Pelvic floor disorders include urinary incontinence, pelvic organ prolapse, fecal incontinence, and other sensor-y and emptying abnormalities of the lower urinary and gastrointestinal tracts. A regional study in the United States found that almost 10% of women have surgery for urinary incontinence, pelvic organ prolapse, or both during their lifetime, and 30% of those women have 2 or more surgical procedures. However, because no single national population-based survey has assessed the prevalence of the 3 major pelvic floor disorders in US women, the national burden related to these diseases remains unknown.

Thus, in 2003, the Pelvic Floor Disorders Network (PFDN) submitted a proposal to add questions about pelvic floor disorders to the 2005-2006 National Health and Nutrition Examination Survey (NHANES). The PFDN, a clinical trials network of investigators from 7 clinical centers and a data coordinating center, is supported by the Eunice Kennedy Shriver National Institute of Child Health and Human Development (Bethesda, Maryland) and the National Institute of Diabetes and Digestive and Kidney Diseases (Bethesda).

Context Pelvic floor disorders (urinary incontinence, fecal incontinence, and pelvic organ prolapse) affect many women. No national prevalence estimates derived from the same population-based sample exist for multiple pelvic floor disorders in women in the United States.

Objective To provide national prevalence estimates of symptomatic pelvic floor disorders in US women.

Design, Setting, and Participants A cross-sectional analysis of 1961 nonpregnant women (≥20 years) who participated in the 2005-2006 National Health and Nutrition Examination Survey, a nationally representative survey of the US noninstitutionalized population. Women were interviewed in their homes and then underwent standardized physical examinations in a mobile examination center. Urinary incontinence (score of ≥3 on a validated incontinence severity index, constituting moderate to severe leakage), fecal incontinence (at least monthly leakage of solid, liquid, or mucous stool), and pelvic organ prolapse (seeing/feeling a bulge in or outside the vagina) symptoms were assessed.

Main Outcome Measures Weighted prevalence estimates of urinary incontinence, fecal incontinence, and pelvic organ prolapse symptoms.

Results The weighted prevalence of at least 1 pelvic floor disorder was 23.7% (95% confidence interval [CI], 21.2%-26.2%), with 15.7% of women (95% CI, 13.2%-18.2%) experiencing urinary incontinence, 9.0% of women (95% CI, 7.3%-10.7%) experiencing fecal incontinence, and 2.9% of women (95% CI, 2.1%-3.7%) experiencing pelvic organ prolapse. The proportion of women reporting at least 1 disorder increased incrementally with age, ranging from 9.7% (95% CI, 7.8%-11.7%) in women between ages 20 and 39 years to 49.7% (95% CI, 40.3%-59.1%) in those aged 80 years or older (P < .001), and parity (12.8% [95% CI, 9.0%-16.6%], 18.4% [95% CI, 12.9%-23.9%], 24.6% [95% CI, 19.5%-29.8%], and 32.4% [95% CI, 27.8%-37.1%]) for 0, 1, 2, and 3 or more deliveries, respectively; P < .001. Overweight and obese women were more likely to report at least 1 pelvic floor disorder than normal weight women (26.3% [95% CI, 21.7%-30.9%], 30.4% [95% CI, 25.8%-35.0%], and 15.1% [95% CI, 11.6%-18.7%], respectively; P < .001). We detected no differences in prevalence by racial/ethnic group.

Conclusion Pelvic floor disorders affect a substantial proportion of women and increase with age.
tute of Child Health and Human Development and the National Institutes of Health Office of Research on Women’s Health. The primary goal of the PFDN is to improve diagnosis, treatment, and prevention of pelvic floor disorders in women.

The goal of this research study is to provide prevalence estimates of symptomatic pelvic floor disorders by demographic characteristics in nonpregnant women aged 20 years or older between January 2005 and December 2006.

