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Assessment of Sexual Function in Women with Pelvic Organ Prolapse Using the PISQ-12: A Comparative Study

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Abstract

Background: Pelvic organ prolapse (POP) is a prevalent pelvic floor disorder that significantly affects women's physical, psychological, and sexual health. Despite its high incidence, the impact of POP on sexual function remains underexplored, particularly among Indian women. This study aimed to evaluate sexual dysfunction in women with POP using the Pelvic Organ Prolapse/Urinary Incontinence Sexual Questionnaire (PISQ-12) and to identify key contributing factors.

Methods: A hospital-based cross-sectional study was conducted among 100 sexually active women with clinically diagnosed POP (POP-Q ≥ Stage I) and 100 age-matched controls. Sexual function was assessed using the PISQ-12, and scores were analyzed in relation to prolapse severity, age, parity, and body mass index (BMI). Data were analyzed using SPSS v25, with $p < 0.05$ considered statistically significant.

Results: Women with POP had significantly higher PISQ-12 scores than controls (35.0 ± 2.25 vs. 25.9 ± 2.53; $p < 0.001$), indicating greater sexual dysfunction. Mean scores increased with prolapse severity (Stage I = 32.1; Stage III = 37.3; $p < 0.001$). Dysfunction was more pronounced in older, multiparous, and obese women. Item-wise analysis revealed that physical symptoms—pain during intercourse, urinary leakage, and fear of

bulge—were the most affected domains, while partner-related factors were least impacted.

Conclusion: POP significantly impairs sexual function, with severity correlating with anatomical grade, age, and BMI. Sexual dysfunction arises through both physical and emotional pathways, underscoring the need for integrated management that includes pelvic floor rehabilitation, weight control, and psychosexual counselling to improve quality of life.

Keywords: Pelvic organ prolapse, Female sexual dysfunction, PISQ-12, Pelvic floor disorders, Body mass index, Quality of life

Introduction

Pelvic organ prolapse (POP) is a significant yet often underrecognized Gynaecological disorder characterized by the descent of pelvic organs—such as the uterus, bladder, or rectum—into or beyond the vaginal canal due to weakening of the pelvic floor muscles and connective tissues.[1] It is one of the most prevalent pelvic floor disorders (PFDs) affecting women, with nearly one in four adult Indian women reporting at least one PFD, and its incidence rises progressively with age.[2] The prevalence increases from 31.6% among women aged 50–59 years to 52.7% in those over 80 years.[3] POP is frequently associated with urinary incontinence (UI), aggravating symptoms such as vaginal bulging, urinary and bowel dysfunction, and pelvic discomfort, thereby substantially compromising quality of life.[4]

Among the varied manifestations of PFDs, female sexual dysfunction (FSD) remains one of the most distressing yet underreported consequences.[5] FSD affects between 38% and 85.2% of women, presenting as dyspareunia, reduced sexual desire, arousal difficulties, and orgasmic dysfunction.[6] The effect of POP on sexual function is multifactorial, influenced by anatomical alterations, physiological impairments, and complex psychosocial and cultural dimensions.[7] Physical contributors—such as vaginal laxity, urinary leakage during intercourse, and discomfort—often coexist with psychological factors, including anxiety, depression, and negative body image, which together can strain intimate relationships.[8] Additionally, sociocultural stigma surrounding female sexuality, especially in conservative societies, perpetuates silence around sexual health concerns, leading to delayed diagnosis and inadequate care.[9]

Despite its considerable prevalence and adverse implications, sexual dysfunction in women with POP often receives insufficient clinical attention. To address this gap, several validated instruments have been developed for evaluating sexual function, including the Pelvic Organ Prolapse/Urinary Incontinence Sexual Questionnaire (PISQ-12) and the Female Sexual Function Index (FSFI).[10,11] Although the FSFI is widely applied in assessing general sexual dysfunction, it lacks specificity for pelvic floor–related symptoms. In contrast, the PISQ-12 is a validated, condition-specific tool designed to measure sexual function in women with POP and UI. The PISQ-IR (IUGA-Revised), introduced in 2013, provides a more comprehensive framework but remains limited in widespread application due to the absence of established cutoff values. [12] Consequently, the PISQ-12 continues to be the preferred instrument for both diagnostic and outcome assessment purposes in women with POP. [13]

Given the scarcity of Indian data exploring the relationship between POP and sexual function, this study aims to compare sexual function among women with and without POP using the PISQ-12 questionnaire. It also seeks to identify key determinants—such as age, menopausal status, parity, body mass index, and

comorbidities—that influence sexual function in affected women. The findings are expected to enhance understanding of the interrelationship between pelvic floor disorders and female sexual health, promoting the development of comprehensive, patient-centered management strategies that integrate both functional and sexual well-being.

