Pelvic Floor Dysfunction: Assessment with Combined Analysis of Static and Dynamic MR Imaging Findings

Purpose: To prospectively analyze static and dynamic magnetic resonance (MR) images simultaneously to determine whether stress urinary incontinence (SUI), pelvic organ prolapse (POP), and anal incontinence are associated with specific pelvic floor abnormalities.

Materials and Methods: This study had institutional review board approval, and informed consent was obtained from all participants. There were 59 women: 15 nulliparous study control women (mean age, 25.6 years) and 44 patients (mean age, 43.4 years), who were divided into four groups according to chief symptom. Static T2-weighted turbo spin-echo images were used in evaluating structural derangements; functional dynamic (cine) balanced fast-field echo images were used in detecting functional abnormalities and recording five measurements of supporting structures. Findings on both types of MR images were analyzed together to determine the predominant defect. Analysis of variance and the Bonferroni t test were used to compare groups.

Results: In the four patient groups, POP was associated with levator muscle weakness in 16 (47%) of 34 patients, with level I and II fascial defects in seven (21%) of 34 patients, and with both defects in 11 (32%) of 34 patients. SUI was associated with defects of the urethral supporting structures in 25 (86%) of 29 patients but was not associated with bladder neck descent. Levator muscle weakness may lead to anal incontinence in the absence of anal sphincter defects. Measurements of supporting structures were significant ($P < .05$) in the identification of pelvic floor laxity.

Conclusion: Combined analysis of static and dynamic MR images of patients with pelvic floor dysfunction allowed identification of certain structural abnormalities with specific dysfunctions.

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Female pelvic floor dysfunction is a general term applied to a wide variety of clinical conditions, most commonly stress urinary incontinence (SUI), pelvic organ prolapse (POP), and anal incontinence (1).

Static magnetic resonance (MR) imaging is utilized to delineate components of the pelvic organ support system, including the anal sphincter complex (2–9). Dynamic (cine) MR imaging with fast sequences enables functional evaluation to assess pelvic floor relaxation and pelvic organ descent (10–16). However, the precise anatomic causes of POP and SUI remain somewhat unclear. POP has been attributed both to damage to the levator ani muscle (10) and to an endopelvic fascial defect (17); however, some believe that it is still unclear which of these factors is more responsible (18–20). Similarly, SUI has been attributed to urethral hypermobility (21,22), to unequal movement of the urethral walls (23), and to defects in the urethral supporting structures (6,5,24,25).

Because of these controversies, treatment is often started regardless of the specific anatomic lesion involved. A report from Olsen et al (26) indicated that 29% of the procedures performed for lower genitourinary tract symptoms. The women with genitourinary abnormalities, by using a validated questionnaire (28). All control group members were interviewed and were found to be healthy, with no symptoms of lower genitourinary abnormalities, by using a validated questionnaire (28).

The control group was subdivided into two subgroups, volunteer subgroup A and volunteer subgroup B, according to their MR imaging findings. MR images for volunteer subgroup A (n = 9) showed neither anatomic defects nor pelvic organ descent. In contrast, MR images for volunteer subgroup B (n = 6) demonstrated both anatomic defects and pelvic organ descent below the pubococygeal line (PCL).

Patients were classified into one of four groups, depending on their chief symptom: POP without SUI (group A, n = 10), SUI without POP (group B, n = 10), SUI with bladder and/or genital prolapse (group C, n = 16), and anal incontinence associated with POP (group D, n = 8). Three of the eight patients in group D reported SUI in addition to their main disorder. Among the members of the four patient groups, five had undergone prior pelvic or anorectal surgery. Four patients had undergone various procedures for SUI: two patients from group A and one patient from group C had undergone transvaginal taping, one patient from group D had undergone bladder neck suspension, and one patient from group D had undergone hemorrhoidectomy.

Clinical Examination

All control group members were interviewed and were found to be healthy, with no symptoms of lower genitourinary abnormalities, by using a validated questionnaire (28).