METHODS
The 2005-2006 NHANES Program
The NHANES program consists of cross-sectional, national health surveys conducted by the National Centers for Health Statistics Centers for Disease Control and Prevention. Each NHANES provides national estimates of health status of adults in the United States at the time of the survey by selecting a nationally representative sample of the civilian, noninstitutionalized US population, by using a complex, stratified, multistage, probability cluster design. The 2005-2006 NHANES oversampled persons aged 60 years or older, and black, Mexican American, and low-income white individuals to provide more reliable estimates for these groups. The National Centers for Health Statistics Ethics Review Board approved the protocol, and all participants provided written informed consent. This analysis of NHANES data met criteria for exemption of human subjects research review by the University of Utah Institutional Review Board.

Study Population
Participants were interviewed in their homes and then underwent standardized physical examinations, including measured height and weight, in a mobile examination center. Trained interviewers asked about symptoms of pelvic floor disorders and reproductive history as part of a private interview in the mobile examination.

Of 3440 women aged 20 years or older originally selected through a probability sampling for the 2005-2006 NHANES survey, 2592 women (75.4%) agreed to participate and completed the household interview and 2489 women (72.4%) agreed to participate in the mobile examination center. Of these women, 236 (9.5%) were missing data on all 3 pelvic floor outcomes. After eliminating 292 women who were currently pregnant, our final analytic data set comprised 1961 women.

To define urinary incontinence, we used the validated 2-item incontinence severity index, which correlates well with incontinence volume based on pad weights and incontinence frequency obtained on bladder diaries. We defined symptomatic pelvic floor disorders among 4 racial/ethnic groups: (1) non-Hispanic white; (2) non-Hispanic black; (3) Hispanic (composed mostly of Mexican Americans due to the oversampling); and (4) other (Indian [American], Alaska Native, Native Hawaiian, Guamanian, Samoan, other Pacific Islander, Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, and other Asian).

Age was categorized in 20-year increments beginning with 20 years and ending with 80 years or more; education was categorized as less than high school, high school diploma including General Education Development, and more than high school; the poverty income ratio (an indicator of socioeconomic status that uses the ratio of income to the family’s poverty threshold set by the US Census Bureau) was categorized as less than 1 (below the poverty threshold), 1 to 2 (1-2×above the poverty threshold), and more than 2 (>2×above the poverty threshold); body mass index (calculated as weight in kilograms divided by height in meters squared) was categorized as less than 25.0 (underweight/normal weight), 25.0 to 29.9 (overweight), and 30.0 or more (obese); and parity (total number of vaginal and cesarean deliveries) was categorized as 0, 1, 2, and 3 or more.

Statistical Analysis
Weighted prevalence estimates and 95% confidence intervals (CIs) were calculated by using SAS version 9.1 (SAS Institute Inc, Cary, North Carolina), incorporating the design effect, appro-
priate sample weights, stratification, and clustering of the complex NHANES sample design. The sample weights adjust for unequal probabilities of selection and nonresponse. Estimates with relative standard errors of more than 30% were considered statistically unreliable and are identified as such (TABLE). The Rao-Scott Modified $\chi^2$ test was used to test the association between pelvic floor disorders outcome and demographic characteristics. $P<.05$ was considered statistically significant.

**RESULTS**

Overall, 23.7% (95% CI, 21.2%-26.2%) of women had symptoms of at least 1 pelvic floor disorder. Of these, 15.7% (95% CI, 13.2%-18.2%) experienced urinary incontinence, 9.0% (95% CI, 7.3%-10.7%) experienced fecal incontinence, and 2.9% (95% CI, 2.1%-3.7%) experienced symptomatic pelvic organ prolapse. The proportion of women that reported at least 1 pelvic floor disorder increased with age (9.7% [95% CI, 7.8%-11.7%] in women aged 20 to 39 years, 26.5% [95% CI, 23.0%-29.9%] in women aged 40 to 59 years, 36.8% [95% CI, 32.0%-41.6%] in women aged 60 to 79 years, and 49.7% [95% CI, 40.3%-59.1%] in women aged 80 years or older; $P<.001$). The Table shows the percentage of respondents with each pelvic floor disorder by demographic characteristics. Other characteristics that were significantly associated with at least 1 pelvic floor disorder were (1) family poverty income ratio, (2) BMI, and (3) education.

The table below shows the weighted prevalence rates of pelvic floor disorders by demographic categories in nonpregnant US women (N = 1961).