Materials and Methods

Study Design and Setting: This hospital-based, comparative cross-sectional study was conducted in the Department of Obstetrics and Gynaecology, SMS Medical College and Attached Group of Hospitals, Jaipur, Rajasthan, India, between January 2024 and December 2024. The study aimed to compare sexual function in women with and without pelvic organ prolapse (POP) using the Pelvic Organ Prolapse/Urinary Incontinence Sexual Questionnaire (PISQ-12) and to evaluate the association between POP severity and domain-specific sexual dysfunction.

Study Population: A total of 200 sexually active women aged 30–55 years were enrolled. The study population comprised two groups: Group A (Study Group): 100 women with clinically diagnosed pelvic organ prolapse (POP-Q stage ≥1), and Group B (Control Group): 100 age-matched women without clinical evidence of POP. Exclusion criteria included women with a history of psychiatric illness, those on medications known to influence sexual function (e.g., antidepressants, hormonal therapy), pregnant women, and those who had undergone previous pelvic reconstructive surgery or hysterectomy.

Data Collection: After obtaining written informed consent, participants were interviewed using a pretested, structured proforma to record sociodemographic details, obstetric history, menopausal status, comorbidities, and relevant clinical data. Clinical staging of POP was performed using the Pelvic Organ Prolapse Quantification (POP-Q) system, and women were classified according to the most advanced compartment as Stage I, II, or III. Stage IV cases were excluded due to their limited functional capacity and low occurrence rate.

Assessment of Sexual Function: Sexual function was assessed using the Pelvic Organ Prolapse/Urinary Incontinence Sexual Questionnaire (PISQ-12), a validated condition-specific instrument designed to evaluate sexual function in women with POP and urinary incontinence (Rogers et al., 2003). The PISQ-12 comprises 12 items divided into three domains: Behavioural/Emotional domain (Q1–Q4), Physical domain (Q5–Q9), and Partner-related domain (Q10–Q12). Each item is scored from 0 (“never”) to 4 (“always”), with reverse scoring applied to positively phrased items. The total score ranges from 0 to 48, where higher scores indicate greater sexual dysfunction. Domain-specific scores were also calculated separately for detailed comparison.

Ethical Considerations: The study protocol was reviewed and approved by the Institutional Ethics Committee, SMS Medical College and Attached Hospitals, Jaipur (Ref. No.: 109 MC/EC/2023, dated 8 November 2024). Written informed consent was obtained from all participants after explaining the purpose, procedures, and confidentiality of the study.

Statistical Analysis: Data were entered into Microsoft Excel and analyzed using IBM SPSS Statistics for Windows, Version 25.0 (Armonk, NY: IBM Corp.). Descriptive statistics were used to summarize demographic and clinical characteristics. Categorical variables were presented as frequencies and percentages, while continuous variables were expressed as mean ±

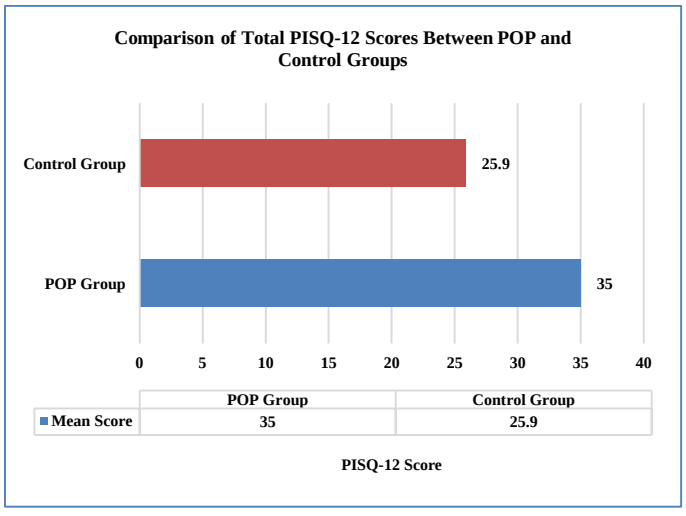
standard deviation (SD). Comparisons between the two groups were made using the Student's t-test or Mann–Whitney U test for continuous variables and the Chi-square test for categorical variables. Within the POP group, One-Way ANOVA or Kruskal–Wallis test (depending on data distribution) was applied to compare PISQ-12 domain scores across POP-Q stages. Correlations between POP severity and total as well as domain-wise PISQ-12 scores were assessed using Spearman's rank correlation coefficient. A p-value < 0.05 was considered statistically significant.

