section are drawn from the 2016 IUGA / ICS joint report on terminology for female POP(14). At the time of the writing of the current report, an update to the Pelvic Organ Prolapse Quantification (POP-Q) System(18) is being prepared by Stakeholders across multiple societies, including IUGA, AUGS, SUFU, and the Society of Gynecologic Surgeons (SGS). At the risk of including content that soon may be outdated, we have included the original POP-Q staging system at the end of this section.

I. Prolapse symptoms – NEW Symptoms caused by descent of the vaginal walls and the accompanying adjacent pelvic organs. These often increase in severity with increased intra-abdominal pressure as might be experienced with increased physical activity, straining, coughing, or prolonged standing. The most consistently reported symptom is the sensation of vaginal bulge,

[20] Nocturia may occur because maximum voided volume is smaller than nocturnal urine volume although nocturnal polyuria is secondary to nocturnal urine over-production in excess of maximum bladder capacity.

but others include difficulty with bladder emptying, and / or difficulty with defecation. These symptoms improve when the anatomic prolapse is reduced, such as with lying down.(11)

Vaginal bulge – UNCHANGED Vaginal bulging: Complaint of a "bulge", lump or "something coming down" or "falling out" through the vaginal introitus.(14)

Pelvic pressure, heaviness, discomfort[21] -- CHANGED Complaint of increased heaviness or dragging in the suprapubic area and/or pelvis attributed to dependent prolapse.(14)

Bleeding, discharge, infection – UNCHANGED Complaint of abnormal vaginal bleeding, discharge or infection which may be related to ulceration of the prolapse.(14)

Splinting/digitation – CHANGED Complaint of the need to digitally replace the prolapse or to otherwise apply manual pressure, e.g. to the vagina or perineum, or to the anterior or posterior vaginal wall or rectum to assist voiding or defecation.(14)

Introital gaping – NEW: The sensation or complaint of separation of openness of the introitus / posterior fourchette.

II. Signs

Pelvic organ prolapse – UNCHANGED The descent of one or more of the anterior vaginal wall, posterior vaginal wall, the uterus (cervix) or the apex of the vagina (vaginal vault or cuff scar after hysterectomy).(14)

Pelvic organ prolapse stage – UNCHANGED Stage assigned to prolapse using the Pelvic Organ Prolapse Quantification system.(18)[22]

Stage 0: No prolapse is demonstrated.

Stage I: Most distal portion of the prolapse is more than 1 cm above the level of the hymen.

Stage II: The most distal portion of the prolapse is situated between 1 cm above the hymen and 1 cm below the hymen.

[21] The writing group agreed the three symptoms are nonspecific and thus amalgamated into a single concept rather than made separate.

[22] At the time of publication, the POPQ System is being revised, and a published updated system is expected imminently

Stage III: The most distal portion of the prolapse is more than 1 cm beyond the plane of the hymen but everted at least 2 cm less than the total vaginal length.

Stage IV: Complete eversion or eversion at least within 2 cm of the total length of the lower genital tract is demonstrated.

Uterine / cervical prolapse – UNCHANGED Observation of descent of the uterus or uterine cervix.(14)

Vaginal vault (cuff scar) prolapse – UNCHANGED Observation of descent of the vaginal vault (cuff scar after hysterectomy).(14)

Anterior vaginal wall prolapse – UNCHANGED Observation of descent of the anterior vaginal wall (compartment). Most commonly this might represent bladder prolapse ("cystocele"). Higher stage anterior vaginal wall prolapse will generally involve descent of uterus or vaginal vault (if uterus is absent). Occasionally, there might be an anterior "enterocele" (hernia of peritoneum and possibly abdominal contents), most commonly after prior reconstructive surgery.(14)

Posterior vaginal wall prolapse – UNCHANGED Observation of descent of the posterior vaginal wall. Commonly, this would represent rectal protrusion into the vagina ("rectocele"). Higher stage posterior vaginal wall prolapse after prior hysterectomy generally involve some vaginal vault ("cuff scar") descent and possible enterocele formation. Enterocele formation can also occur in the presence of an intact uterus.(14)

ANORECTAL DYSFUNCTION

This section draws heavily form the 2016 joint report from IUGA and ICS on the terminology of female anorectal dysfunction(13). After thoughtful consideration, the writing group elected to limit this portion of the terminology report by excluding anorectal physiologic investigations and imaging.