A urogynecologist (M.S.A.A., with 15 years of experience in clinical evaluation and management of pelvic floor dysfunction) examined the patients in groups A, B, and C, and a coloproctologist (A.F.,...
with 19 years of experience) examined patients in group D and documented symptoms and physical findings. During pelvic examination, the Valsalva maneuver was performed, and the results of the clinical urinary stress test, as well as the degree and type of prolapse, were recorded and graded as follows: grade 0 indicated normal findings; grade I, minimal descent; grade II, descent halfway to the introitus; grade III, descent to the introitus; and grade IV, descent beyond the introitus (29). Clinical severity of anal incontinence was assessed by using the Pescatori score for anal incontinence (30). Anal sphincter tone, anal sphincter defects, levator ani tenderness, and defects and degree of relaxation of the puborectalis muscle were assessed with rectal examination (31).

**MR Imaging**

MR imaging was performed with the patient supine in a 1.5-T MR imaging unit (Gyroscan PowerTrak 6000; Philips Medical Systems, Best, the Netherlands) by using a pelvic phased-array coil. No oral or intravenous contrast agent was administered. All patients had undergone a rectal enema with warm water the night before the MR imaging examination and were asked to void 2 hours before the examination. The rectum was opacified with 90–120 mL of ultrasonographic gel (Aquasonic; Parker Laboratories, Fairfield, NJ) in all but eight patients, who either had a painful perianal condition (three patients had perianal fissures, and one had an acute attack of hemorrhoids) or refused the instillation of gel (four patients). The MR images of these patients were still of diagnostic quality; comment on rectocele was included in our report in five of these eight patients in

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**Figure 1**

Normal static and dynamic MR imaging findings in 20-year-old woman in control group. (a) Axial T2-weighted turbo spin-echo image (5000/132) at level of proximal urethra (U) shows normal urethral supporting structures. Arrows = pubourethral slings, = space of Retzius, V = vagina. (b) Axial balanced fast-field echo image (9/4) of anal sphincter. The consecutive layers from the lumen outward include the innermost high-signal-intensity layer (the combined mucosa and submucosa), the low-signal-intensity layer (the submucosal smooth muscle [arrowhead]), the internal anal sphincter (white arrow), and the deep external anal sphincter (black arrows). (c–e) Dynamic (c) sagittal, (d) axial, and (e) coronal balanced fast-field echo MR images (5/1.6) obtained at maximum straining. In c, there is no POP; the H-line and the M-line are illustrated. In d, the width of the levator hiatus corresponds to the dashed line. In e, there is no excessive increase of the iliococcygeus angle (plotted lines).
whom the rectum was clearly delineated by air.

Static images of the pelvis were first acquired in three planes by using T2-weighted turbo spin-echo sequences (repetition time msec/echo time msec, 5000/132; field of view, 240–260 mm; section thickness, 5 mm; gap, 0.7 mm; number of signals acquired, two; flip angle, 90°; matrix, 512 × 512; acquisition time, 3.12 minutes for each sequence). In addition, T2-weighted balanced fast-field echo images (9.0/4.0; field of view, 220 mm; section thickness, 3 mm; number of signals acquired, eight; flip angle, 45°; matrix, 512 × 512; acquisition time, 2.12 minutes) of the anal sphincter complex were obtained in the control group volunteers and in patients in group D. In this sequence, section orientation was parallel and perpendicular to the plane of the anal canal (8,9).

Dynamic MR imaging was performed in the sagittal, axial, and coronal planes by using the balanced fast-field echo sequence (9.0/1.6; field of view, 300 mm; section thickness, 6–7 mm; gap, 0.7 mm). As a modification of a previous technique (14), in each plane we acquired five sections during six phases; each phase took 10 seconds. These six phases were acquired (a) with the patient at rest, (b) during contraction of the pelvic floor (the patient was instructed to squeeze the buttocks as if trying to prevent the escape of urine), (c) during mild straining, (d) during moderate straining, (e) during maximum straining, and (f) during a repeated maximum straining sequence to ensure a maximal Valsalva maneuver (the patient was instructed to bear down as much as she could, as though she were constipated and trying to defecate).