Results

Women with POP had substantially poorer sexual function than controls. The mean total PISQ-12 score was 35.00 ± 2.25 in the POP group versus 25.90 ± 2.53 in controls (independent t-test: t = 27.0, df = 198, p < 0.001), indicating a large and clinically meaningful between-group difference.

Table 1: Total PISQ-12 Score: POP vs Control

Group	Mean ± SD	n	p-value
POP	35.00 ± 2.25	100	<0.001
Control	25.90 ± 2.53	100	



PISQ-12 by POP Severity. Among women with POP, sexual dysfunction increased progressively with anatomical severity. Mean scores rose from 32.1 (Stage I) to 34.4 (Stage II) and 37.3 (Stage III). One-way ANOVA showed a strong overall difference (F = 193; p < 0.001), supporting a clear dose–response relationship between POP severity and sexual dysfunction.

Table 2: PISQ-12 by POP-Q Stage (POP Group Only)

POP-Q Stage	Mean ± SD	n
Stage I	32.1 ± 0.97	22
Stage II	34.4 ± 0.79	37
Stage III	37.3 ± 1.10	41
Overall	35.0 ± 2.25	100

Age-Stratified Comparison. Across all age bands, women with POP had higher PISQ-12 scores than controls. Within the POP group, scores increased with age (from 32.4 at 30–35 years to 37.2 at 51–55 years). Two-way ANOVA demonstrated significant main effects of study group and age, and a significant interaction (Group F = 787.05; Age F = 14.14; Interaction F = 8.73; all p < 0.001), indicating that the adverse effect of POP on sexual function is age-dependent and becomes more pronounced at older ages.

Table 3: Age-wise PISQ-12 (POP vs Control)

Age (years)	POP Mean ± SD (n)	Control Mean ± SD (n)
30–35	32.4 ± 0.70 (10)	25.6 ± 1.87 (22)
36–40	32.3 ± 1.30 (16)	25.6 ± 3.07 (20)
41–45	34.3 ± 1.07 (14)	26.4 ± 2.03 (18)
46–50	34.8 ± 1.12 (20)	25.8 ± 2.61 (20)
51–55	37.2 ± 1.07 (40)	26.3 ± 3.01 (20)
Overall	35.0 ± 2.25 (100)	25.9 ± 2.53 (100)

Parity-Stratified Comparison. POP was associated with higher PISQ-12 scores at every parity level, with a stepwise rise from 32.4 (parity 1) to 37.2 (parity 4). Two-way ANOVA showed significant main effects and interaction (Group F = 725.2; Parity F = 20.8;

Interaction F = 13.5; all p < 0.001), indicating that the negative effect of POP increases with higher parity.

Table 4: Parity and PISQ-12 (POP vs Control)

Parity	POP Mean ± SD (n)	Control Mean ± SD (n)
1	32.4 ± 0.70 (10)	25.6 ± 1.85 (20)
2	32.2 ± 1.27 (15)	25.7 ± 2.64 (30)
3	34.5 ± 1.09 (35)	26.1 ± 2.56 (25)
4	37.2 ± 1.07 (40)	26.2 ± 2.92 (25)
Overall	35.0 ± 2.25 (100)	25.9 ± 2.53 (100)

BMI-Stratified Comparison. In all BMI categories, POP was associated with worse sexual function than controls. Within the POP group, mean PISQ-12 scores increased with adiposity (Normal 32.7 → Overweight 35.4 → Obese 38.0). Two-way ANOVA confirmed significant main effects and an interaction (Group F = 247.8; BMI F = 25.9; Interaction F = 15.4; all p < 0.001), indicating that higher BMI amplifies the detrimental impact of POP on sexual function.