I. Symptoms

a. Anorectal incontinence symptoms

Anal incontinence -- UNCHANGED Complain of involuntary loss of feces or flatus.(13)

Fecal Incontinence -- **UNCHANGED** complaint of involuntary loss of feces. a) solid, b) liquid(13)

Flatus incontinence -- UNCHANGED Complaint of involuntary loss of flatus (gas)

Double ("dual") incontinence -- CHANGED Complaint of both anal and urinary incontinence.(13)

Passive fecal incontinence -- **UNCHANGED** Involuntary soiling of liquid or solid stool without sensation or warning or difficulty wiping clean.(13)

Overflow fecal incontinence -- UNCHANGED Seepage of stool due to fecal impaction.(13)

b. Anorectal storage symptoms

Increased daytime defecation -- **CHANGED** Complaint that defecation occurs more frequently than deemed normal during the main awake period by the individual (or caregiver).(13)

Nocturnal defecation – CHANGED The complaint of interruption of sleep because of the need to defecate. Each defecation is preceded and followed by sleep.(13)

Fecal urgency -- UNCHANGED Complaint of a sudden compelling desire to defecate that is difficult to defer.

Fecal urgency warning time: time from first sensation of urgency to voluntary defecation or fecal incontinence.(13)

Fecal (flatal) urgency incontinence -- UNCHANGED Complaint of involuntary loss of feces (gas) associated with (fecal) urgency.(13)

Tenesmus -- UNCHANGED A desire to evacuate the bowel, often accompanied by pain, cramping, and straining, in the absence of feces in the rectum.(13)

c. Anorectal sensory symptoms

Diminished rectal sensation -- UNCHANGED Complaint of diminished or absent sensation in the rectum.(13)

Increased rectal sensation – UNCHANGED Complaint of a desire to defecate (during rectal filling) that occurs earlier or more persistent to that previously experienced.(13)

d. Defecatory and post-defecatory symptoms

Constipation -- UNCHANGED[23] Complaint that bowel movements are infrequent and/or incomplete and/or there is a need for frequent straining or manual assistance to defecate.

(a) Slow transit – **UNCHANGED** Infrequent bowel motions due to delay in transit of bowel contents to reach rectum.

(b) Obstructed defecation – **CHANGED** Difficulty evacuating stool, requiring straining efforts at defecation often associated with lumpy or hard stools, sensation of incomplete evacuation, feeling of anorectal blockage/obstruction or manual assistance to defecate (or inability to relax EAS suggesting dyssynergic defecation).(13)

Feeling of incomplete bowel evacuation -- UNCHANGED Complaint that the rectum does not feel empty after defecation and may be accompanied by a desire to defecate again.(13)

Straining to defecate -- UNCHANGED Complaint of the need to make an intensive effort (by abdominal straining or Valsalva) to either initiate, maintain, or improve defecation.(13)

Sensation of blockage -- UNCHANGED: Complaint suggestive of anorectal obstruction.(13)

Digitation[24] **- UNCHANGED:** Digitally assisted defecation

(a) Rectal digitation: Use of fingers in rectum to physically extract stool contents to assist in evacuation.

(b) Vaginal digitation: Use of thumb or fingers in the vaginal to assist in evacuation of stool(13)

(c) Perineal digitation: Supporting the perineum manually to assist in evacuation of stool content.(13)

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[23] Several other definitions of constipation exist as described in Rome IV (19. Mearin F, Lacy BE, Chang L, Chey WD, Lembo AJ, Simren M, et al. Bowel Disorders. Gastroenterology. 2016.) or patient-facing NIDDK literature (20. Definition and Facts for Constipation [updated May 2018. This content is provided as a service of the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), part of the National Institutes of Health. NIDDK translates and disseminates research findings to increase knowledge and understanding about health and disease among patients, health professionals, and the public. Content produced by NIDDK is carefully reviewed by NIDDK scientists and other experts.]. Available from: https://www.niddk.nih.gov/health-information/digestive-diseases/constipation/definition-facts.), and we recognize an opportunity to collaborate with other medical specialties and organizations toward a common definition for all.