<table>
<thead>
<tr>
<th>Variable</th>
<th>No. of Women</th>
<th>Urinary Incontinence (n = 331)</th>
<th>Fecal Incontinence (n = 176)</th>
<th>Pelvic Organ Prolapse (n = 58)</th>
<th>≥1 Pelvic Floor Disorder (n = 470)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall</strong></td>
<td>1961</td>
<td>15.7 (13.2-18.2)</td>
<td>9.0 (7.3-10.7)</td>
<td>2.9 (2.1-3.7)</td>
<td>23.7 (21.2-26.2)</td>
</tr>
<tr>
<td><strong>Age, y</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-39</td>
<td>641</td>
<td>6.9 (4.9-9.0)</td>
<td>2.9 (1.9-3.9)</td>
<td>1.6 (0.6-2.6)</td>
<td>9.7 (7.8-11.7)</td>
</tr>
<tr>
<td>40-59</td>
<td>668</td>
<td>17.2 (13.9-20.5)</td>
<td>9.9 (7.4-12.5)</td>
<td>3.8 (2.0-5.7)</td>
<td>26.5 (23.0-29.9)</td>
</tr>
<tr>
<td>60-79</td>
<td>488</td>
<td>23.3 (17.0-29.7)</td>
<td>14.4 (10.4-18.3)</td>
<td>3.0 (0.9-5.1)</td>
<td>36.8 (32.0-41.6)</td>
</tr>
<tr>
<td>≥80</td>
<td>150</td>
<td>31.7 (22.3-41.2)</td>
<td>21.6 (12.8-30.4)</td>
<td>4.1 (1.1-7.1)</td>
<td>49.7 (40.3-59.1)</td>
</tr>
<tr>
<td><strong>P value</strong></td>
<td></td>
<td>&lt;.001</td>
<td>&lt;.001</td>
<td>.14</td>
<td>&lt;.001</td>
</tr>
<tr>
<td><strong>Race/ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>420</td>
<td>15.9 (11.1-20.7)</td>
<td>4.8 (1.9-7.6)</td>
<td>5.1 (1.6-8.6)</td>
<td>20.6 (14.5-26.8)</td>
</tr>
<tr>
<td>Non-Hispanic white</td>
<td>993</td>
<td>16.0 (13.1-19.0)</td>
<td>9.8 (7.6-11.9)</td>
<td>2.8 (1.8-3.8)</td>
<td>24.8 (21.6-28.0)</td>
</tr>
<tr>
<td>Non-Hispanic black</td>
<td>461</td>
<td>13.8 (10.5-17.1)</td>
<td>7.9 (4.9-11.0)</td>
<td>1.9 (0.1-3.9)</td>
<td>20.7 (16.4-24.9)</td>
</tr>
<tr>
<td>Other</td>
<td>87</td>
<td>15.0 (6.3-23.7)</td>
<td>8.2 (3.7-12.6)</td>
<td>1.5 (0.0-4.7)</td>
<td>21.6 (14.3-29.0)</td>
</tr>
<tr>
<td><strong>P value</strong></td>
<td></td>
<td>.83</td>
<td>.04</td>
<td>.27</td>
<td>.26</td>
</tr>
<tr>
<td><strong>Parity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>396</td>
<td>6.5 (4.2-8.9)</td>
<td>6.3 (2.9-9.6)</td>
<td>0.6 (0.0-1.5)</td>
<td>12.8 (9.0-16.6)</td>
</tr>
<tr>
<td>1</td>
<td>293</td>
<td>9.7 (6.4-13.0)</td>
<td>8.8 (4.3-13.3)</td>
<td>2.5 (0.1-4.9)</td>
<td>18.4 (12.9-23.9)</td>
</tr>
<tr>