All participants were trained regarding these instructions before going to the MR imaging examination. A radiologist (R.F.E.S.) attended each MR imaging examination to ensure the compliance of the woman’s response by observing the movement of the anterior abdominal wall, as well as the movement of the pelvic organs, to minimize variations between examinations.

Data Analysis
The MR imaging data sets were assessed by a radiologist (R.F.E.S., with 7 years of experience interpreting pelvic floor MR images). The radiologist was aware of each patient’s clinical history and diagnosis. All measurements were obtained with software (DicomWorks, version 1.3.5; http://dicom.online.fr/). A consensus reading of the MR images for patients in groups A, B, and C was performed by the radiologist (R.F.E.S.) and the urogynecologist (M.S.A.A.).

Figure 2

A. Location and type of prolapse:
1. Anterior compartment:
   a. Bladder neck descent; grade: 
   b. Bladder base descent; grade: 
2. Middle compartment:
   a. Uterine descent; grade: 
   b. Enterocele/peritonecele; grade: 
3. Posterior compartment:
   a. Anorectal junction descent; grade: 
   b. Rectocele; grade: 

B. Defects in the pelvic supporting system:
1. Urethral supporting structures:
   a. Ligament(s); type of injury: ; side: 
   b. Fascia level III: 
   c. Pubourethalis; type of injury: ; side: 
2. Vaginal supporting structures:
   a. Vaginal fascia level I and II; side: 
   b. Iliococcygeus; type of injury: ; side: 

C. Anal sphincter:
1. External anal sphincter; level of injury: ; site: ; type of injury: 
2. Internal anal sphincter; level of injury: ; site: ; type of injury: 

D. Measurements of supporting structures:
   H-Line: ; M-line: ; levator plate angle: 
   Width of levator hiatus: 
   Iliococcygeus angle: 

Opinion
The predominant defect(s) is(are): 
Ligaments: 
Fascia: 
Muscles injury and/or weakness: 

Figure 2: Schematic presentation of MR imaging report.
and a consensus reading of the MR images for patients in group D was performed by the radiologist and the coloproctologist (A.F.).

Analysis of static MR images.—
Analysis of static images in the control and patient groups was based on scrutiny of the urethral supporting system, the vaginal supporting system, and the anal sphincter complex.

The urethral supporting structures consist of ligaments (32), level III fascial support (18), and the puborectalis muscle (4). On images obtained in the axial plane, urethral ligament abnormalities were classified as distorted when internal architectural changes with waviness of the ligaments were seen and as a defect when there was discontinuity of the ligament with visualization of the torn parts (5, 6). A level III fascial defect was recognized by the “drooping mustache sign,” which is formed by fat in the prevesical space against the bilateral sagging of the detached lower third of the anterior vaginal wall from the arcus tendineus fascia (7). A puborectalis muscle defect was recognized by the loss of the normal symmetric appearance of the muscle slings or disruption of the attachment of the muscle to the pubic bone (4–6).

Vaginal supporting structures include level I fascia (which suspend the upper portion of the vagina from the pelvic wall), level II fascia (which attach the midportion of the vagina more directly to the pelvic wall) (19), and the iliococcygeus muscle. In the axial plane, a defect in the fascia was visualized as sagging of the fluid-filled posterior urinary bladder wall due to the detachment of the vaginal supporting fascia from the lateral pelvic wall, known as the “saddlebags sign” (7). The iliococcygeus muscle was assessed for loss of the normal symmetric appearance of its muscle slings or disruption of its attachment to the obturator internus muscle in the coronal plane.