[24] Previously used “splinting” terms have been incorporated into 4 types of digitation to minimize redundancy

(d) Buttocks digitation: Supporting the buttocks manually to assist in evacuation of stool content.(13)

Splinting – CHANGED Supporting the perineum or buttocks manually to assist in evacuation of stool content.(13)

Post defecatory soiling -- UNCHANGED Soiling occurring after defecation.(13)

e. **Anorectal pain symptoms -- UNCHANGED** This refers to pain localized to the anorectal region, and may include pain, pressure, or discomfort in the region of the rectum, sacrum, and coccyx that may be associated with pain in the gluteal region and thighs.(13)

Pain during straining/defecation -- UNCHANGED Complaint of pain during defecation or straining to defecate.(13)

Inflammatory anorectal pain – UNCHANGED Complaint of pain characterized by burning or stinging (fissure, inflammation, sepsis).(13)

Non-inflammatory anorectal pain -- UNCHANGED Complaint of blunted anorectal pain, as opposed to sharp stinging or burning type of pain (proctalgia fugax, Levator ani syndrome, pudendal neuralgia).(13)

f. Other anorectal symptoms

Anorectal prolapse -- CHANGED Complaint of a ‘‘bulge’’ or ‘‘something coming down’’ towards or through the anus/rectum[25]. (13)

Rectal bleeding / mucous – UNCHANGED Complaint of the loss of blood / mucous per rectum.(13)

Anal laxity – **UNCHANGED** Complaint of the feeling of a reduction in anal tone.(13)

Perianal itching/pruritus ani -- UNCHANGED Complaint of itchy anus.(13)

Flaturia -- UNCHANGED Complaint of passage of gas per urethra.(13)

Fecaluria -- UNCHANGED Complaint of passage of fecal material per urethra. (13)

[25] The patient may state she can either feel the bulge by direct palpation or see it aided with a mirror.

II. Anorectal Signs

Excoriation – **CHANGED** Physical exam evidence of perianal skin scratching.(13)

Soiling – CHANGED The appearance of perianal or vaginal fecal material.(13)

Gaping anus -- UNCHANGED Non-coaptation of anal mucosa at rest.(13)

Deficient perineum / cloacal-like defect --UNCHANGED A spectrum of tissue loss from the perineal body and rectovaginal septum with variable appearance. There can be a common cavity made up of the anterior vagina and posterior rectal walls or just an extremely thin septum between the anorectum and vagina.(13)

Anal fissures -- UNCHANGED Longitudinal split in the skin of the anal canal, exposing the internal anal sphincter muscle. The majority of fissures are found in the mid-line posteriorly and there may be a skin tag associated with them.(13)

Hemorrhoids -- UNCHANGED Abnormality of the normal cushion of specialized, highly vascular tissue in the anal canal in the submucosal space. Hemorrhoids can be divided into those originating above the dentate line which are termed internal and those originating below the dentate line which are termed external. Internal hemorrhoids are graded as follows: Grade I - bleeding without prolapse. Grade II - prolapse with spontaneous reduction. Grade III - prolapse with manual reduction. Grade IV - incarcerated, irreducible prolapse. Grade II and Grade III hemorrhoids will become evident on asking the patient to bear down and grade IV hemorrhoids are obvious at the time of the examination. A proctoscopy is essential in examining for hemorrhoids unless they are completely prolapsed.(13)

Anorectal prolapse -- CHANGED Full thickness eversion of the lower part of the rectum and anal canal. The exposed mucosa is red with circumferential folds around the central pit, which is the lumen of the rectum[26].(13)

[26] Look for associated utero-vaginal prolapse, fistulas, sepsis, and ulcers.

Fistula in ano -- UNCHANGED An anal fistula is an abnormal connection between the anal canal epithelium (or rarely rectal epithelium) and the skin epithelium. Patients may complain of pain, swelling, intermittent discharge of blood or pus from the fistula, and recurrent abscesses formation.(13)

Rectovaginal fistula -- UNCHANGED A communication from the rectum to the vagina.(13)

Anorectal / vaginal / perineal fistula -- UNCHANGED An abnormal communication from the anal canal to the vagina or perineal area.(13)

SEXUAL FUNCTION AND DYSFUNCTION

The vast majority of terms presented in this section are drawn from the 2018 IUGA and ICS joint report on the terminology for the assessment of sexual health in women.(21) Past terminology documents on LUTS, POP, and anorectal dysfunction also contain terms related to sexual dysfunction, but in this report, all sexual dysfunction terms overlapping with other sections appear only here.