<td>2</td>
<td>475</td>
<td>16.3 (12.3-20.3)</td>
<td>8.4 (5.8-11.0)</td>
<td>3.7 (1.7-5.6)</td>
<td>24.6 (19.5-29.8)</td>
</tr>
<tr>
<td>≥3</td>
<td>768</td>
<td>23.9 (20.1-27.7)</td>
<td>11.5 (8.7-14.3)</td>
<td>3.8 (2.1-5.4)</td>
<td>32.4 (27.8-37.1)</td>
</tr>
<tr>
<td><strong>P value</strong></td>
<td></td>
<td>&lt;.001</td>
<td>.07</td>
<td>.04</td>
<td>&lt;.001</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;High school</td>
<td>484</td>
<td>19.5 (15.4-23.6)</td>
<td>10.6 (6.3-14.8)</td>
<td>4.1 (1.7-6.5)</td>
<td>27.5 (21.4-33.5)</td>
</tr>
<tr>
<td>High school diploma</td>
<td>470</td>
<td>16.3 (13.1-19.0)</td>
<td>9.8 (7.0-12.6)</td>
<td>2.2 (0.7-3.8)</td>
<td>25.9 (23.7-28.2)</td>
</tr>
<tr>
<td>≥High school</td>
<td>1006</td>
<td>14.5 (11.5-17.4)</td>
<td>8.2 (5.7-10.7)</td>
<td>2.8 (1.8-3.9)</td>
<td>21.8 (18.4-25.3)</td>
</tr>
<tr>
<td><strong>P value</strong></td>
<td></td>
<td>.06</td>
<td>.49</td>
<td>.38</td>
<td>.06</td>
</tr>
<tr>
<td><strong>Family poverty income ratio</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;1</td>
<td>316</td>
<td>21.5 (15.3-27.7)</td>
<td>8.1 (4.2-12.1)</td>
<td>5.5 (2.4-8.5)</td>
<td>28.8 (21.8-35.7)</td>
</tr>
<tr>
<td>1-2</td>
<td>496</td>
<td>21.4 (17.3-25.4)</td>
<td>10.7 (8.1-13.4)</td>
<td>4.0 (1.8-6.2)</td>
<td>29.7 (25.1-34.3)</td>
</tr>
<tr>
<td>&gt;2</td>
<td>1067</td>
<td>12.8 (10.8-14.9)</td>
<td>8.5 (6.3-10.8)</td>
<td>2.2 (1.3-3.2)</td>
<td>20.8 (18.1-23.5)</td>
</tr>
<tr>
<td><strong>P value</strong></td>
<td></td>
<td>&lt;.001</td>
<td>.37</td>
<td>.08</td>
<td>.002</td>
</tr>
<tr>
<td><strong>BMI</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;25.0</td>
<td>658</td>
<td>8.1 (5.4-10.7)</td>
<td>6.4 (4.6-8.3)</td>
<td>1.7 (0.6-2.9)</td>
<td>15.1 (11.6-18.7)</td>
</tr>
<tr>
<td>25.0-29.9</td>
<td>533</td>
<td>19.0 (14.8-23.1)</td>
<td>9.3 (6.4-12.2)</td>
<td>3.4 (1.2-5.5)</td>
<td>26.3 (21.7-30.9)</td>
</tr>
<tr>
<td>≥30.0</td>
<td>746</td>
<td>21.1 (16.9-25.4)</td>
<td>11.0 (7.4-14.6)</td>
<td>3.6 (2.0-5.2)</td>
<td>30.4 (25.8-35.0)</td>
</tr>
<tr>
<td><strong>P value</strong></td>
<td></td>
<td>&lt;.001</td>
<td>.05</td>
<td>.20</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