For evaluation of the anal sphincter complex, the normal thickness of each muscle layer and the total thickness of the anal sphincter (measured from the inner border of the internal anal sphincter to the outer border of the external

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Findings Regarding Pelvic Organ Support System Defects on Static Axial MR Images in Control Group</th>
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<tbody>
<tr>
<td></td>
<td>Urethral Supporting Structures</td>
</tr>
<tr>
<td>Volunteer Subgroup</td>
<td>Ligaments</td>
</tr>
<tr>
<td>A (n = 9)</td>
<td>0</td>
</tr>
<tr>
<td>B (n = 6)</td>
<td>0</td>
</tr>
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</table>

Note.—Data are numbers of volunteers with a defect in the given structure.

Figure 3: Static and dynamic MR images in two women in control group (one 20-year-old woman [a] and one 25-year-old woman [b–d]). (a, b) Static axial 12-weighted turbo spin-echo images (5000/132) show (a) normal level I vaginal fascial support, compared with (b) central (dashed arrow) and paravaginal (solid arrow) level I fascial defects. UB = urinary bladder. (c) Dynamic cine midsagittal and (d) parasagittal balanced fast-field echo MR images (5/1.6) obtained at maximum straining. d (obtained routinely within the five sections in each dynamic sequence) demonstrates uterine descent (UD) and the iliococcygeus muscle (arrow) better than c alone does.
anal sphincter) were measured in the control group. Anal sphincter lesions were classified according to the muscle injured (the internal or external anal sphincter or the puborectalis muscle) and according to lesion type (defect and/or scarring). A sphincteric defect was defined as discontinuity of the muscle ring; scarring was defined as a low-signal-intensity deformation of the normal pattern of the muscle layer (33).

Analysis of dynamic MR images.—In the sagittal plane, the PCL, which extends from the inferior border of the pubis anteriorly to the tip of the coccyx posteriorly, was used as the reference line. For each participant, the descent of the bladder neck, bladder base, uterus, and anorectal junction below the PCL (13) was recorded. In the patient groups, loss of urine through the urethra at maximum straining was also recorded. (However, absence of urine loss during MR imaging was not considered to invalidate the patient’s report of SUI.)

Other measurements in the sagittal plane during maximum straining included the H-line, which extends from the inferior aspect of the pubic symphysis to the anorectal junction; the M-line, which drops as a perpendicular line from the PCL to the posterior aspect of the H-line (11); and the levator plate angle, which is enclosed between the levator plate and the PCL (12). In the axial and coronal planes, respectively, the width of the levator hiatus (14) and the iliococcygeus angle (2) were measured at rest and during maximum straining. These five measurements of supporting structures were all considered to reflect the status and the weakness of the levator ani (Fig 1).

Combined analysis of static and dynamic MR images.—Findings obtained from static and dynamic MR images in the same patient were then analyzed simultaneously to determine whether a particular anatomic defect detected on static images was associated with a specific dysfunction on dynamic images. The most marked type of pelvic supporting system defect was reported as the predominant defect (Fig 2).

Statistical Analysis
The mean and standard deviation of the measurements for the control subgroups and for each patient group were calculated.

The mean and standard deviation of the measurements of supporting struc-
tures in volunteer subgroup A were compared with those in volunteer subgroup B and with those in patient groups by using software (InStat, version 3.05; GraphPad Software, San Diego, Calif). We used one-way analysis of variance to determine the statistical difference between these measurements. Whenever a measurement was shown to be statistically significant, we then used the Bonferroni t test to determine which group’s measurements were statistically significant compared with those for volunteer subgroup A. Differences were considered significant at \( P < .05 \) and highly significant at \( P < .001 \).

**Results**

**Combined Analysis of Static and Dynamic MR Images**

**Control group.**—On static axial MR images, a central type of fascial defect was detected in combination with a paravaginal defect in four members of volunteer subgroup B (Table 1). This type of defect led to sagging of the midportion of the posterior wall of the urinary bladder (Fig 3).

Combined analysis of static and dynamic MR images in volunteer subgroup B (Tables 1 and 2) demonstrated that POP was mainly due to the presence of defects in level I and level II endopelvic fascia, because levator muscle weakness, as indicated by all measurements of supporting structures in this subgroup except the levator plate angle, was of no significant statistical difference from that in volunteer subgroup A.