Sexual Dysfunction Symptoms

Obstructed vaginal intercourse -- UNCHANGED Vaginal intercourse that is difficult or not possible due to obstruction by genital prolapse or shortened vagina or pathological conditions such as lichen planus or lichen sclerosis.(21)

Vaginal laxity -- UNCHANGED Feeling of vaginal looseness.(21)

Anorgasmia -- UNCHANGED Complaint of lack of orgasm; the persistent or recurrent difficulty, delay in or absence of attaining orgasm following sufficient sexual stimulation and arousal, which causes personal distress.(21)

Vaginal dryness -- UNCHANGED Complaint of reduced vaginal lubrication or lack of adequate moisture in the vagina.(21)

Sexual activity urinary incontinence – NEW: Complaint of urinary incontinence associated with, or during, sexual activity. This includes

Sexual Arousal Incontinence -- UNCHANGED Complaint of urinary incontinence during sexual arousal, foreplay and/or masturbation.(3)

Penetration Incontinence – UNCHANGED: complaint of involuntary leakage of urine during penetration (penile, manual, or sexual device) (includes coitus and vaginal intercourse).(17)

Climacturia (orgasmic urinary incontinence) – CHANGED Complaint of urinary incontinence at the time of orgasm.(3, 17)

Coital urinary urgency – CHANGED Sudden compelling desire to void during vaginal intercourse that is difficult to defer.(21)

Post-coital LUTS -- **CHANGED** Onset or worsening of urinary frequency or urgency, dysuria, suprapubic tenderness, etc. following sexual intercourse.(21)

Coital fecal / flatal incontinence -- CHANGED Fecal / flatal incontinence occurring with vaginal intercourse.(21)

Coital fecal urgency -- CHANGED Sudden compelling feeling of impending bowel action during vaginal intercourse.(21)

Anal dyspareunia -- CHANGED Complaint of pain or discomfort associated with attempted or complete anal penetration.(21)

Vaginal flatus -- UNCHANGED Passage of air from vagina (usually accompanied by sound)

Dyspareunia -- UNCHANGED Complaint of persistent or recurrent pain or discomfort associated with attempted or complete vaginal penetration.(21)

Introital dyspareunia -- CHANGED Complaint of pain or discomfort at the vaginal introitus during attempted penetration

Deep dyspareunia -- UNCHANGED Complaint of pain or discomfort on deeper penetration (mid or upper vagina).(21)

Vaginismus -- UNCHANGED Recurrent or persistent spasm of vaginal musculature that interferes with vaginal penetration.(21)

Dyspareunia with penile vaginal movement -- UNCHANGED Pain that is caused by and is dependent on penile movement.(21)

Non coital sexual pain -- UNCHANGED Pain induced by non coital stimulation(21)

Post coital pain -- UNCHANGED Pain after intercourse such as vaginal burning sensation or pelvic pain

Vulvodynia -- UNCHANGED Persistent vulvar pain without clear identifiable cause.(21)

De novo sexual dysfunction -- CHANGED New onset sexual dysfunction symptoms not previously reported.(21)

De novo dyspareunia -- CHANGED New onset of dyspareunia not previously reported.(21)

Shortened vagina -- CHANGED Perception of a short vagina expressed by the patient or partner.(21)

Tight vagina -- CHANGED – Perception of introital narrowing making vaginal entry difficult or impossible. (21)

Scarred vagina – CHANGED Perception by the patient or partner of a "stiff" vagina or a foreign body (stitches, mesh exposure, mesh shrinkage) in the vagina.(21)

Hispareunia -- CHANGED Partner pain during vaginal penetrative intercourse.(21)

Decreased sexual desire -- CHANGED Absent or diminished feelings of sexual interest or desire.(21)

Decreased sexual arousal -- CHANGED: Inability to achieve or maintain sexual excitement.(21)

Sexual Dysfunction Signs

Hypertonic pelvic floor muscle -- CHANGED A general increase in muscle tone that can be associated with either elevated contractile activity and/or passive stiffness in the muscle.(21)

Vulval gaping -- UNCHANGED Non-coaptation of vulva at rest, commonly associated with increased size of genital hiatus.(21)

Deficient perineum/cloacal-like defect -- UNCHANGED A spectrum of tissue loss from the perineal body and rectovaginal septum with variable appearance. There can be a common cavity made up of the anterior vagina and posterior rectal walls or just an extremely thin septum between the anorectum and vagina.