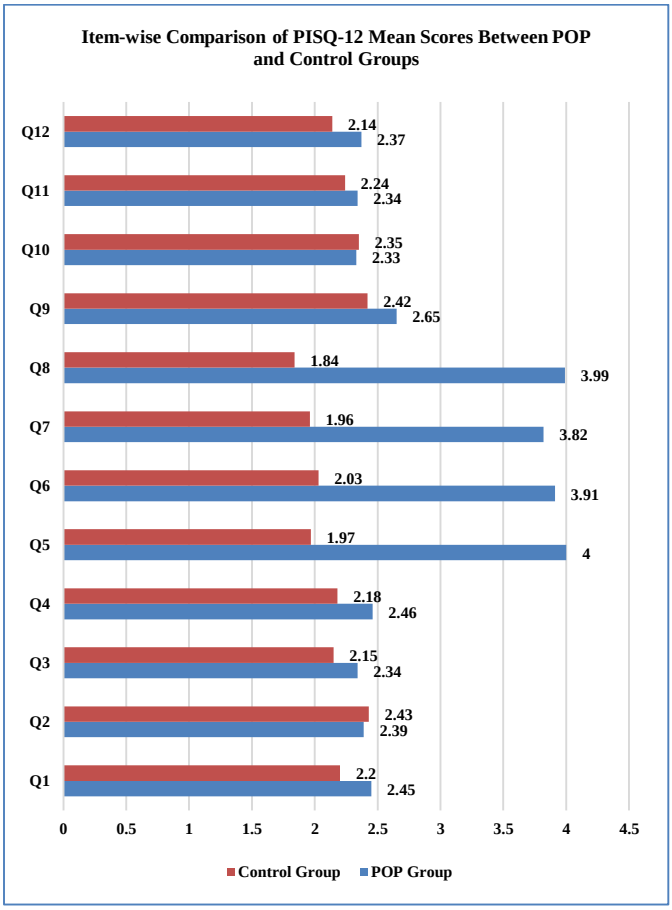
Table 5: BMI Category and PISQ-12 (POP vs Control)

BMI Category	POP Mean ± SD (n)	Control Mean ± SD (n)
Underweight	30.0 ± 0.00 (2)	27.3 ± 3.06 (3)
Normal	32.7 ± 0.84 (30)	25.6 ± 2.32 (45)
Overweight	35.4 ± 0.98 (45)	25.8 ± 2.67 (35)
Obese	38.0 ± 0.93 (23)	26.7 ± 2.66 (17)
Overall	35.0 ± 2.25 (100)	25.9 ± 2.53 (100)

Item-wise PISQ-12 Differences. Marked between-group differences were concentrated in physical symptom items (Q5–Q8), all highly significant (p < 0.001), reflecting pain, incontinence, fear of leakage/bulge, and avoidance. Statistically significant differences also appeared in desire (Q1), satisfaction (Q4), emotional discomfort (Q9), and orgasm intensity (Q12). Items related to partner factors (Q10–Q11) showed no significant differences.

Table 6: Item-wise PISQ-12 (POP vs Control)

Item	POP Mean ± SD	Control Mean ± SD	p
Q1	2.45 ± 0.744	2.20 ± 0.778	0.021
Q2	2.39 ± 0.840	2.43 ± 0.700	0.715
Q3	2.34 ± 0.934	2.15 ± 0.730	0.111
Q4	2.46 ± 0.915	2.18 ± 0.757	0.019
Q5	4.00 ± 0.000	1.97 ± 0.577	<0.001
Q6	3.91 ± 0.288	2.03 ± 0.784	<0.001
Q7	3.82 ± 0.386	1.96 ± 0.695	<0.001
Q8	3.99 ± 0.100	1.84 ± 0.707	<0.001
Q9	2.65 ± 0.757	2.42 ± 0.794	0.037
Q10	2.33 ± 0.726	2.35 ± 0.833	0.857
Q11	2.34 ± 0.742	2.24 ± 0.740	0.341
Q12	2.37 ± 0.837	2.14 ± 0.779	0.046



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Discussion

Women with pelvic organ prolapse (POP) exhibited significantly higher PISQ-12 scores than controls (35.0 ± 2.25 vs. 25.9 ± 2.53; $p < 0.001$), confirming a clinically meaningful reduction in sexual function. This nearly 9-point gap on a 48-point scale underscores the major negative impact of POP on sexual well-being. These findings concur with Trang et al. (2019)[14] and Grzybowska et al. (2019)[15], who documented a high prevalence of female sexual dysfunction (FSD) in women with prolapse, particularly in behavioural-emotional and physical domains. The results also echo Lau et al. (2020)[16] and Antosh et al. (2020, 2021)[17], who demonstrated significant postoperative improvement in PISQ scores, confirming that POP is a reversible and independent determinant of sexual dysfunction.