**Abbreviation:** BMI, body mass index, calculated as weight in kilograms divided by height in meters squared.

A complete case analytic approach was used and of the 1961 women with pelvic floor disorders information, 14 women had missing age, 29 missing parity, 1 missing education, 82 missing poverty income ratio, and 24 missing BMI. See the "Methods" section for descriptions of race/ethnicity, parity, education, family poverty income ratio, and BMI. Relative standard errors of more than 30% (reflecting unreliable estimates).
COMMENT

These data represent the first nationwide, population-based estimates of the 3 primary pelvic floor disorders in women in the United States derived from a single source. Nearly one-quarter of all women and more than one-third of older women reported symptoms of at least 1 pelvic floor disorder. By 2030, more than one-fifth of women will be 65 years or older. As the population of older women increases, the national burden related to pelvic floor disorders in terms of health care costs, lost productivity, and decreased quality of life will be substantial. Furthermore, our prevalence estimates are likely underestimates for several reasons: (1) they do not reflect symptoms of women who have undergone successful treatment for pelvic floor disorders; (2) we used conservative definitions; and (3) symptom-based diagnosis underestimates the true prevalence of pelvic organ prolapse diagnosed by physical examination.

Other studies, including data from NHANES in earlier waves, concluded that between 25% and 75% of women have urinary incontinence, depending on how the condition is defined. Higher rates represent a symptom of occasional leakage, while lower rates are more likely to represent a disease. We limited our definition to those women with moderate to severe leakage to better reflect the population of women more likely to seek treatment.

Similarly, published estimates of the prevalence of fecal incontinence in the community range widely, from 2.2% to 24%. As with urinary incontinence, differences in prevalence estimates are explained in part by differences in case definition, with some studies including involuntary loss of flatus in the definition and other studies limiting the definition to loss of stool or mucus.

Population-based epidemiological studies of pelvic organ prolapse are rare, despite the fact that it is a common indication for gynecological surgery in older women. A major impediment to population-based studies is the requirement of an examination to assess vaginal support. Several studies including our study, avoided this limitation by screening for prolapse based on the presence of prolapse-related symptoms rather than examination. The symptom most strongly correlated with the presence of advanced pelvic organ prolapse is “seeing” or “feeling” a vaginal bulge. There is no clear consensus about what level of prolapse represents a variation of normal uterovaginal support and what represents disease, although there is growing consensus that prolapse beyond the hymen is more likely to be clinically significant. Up to 75% of women presenting for routine gynecological care demonstrate some prolapse, and 3% to 6% have descent beyond the hymen. The specificity of vaginal bulge symptoms for predicting prolapse beyond the hymen is high in low-prevalence populations (99%-100%); however, the sensitivity is low (16%-35%), because some women with even advanced prolapse deny symptoms.

Thus, prolapse prevalence in studies using symptom-based screening such as this one underestimate the true prevalence of anatomic disease. However, because women typically do not seek care for prolapse until symptoms develop and physicians generally do not offer surgical treatment until symptoms become bothersome, symptom-based prevalence estimates likely represent the best estimate of disease burden on the population.

The finding that both urinary and fecal incontinence increase with age is consistent with the epidemiological literature. The few studies available show that apical, anterior, and posterior vaginal wall prolapse also increases with advancing age. The relationship between pelvic floor disorders and age is usually attributed to age-related connective tissue and neuromuscular changes and to comorbidities, such as obesity, pulmonary disease, and diabetes, that occur more commonly among older adults.

Consistent with prior studies, these data demonstrate a significant association between childbirth and pelvic floor disorders. In the Oxford Family Planning Study, women with 2 deliveries were substantially more likely to have surgery for prolapse compared with women with no delivery. In a cross-sectional study of Norwegian women, compared with women with no deliveries, the effect of 2 or more deliveries on urinary incontinence was greatest in younger women aged 20 to 34 years (relative risk [RR], 2.8; 95% CI, 2.3-3.3), decreased among women aged 35 to 64 years (RR, 2.0; 95% CI, 1.6-2.3), and then, consistent with other literature, was not associated with urinary incontinence in women older than 65 years. The association between female incontinence and parity is inconsistent. However, the fact that more than 1 in 8 nulliparous women in the United States derived from a single source is consistent with prior studies.
2005-2006 NHANES reported at least 1 symptomatic pelvic floor disorder demonstrates the multifactorial nature of these conditions. In contrast with several other large studies in which white women had a higher prevalence of urinary incontinence and pelvic organ prolapse than did black or Hispanic women, we found no difference in prevalence in comparisons of black, non-Hispanic white, or Hispanic women. We did not categorize urinary incontinence by subtype (stress or urge) in this analysis, which may account for this difference. A recent analysis using earlier NHANES data (2001-2004) found a higher prevalence of stress urinary incontinence in white and Mexican American women than black women, but no differences in other incontinence subtypes. Although national hospital discharge statistics show that black women have lower rates of prolapse surgery than white women, this difference cannot be attributed to race. Many factors, including access to care, contribute to the decision to undergo surgery, and therefore to surgical prevalence rates. Because we have no information about treatment for pelvic floor disorders, we cannot comment on whether treatment varies by race/ethnicity in our sample. Although Hispanic women were less likely than white or black women to report fecal incontinence in our study, other studies found no such difference in community-dwelling adults. Further research is needed to better characterize racial and ethnic variations in pelvic floor disorders and to understand why such differences exist. In addition, although the sample sizes were adequate to describe prevalence rates by demographic characteristics, they were too small to provide meaningful estimates of adjusted risk factors, including the effect of delivery type on pelvic floor disorders. Additional years of data will allow for these analyses.