Vulval agglutination -- CHANGED Fusion of labia majora or minora.(21)

Vaginal agglutination -- CHANGED Fusion of the vaginal walls above the hymen.(21)

Vulvo-vaginal hypoesthesia -- CHANGED Reduced vulvo-vaginal sensitivity. (21)

Pudendal neuralgia[27] -- UNCHANGED elicited or described by the patient as burning vaginal and vulva pain (anywhere between the anus and the clitoris) with tenderness over the course of the pudendal nerve.(21)

DISCUSSION

The aim of medical terminology documents is to provide a common language for clinical care, education, research and advocacy in a specific field. Creating a collaborative resource of up-to-date terms agreed upon by representatives of 4 different societies has been an enormous task. Particular complexity was imposed by the broad scope of this project, differences in professional backgrounds and perspectives between writing group members, and difficulties in translating definitions into a common language. Approaching this terminology document required restraint among writing group members. The opportunity to take stock of the words we use every day can make us want to perfect them in our own minds. Indulging this temptation, however, can fundamentally change the everyday language of stakeholders in adjacent, but not identical, disciplines. A focus on inclusiveness and clarity allowed the completion of this project.

In 2021, American urogynecologist Steven Swift, a devoted, longtime scholar of terminology in women's pelvic health, directed our focus toward the potentially excessive, often duplicative efforts of our professional societies to produce useful terminology documents(22). He referenced the mostly historical practice of journals requiring new submissions to adhere to published terminology resources. Bringing

[27]This term was introduced with some hesitation as the authors posit that it refers to a diagnostic interpretation of anterior perineal pain. The understanding that "pudendal neuralgia" applies to many different conditions which are beyond the scope of the current paper must accompany use of the term in discussions of sexual dysfunction.

together stakeholders with diverse but overlapping niche disciplines to thoroughly review the literature and build consensus on this broad body of terminology produced an immensely valuable resource. In producing this terminology report, many terms were retired, consolidated, and changed. Still more were found to have stood the test of time, allowing a common thread connecting our future publications to our previous ones. This comprehensive update to the landmark terminology document published by Haylen, et al, in 2010 (1) may be a step toward unravelling the tangled strings of pelvic health terminology publications published in the last 16 years.

The size and scope of this project highlight a need for structured review and revision of the terms that make up our field. Minor changes of terminology were proposed and were mainly caused by harmonizing definitions when terms apply to different domains such as urinary and anal incontinence. This successful collaboration of 4 professional societies including stakeholders from around the world is an opportunity to strengthen our commitment to a common lexicon. Perhaps now is the moment to ask our journals to enforce adherence to the terms presented here.

CONCLUSIONS

This updated terminology document has harmonized definitions of terms used by clinicians, trainees, and researchers in women's pelvic health. We believe it will improve collaboration, communication and dissemination of knowledge in this therapeutic area. It also provides an opportunity to identify the tools and processes that allowed this project to move forward for similar project in the future.

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References

1. Haylen BT, de Ridder D, Freeman RM, Swift SE, Berghmans B, Lee J, et al. An International Urogynecological Association (IUGA)/International Continence Society (ICS) joint report on the terminology for female pelvic floor dysfunction. Neurourol Urodyn. 2010;29(1):4-20.

2. Chapple CR, Osman NI, Birder L, Dmochowski R, Drake MJ, van Koeveringe G, et al. Terminology report from the International Continence Society (ICS) Working Group on Underactive Bladder (UAB). Neurourol Urodyn. 2018;37(8):2928-31.

3. D'Ancona C, Haylen B, Oelke M, Abranches-Monteiro L, Arnold E, Goldman H, et al. The International Continence Society (ICS) report on the terminology for adult male lower urinary tract and pelvic floor symptoms and dysfunction. Neurourol Urodyn. 2019;38(2):433-77.

4. Doggweiler R, Whitmore KE, Meijlink JM, Drake MJ, Frawley H, Nordling J, et al. A standard for terminology in chronic pelvic pain syndromes: A report from the chronic pelvic pain working group of the international continence society. Neurourol Urodyn. 2017;36(4):984-1008.

5. Drake MJ. Fundamentals of terminology in lower urinary tract function. Neurourol Urodyn. 2018;37(S6):S13-S9.

6. Gajewski JB, Drake MJ. Neurological lower urinary tract dysfunction essential terminology. Neurourol Urodyn. 2018;37(S6):S25-S31.