Sexual dysfunction worsened progressively with anatomical severity, with mean PISQ-12 scores increasing from 32.1 in Stage I to 37.3 in Stage III prolapse ($p < 0.001$). This strong dose–response trend indicates that as prolapse advances, both physical and psychological aspects of sexuality deteriorate. Similar gradients were described by Darvish et al. (2024)[18] and Trang et al. (2019)[14]. Importantly, even Stage I women reported substantial dysfunction, aligning with Moroni et al. (2018)[19], who noted that body-image distress and fear of worsening symptoms contribute to sexual avoidance even in early disease. These findings reinforce the need for early recognition and counselling for sexual health in all stages of POP.

Across all age strata, POP patients had significantly higher PISQ-12 scores than controls ($p < 0.001$). Within the POP group, dysfunction increased with age (32.4 → 37.2). However, even younger women (30–35 years) exhibited considerable impairment, challenging the assumption that sexual dysfunction is purely age-related. Similar patterns were reported by Zhuo et al. (2021)[20] and Ugurlucan et al. (2020)[21], who emphasized that prolapse severity rather than chronological age predicts sexual decline. The control group's stable scores across ages suggest that aging alone does not impair sexual function in the absence of pelvic floor pathology.

Higher parity was associated with elevated PISQ-12 scores in POP women, with mean values rising from 32.4 in parity 1 to 37.2 in parity 4 ($p < 0.001$). Nonetheless, even primiparous women with POP experienced significant dysfunction, indicating that once prolapse develops, anatomical and psychological factors outweigh parity count. These results align with Darvish et al. (2024)[18] and Moradi et al. (2025)[22], who observed that prolapse severity—not parity itself—is the dominant determinant of sexual impairment. In controls, parity did not affect sexual function, reinforcing that the presence of prolapse, not childbirth history alone, drives dysfunction.

Body mass index showed a strong modifying effect on sexual function among POP women. Mean PISQ-12 scores increased steadily from normal-weight (32.7 ± 0.84) to overweight (35.4 ± 0.98) and obese groups (38.0 ± 0.93; $p < 0.001$), while remaining stable among controls. The significant interaction between study group and BMI indicates that excess weight amplifies the adverse sexual impact of POP. This is consistent with Sartori et al. (2021)[23] and Zhuo et al. (2021)[20], who identified obesity and reduced pelvic muscle tone as risk factors for poor sexual outcomes. The findings highlight the importance of weight management and pelvic-floor rehabilitation in prolapse care.

Item-wise comparison revealed that the largest between-group differences occurred in the physical domain (Q5–

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Q8: dyspareunia, coital incontinence, fear of bulge, vaginal dryness; all $p < 0.001$). Significant deficits were also noted in behavioural-emotive items (Q1 and Q4) reflecting reduced desire and satisfaction, whereas partner-related items (Q10–Q11) showed minimal difference. This pattern indicates that POP primarily impairs sexual function through symptom-driven physical and emotional mechanisms rather than partner factors. These results align with Zhuo et al. (2021)[20] and Martins (2025)[24], emphasizing the dual physical-psychological burden of prolapse on sexual well-being.

Conclusion

Pelvic organ prolapse (POP) has a profound and multidimensional impact on female sexual function. In this study, women with POP demonstrated significantly higher PISQ-12 scores compared to controls, confirming the presence of clinically meaningful sexual dysfunction. The severity of dysfunction increased progressively with prolapse stage and was further amplified by advancing age, higher parity, and obesity. Item-wise analysis revealed that physical symptoms such as dyspareunia, fear of incontinence, and vaginal dryness were the most affected domains, accompanied by emotional and relational disturbances. These results highlight that POP compromises sexual health not only through anatomical distortion but also through psychological and quality-of-life dimensions. Comprehensive management of women with prolapse should therefore include systematic assessment of sexual function, targeted pelvic floor rehabilitation, weight management, and psychosexual counselling. Early identification and multidisciplinary care—addressing both physical and emotional aspects—are essential to restore sexual well-being and overall quality of life in affected women.

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