The thicknesses of the muscle layers of the anal sphincter complex in the control group were as follows: external muscle layer, 2.07 mm ± 0.45 (standard deviation); internal muscle layer, 4.16 mm ± 0.72; and longitudinal muscle layer, 1.04 mm ± 0.4. The total thickness of the anal sphincter was 9.07 mm ± 2.59.

**Patient group A.**—In the patient group with POP but without SUI, POP was found to be related to a predominant fascial defect in three patients, to levator muscle weakness in two pa-
patients, and to both abnormalities in five patients (Tables 3, 4; Fig 4). Urinary loss did not accompany the bladder neck descent that was detected in seven patients; none of these patients reported SUI.

Patient group B.—In the patient group with SUI but without POP, level III fascial anatomic defects in the urethral supporting structures were detected in nine patients (Table 3). Dynamic sagittal images revealed a characteristic vertical direction of bladder neck movement (Fig 5). In one patient, no gross defects of urethral supporting structures were detected.

Patient group C.—In the patient group with SUI and bladder and/or genital prolapse, on static axial MR images, all patients were seen to have anatomic defects at the vaginal fascial levels. For the urethral supporting system, defects involving the muscular and ligamentous structures were detected in five of 16 patients (Fig 6), whereas eight of 16 patients had a level III fascial defect (Table 3). In three of 16 patients, atypical distortion of the ligaments and level III fascia was detected.

POP was due to a fascial defect in four patients, to levator muscle weakness in six patients, and to both defects in six patients. SUI was almost always associated with defects in one of the urethral supporting structures.

Patient group D.—In the patient group with anal incontinence and POP with or without SUI, on static MR images, structural defects of the anal sphincter were detected in six patients (Fig 7), three of whom also reported SUI. These three patients also had anatomic defects of the urethral supporting structures. On images obtained with dynamic sequences, there was marked levator muscle weakness (Table 4). Combined analysis of static and dynamic MR images suggested that marked levator muscle weakness was the main factor leading to POP in all patients in this group. This weakness was suggested as the cause of anal incontinence in the two patients who had no anal sphincter defects (Fig 8).

Statistical Analysis

The mean pelvic organ descent and the mean measurements of supporting structures in the control and patient groups (with standard deviations) are presented in Tables 1 and 2 and Tables 3 and 4, respectively.

Analysis of variance revealed that measurements of supporting structures were of highly significant difference ($P < .001$) between the six groups. Detailed values of $t$ tests and the exact $P$ values for each measured criterion of volunteer subgroup A versus other groups are presented in Tables 5 and 6.

The differences in measurements of supporting structures between patient groups C and D were either significant ($P < .05$) or highly significant ($P < .001$).
The frequency of defects and the most common predominant defects were as follows: In the four patient groups \((n = 44)\), 34 patients reported POP, and levator muscle weakness was the predominant defect, being seen in 16 (47%) of 34 patients. Level I and II fascial defects were seen in seven (21%) of 34 patients, and both muscular and fascial defects were seen in 11 (32%) of 34 patients. Of the 29 women with SUI, 25 (86%) had an injury involving one of the urethral supporting structures. The most frequent injury was a level III fascial defect, detected in 19 (76%) of these 25 women.

### Discussion

In our study, we found a noteworthy relationship between static and dynamic MR imaging findings. This relationship provided insight into the association between MR imaging findings and pelvic floor symptoms.

In patients with POP, we were able to differentiate whether POP was due to endopelvic fascial defects, to marked levator muscle weakness, or to both by comparing volunteers in subgroup B and patients in group D. Static and dynamic MR images in volunteer subgroup B showed that POP was caused mainly by defects in level I and level II endopelvic fascia, as levator muscle weakness was mild in this control subgroup. In contrast, group D patients demonstrated a more advanced degree of muscle weakness relative to the fascial defect; these findings indicated that levator muscle weakness, rather than defects in the endopelvic fascia, was the main factor responsible for POP. The MR imaging findings in volunteer subgroup B also indicated that absence of symptoms is not necessarily associated with absence of structural defects or pelvic organ descent.