In conclusion, pelvic floor disorders affect a substantial proportion of women and increase with age. Indeed, in a health maintenance organization, older women generated 10 times the number of consults per 1000 women-years for treatment of pelvic floor disorders than did younger women. Given the burden pelvic floor disorders place on US women and the health care system, research is needed to further understand their pathophysiology, prevention, and treatment.

Author Contributions: Dr Spino had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Study concept and design: Nygaard, Burgio, Meikle, Whitehead, Wu, Brody.

Acquisition of data: Nygaard, Meikle, Whitehead, Brody.

Analysis and interpretation of data: Nygaard, Barber, Kenton, Schafer, Spino, Brody.

Drafting of the manuscript: Nygaard, Barber, Burgio, Kenton, Meikle, Schafer, Spino, Whitehead, Wu, Brody.

Critical revision of the manuscript for important intellectual content: Nygaard, Barber, Burgio, Kenton, Meikle, Spino, Whitehead, Wu, Brody.

Statistical analysis: Spino.

Administrative, technical, or material support: Nygaard, Brody.

Study supervision: Nygaard.

Financial Disclosures: Dr Barber reported receiving research support from American Medical Systems and Pfizer, and speaking fees for American Medical Systems. Dr Burgio reported receiving research support from Cook Medical Inc and speaking fees from Astellas/GlaxoSmithKline. Dr Whitehead reported receiving research support from Pfizer, Astellas, GlaxoSmithKline, Eli Lilly, Ortho-McNeil, Novartis, and Merck; and receiving research support from Pfizer and Alza. Dr Kenton reported receiving research support from Pfizer and Meikle, a National Institute of Child Health and Human Development (NICHD) employee, is the Pelvic Floor Disorders Network project scientist. Dr Schafer reported receiving research support from Cook Medical Inc and speaking fees from Astellas/GlaxoSmithKline. Dr Spino was employed by Pfizer until August 10, 2007. She has no ownership interests and no ongoing financial relationship with Pfizer. Dr Barber reported receiving research support and being a paid consultant to McNeil Pharmaceuticals (makers of Imodium). No other authors reported any financial disclosures.

Funding/Support: This work was supported by grants U01 HD14249, U10 HD14268, U10 HD14248, U10 HD14250, U10 HD14261, U10 HD14263, U10 HD14269, U10 HD14267, U10 HD14316, U10 HD54214, and U110 HD84215 from the Eunice Kennedy Shriver NICHD and funding from the National Institute of Diabetes and Digestive and Kidney Diseases and the National Institutes of Health Office of Research on Women's Health.

Role of Sponsors: The sponsors had no role in the design and conduct of the study, in the collection, management, analysis, or interpretation of the data, or in the preparation, review, or approval of the manuscript.