7. Gajewski JB, Schurch B, Hamid R, Averbeck M, Sakakibara R, Agro EF, et al. An International Continence Society (ICS) report on the terminology for adult neurogenic lower urinary tract dysfunction (ANLUTD). Neurourol Urodyn. 2018;37(3):1152-61.

8. Hashim H, Blanker MH, Drake MJ, Djurhuus JC, Meijlink J, Morris V, et al. International Continence Society (ICS) report on the terminology for nocturia and nocturnal lower urinary tract function. Neurourol Urodyn. 2019;38(2):499-508.

9. Van Kerrebroeck P, Abrams P, Chaikin D, Donovan J, Fonda D, Jackson S, et al. The standardization of terminology in nocturia: report from the standardization subcommittee of the International Continence Society. BJU Int. 2002;90 Suppl 3:11-5.

10. Joint Terminology Report: Terminology Standardization for Female Bladder Pain Syndrome. Urogynecology (Phila). 2025;31(2):74-85.

11. Collins SA, O'Shea M, Dykes N, Ramm O, Edenfield A, Shek KL, et al. International Urogynecological Consultation: clinical definition of pelvic organ prolapse. Int Urogynecol J. 2021;32(8):2011-9.

12. Haylen BT, Freeman RM, Swift SE, Cosson M, Davila GW, Deprest J, et al. An International Urogynecological Association (IUGA) / International Continence Society (ICS) joint terminology and classification of the complications related directly to the insertion of prostheses (meshes, implants, tapes) & grafts in female pelvic floor surgery. Int Urogynecol J. 2011;22(1):3-15.

13. Sultan AH, Monga A, Lee J, Emmanuel A, Norton C, Santoro G, et al. An International Urogynecological Association (IUGA)/International Continence Society (ICS) joint report on the terminology for female anorectal dysfunction. Int Urogynecol J. 2017;28(1):5-31.

14. Haylen BT, Maher CF, Barber MD, Camargo S, Dandolu V, Digesu A, et al. An International Urogynecological Association (IUGA)/International Continence Society (ICS) joint report on the terminology for female pelvic organ prolapse (POP). Int Urogynecol J. 2016;27(4):655-84.

15. Bo K, Frawley HC, Haylen BT, Abramov Y, Almeida FG, Berghmans B, et al. An International Urogynecological Association (IUGA)/International Continence Society (ICS) joint report on the terminology for the conservative and nonpharmacological management of female pelvic floor dysfunction. Int Urogynecol J. 2017;28(2):191-213.

16. International Classification of Diseases, Eleventh Revision (ICD-11). Geneva: World Health Organization; 2025.

17. Abrams P, Cardozo L, Fall M, Griffiths D, Rosier P, Ulmsten U, et al. The standardisation of terminology of lower urinary tract function: report from the Standardisation Sub-committee of the International Continence Society. Am J Obstet Gynecol. 2002;187(1):116-26.

18. Bump RC, Mattiasson A, Bo K, Brubaker LP, DeLancey JO, Klarskov P, et al. The standardization of terminology of female pelvic organ prolapse and pelvic floor dysfunction. Am J Obstet Gynecol. 1996;175(1):10-7.

19. Mearin F, Lacy BE, Chang L, Chey WD, Lembo AJ, Simren M, et al. Bowel Disorders. Gastroenterology. 2016.

20. Definition and Facts for Constipation [updated May 2018. This content is provided as a service of the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), part of the National Institutes of Health. NIDDK translates and disseminates research findings to increase knowledge and understanding about health and disease among patients, health professionals, and the public. Content produced by NIDDK is carefully reviewed by NIDDK scientists and other experts.]. Available from: https://www.niddk.nih.gov/health-information/digestive-diseases/constipation/definition-facts.

21. Rogers RG, Pauls RN, Thakar R, Morin M, Kuhn A, Petri E, et al. An International Urogynecological Association (IUGA)/International Continence Society (ICS) joint report on the terminology for the assessment of sexual health of women with pelvic floor dysfunction. Neurourol Urodyn. 2018;37(4):1220-40.

22. Swift SE. Joint terminology documents: are there too many or is this the way forward? Int Urogynecol J. 2021;32(12):3103-4.