In previous work (10), POP has been attributed to damage to the levator muscle. DeLancey (18,19), however, described the interaction between pelvic floor muscles and endopelvic fascia and maintained that it was not possible to determine whether damage to muscle or damage to fascia is responsible for prolapse, because these two aspects of pelvic support are intimately independent.

Our results demonstrate that SUI is associated with the presence of defects in the urethral supporting structures. We found mainly level III endopelvic fascial defects on static MR images but no bladder neck hypermobility on dynamic MR images. These findings were supported by the fact that SUI was neither accompanied by bladder neck descent in seven patients in group A nor associated with the advanced degree of bladder neck descent encountered in group D. In addition, in the latter group, only the three patients who had SUI also had defects in the urethral supporting structures on static MR images. At the same time, the presence of defects in level I and level II endopelvic fascia in patients with SUI could not be considered a contributing factor to the patients' symptoms, because the existence of similar defects in volunteer subgroup B and in group A patients was not accompanied by SUI.

In agreement with our findings is the hammock hypothesis suggested by DeLancey (24), who reported that loss of level III endopelvic fascial support at the vesical neck is one of the factors responsible for SUI. Our findings demonstrate at imaging what had been hypothesized. Furthermore, in more recent studies (5,6), static MR imaging revealed a higher prevalence of lesions of the urethral supporting system in patients with SUI than in age-matched study control subjects.

In contrast to our findings, Klutke et al (3), who used static MR imaging, and others (14,16), who used dynamic MR imaging, have suggested urethral hypermobility as one of the causes of SUI. Yang et al (10), who used only dynamic MR imaging, did not resolve the paradoxical lack of urinary incontinence in some patients with large cystoceles because they believed it was un-
clear whether the cause was kinking of the urethra or other factors.

In addition to pinpointing the underlying structural abnormality of these disorders, our approach has several clinical implications. In SUI, combined analysis of static and cine MR images revealed an association between level III fascial defects and vertical bladder neck movement. We believe that identification of a predominant anatomic defect on static images and its effect on the kinematics of the pelvic organ in dynamic sequences could be of value, making it possible in the future to use MR imaging to choose the most appropriate surgical technique from among the available therapeutic options for SUI (34,35). For POP, many types of cystocele are currently lumped under this single term and can be documented on sagittal dynamic MR images obtained at maximum straining. However, it is not possible from these midline images to see the specific differentiating structural defects (27). Therefore, instead of the clinician focusing on a “dropped bladder,” combined analysis of both kinds of MR images can provide the clinician with complete mapping of the site and type of defects. Such information may help the clinician decide on physiotherapy for a patient with global muscle weakness and normal fascia but on surgical repair for a patient with a focal break in the fascia and/or a muscle tear. Thus, the suggested approach allows integration of static and dynamic MR imaging findings so that clinicians can more precisely identify the underlying anatomic defect responsible for symptoms in individual patients with pelvic floor dysfunction (even allowing differentiation of the underlying anatomic defect when any two patients have the same symptoms) and can thus decide on a more tailored treatment of the underlying abnormality.

Our study used phased-array coils in MR imaging in patients with anal incontinence. The different patterns and sites of injuries diagnosed in patients in group D in our study are comparable to those in previous reports (33,36). In group D patients with anal incontinence, static MR imaging showed no sphincter defect in two patients, whereas dynamic images revealed marked muscle weakness in all members of this group. Combined analysis of both types of MR images suggested that in the absence of an anal sphincter defect, anal incontinence could be associated with marked levator muscle weakness.

In contrast to other reported findings (2,14), we observed the width of the levator hiatus and the iliococcygeus angle to be statistically significant in the identification of pelvic floor laxity. Thus, we recommend that these measurements be added to the supporting measurements that have been found useful in the quantification of pelvic organ descent (14).