The Pelvic Floor Disorders Network Members: Cleveland Clinic, Cleveland, Ohio: Mathew D. Barber, MD, MHS, principal investigator; Marie Fidelia R. Paraiso, MD, MS, principal investigator; Paul L. Bump, MD, co-investigator; Mark D. Walters, MD, co-investigator; I. Eric Jelovsek, MD, co-investigator; Linda McElrath, RN, research nurse; Donel Murphy, RN, MSN, coordinator research nurse; Cheryl Williams, research assistant; Duke University, Durham, North Carolina: Anthony G. Visco, MD, principal investigator; Jennifer Wu, MD, MPH, co-investigator; Alison Weidner, MD, co-investigator; Cindy Amundson, MD, co-investigator; Mary L. Loth, RN, BSN, research coordinator; Loyola University, Chicago, Illinois: Linda Brubaker, MD, MS, principal investigator; Kimberly Kenton, MD, MS, investigator; Mary Pat Fitzgerald, MD, MS, investigator; Elizabeth Mueller, MD, MSME, investigator; Kathy Marchese, RN, study coordinator; Mary Tulke, RN, study coordinator; University of Alabama at Birmingham: Holly E. Richter, PhD, MD, principal investigator; R. Edward Varner, MD, co-investigator; Robert L. Holley, MD, co-investigator; Thomas L. Wheeler, MD, co-investigator; Patricia S. Goode, MD, co-investigator; Kathryn L. Burgio, PhD, co-investigator; Mary Alayne D. Markland, DO, co-investigator; Velina Willis, RN, BSN, research coordinator; Nancy Saxon, BSN, research nurse clinician; LaChele Ward, LPN, research assistant; Lisa S. Pair, CRNP, University of California, San Diego, and Kaiser, San Diego: Charles W. Nager, MD, principal investigator; Shawn A. Meneely, MD, co-investigator; Emily Lukacz, MD, co-investigator; Karl M. Luber, MD, co-investigator; Michael E. Albo, MD, co-investigator; Margie Kahn, MD, co-investigator; Lysa Woodall, RN, study coordinator; Giselle Zazueta-Damian, study coordinator; University of Michigan, Ann Arbor: Morton B. Brown, PhD, co-investigator; Cathie Spino, DSC, principal investigator; John T. Wei, MD, MS, co-principal investigator; Beverly Marchant, RN, BS, project manager; Donna Diffance, BS, clinical monitor; John O. L. Delaney, MD, co-investigator; Dee Fenner, MD, co-investigator; Nancy K. Janz, PhD, co-investigator; Wen Ye, PhD, and Zhen Chen, MS, statistician; Yang Wang, RT, MS, database programmer; University of Texas, Southwestern: Joseph Schafer, MD, principal investigator; Clifford Wai, MD, co-investigator; Marlene Corton, MD, co-investigator; Gary Lemack, MD, co-investigator; Kelly Moore, research coordinator; David Rahn, MD, co-investigator; Amanda White, MD, co-investigator; Shanah Atnip, NP, Margaret Hull, NP, Pam Martinez, NP, Deborah Lawson, NP, University of Utah, Salt Lake City: Ingrid Nager, MD, MS, principal investigator; Peggy Norton, MD, co-investigator; Linda Freeman, RN, research coordinator; Jan Baker, NP, National Institutes of Health Project Scientist: Susan Meikle, MD, MPH.

Additional Information: The National Centers for Health Statistics acquired the data, as they actually interviewed the patients; therefore, 2005-2006 NHANES collected all data. However, Dr Nygaard, Meikle, and Whitehead and Ms Brody were responsible for spearheading the effort to add the Pelvic Floor Disorders questions to NHANES, assisting with pilot testing of questions, and assisting with training field workers on administering questions.

REFERENCES

6. Barber MD, Kuchibhatla MN, Pieper CF, Bump RC. Psychometric evaluation of 2 comprehensive condition-

**SYMPTOMATIC PELVIC FLOOR DISORDERS IN US WOMEN**

**Author in the Room Teleconference**

Join Dr Nygaard, an author of this article, on Wednesday, October 15, 2008, from 2 to 3 PM ET for “Author in the Room,” an interactive teleconference aimed at closing the gap between knowledge—what is published in this article—and action—how much of this knowledge can be put into your actual practice. This teleconference, facilitated by clinical experts, should help readers answer their questions and consider the implications of the article for their practice.

Author in the Room is brought to you by JAMA and the Institute for Healthcare Improvement. To register for Author in the Room, please visit http://www.ihi.org/authorintheroom. You can listen to past conferences or subscribe to the podcast at http://jama.ama-assn.org/authorintheroom/authorindex.dtl.