A limitation of our study was the heterogeneity of the patient groups. However, it was important to include patients with different clinical symptoms of pelvic dysfunction so that we could identify differences in the underlying anatomic derangement. For the
Figure 7: Static MR images in two patients (one 54-year-old woman [a] and one 33-year-old woman [b, c]) with both anal incontinence and POP. (a) Axial balanced fast-field echo image (9/4) of anal sphincter complex. Arrow = scarring of external anal sphincter, arrowhead = scarring of internal anal sphincter. (b) Axial and (c) coronal MR images obtained with the same sequence as a show fraying and an anterior defect (•) of the internal anal sphincter with bulging mucosa (white arrow), plus a defect of the external anal sphincter (black arrows). The brace in c indicates a defect of the deep part of the external anal sphincter as well as the puborectalis muscle.

Table 5

Comparison of H-Line, M-Line, and Levator Plate Angle Measurements in Volunteer Subgroup A with Those in Volunteer Subgroup B and Patient Groups

<table>
<thead>
<tr>
<th>Group Compared with</th>
<th>H-Line</th>
<th>M-Line</th>
<th>Levator Plate Angle</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>t Value</td>
<td>P Value</td>
<td>95% CI (cm)</td>
</tr>
<tr>
<td>Volunteer subgroup B</td>
<td>0.5488</td>
<td>.592</td>
<td>−1.585, 1.045</td>
</tr>
<tr>
<td>Patient group A</td>
<td>2.891</td>
<td>.010</td>
<td>−2.386, −0.094</td>
</tr>
<tr>
<td>B</td>
<td>0.349</td>
<td>.730</td>
<td>−1.296, 0.996</td>
</tr>
<tr>
<td>C</td>
<td>11.332</td>
<td>&lt;.001</td>
<td>−6.352, −3.928</td>
</tr>
</tbody>
</table>

Note.—Measurements were obtained in the sagittal plane at maximum straining. CI = confidence interval.

Table 6

Comparison of Levator Hiatus and Iliococcygeus Angle Measurements in Volunteer Subgroup A with Those in Volunteer Subgroup B and Patient Groups

<table>
<thead>
<tr>
<th>Group Compared with</th>
<th>Width of Levator Hiatus in Axial Plane</th>
<th>Iliococcygeus Angle in Coronal Plane</th>
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<tbody>
<tr>
<td></td>
<td>At Rest</td>
<td>At Maximum Straining</td>
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<tr>
<td></td>
<td>t Value</td>
<td>P Value</td>
</tr>
<tr>
<td>Volunteer subgroup B</td>
<td>0.6292</td>
<td>.540</td>
</tr>
<tr>
<td>Patient group A</td>
<td>4.427</td>
<td>&lt;.004</td>
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<tr>
<td>B</td>
<td>0.5293</td>
<td>.603</td>
</tr>
<tr>
<td>C</td>
<td>4.689</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>D</td>
<td>5.550</td>
<td>&lt;.0005</td>
</tr>
</tbody>
</table>

Note.—CI = confidence interval.
same reason, the clinical data were made available to the radiologist who analyzed the images: to allow determination of whether combined analysis of both types of MR images could detect differences in the pathogenesis of these clinical problems and to determine whether analyzing both types of images together could provide all of the information necessary for diagnosis and relevant to treatment. We recognize that the utility of demonstrating the specific abnormality in the pelvic supporting structures in the management and treatment of pelvic floor dysfunction still must be validated, just as the reproducibility of our proposed analytic approach has to be determined. Nevertheless, it is worth mentioning that promising results have been reported with respect to the ability of imaging to change patient care in 41.6% (37), 41% (38), and 75% (39) of patients with different spectra of pelvic floor dysfunction.

In conclusion, combined analysis of both static and dynamic MR images in patients reporting SUI, POP, and anal incontinence provides complementary information and allows identification of certain structural abnormalities and their association with specific pelvic floor dysfunctions. This analytic approach gives insight into the diagnosis of these complex disorders and may also allow for a defect-specific approach to disease management and surgical technique.

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