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ORIGINAL ARTICLE

Validation of the Brazilian Portuguese version of the pelvic floor bother questionnaire

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Abstract

Introduction and hypothesis The Pelvic Floor Bother Questionnaire (PFBQ) was designed to identify the presence and degree of bother associated with common pelvic floor symptoms. The PFBQ can be used in clinical practice and for research purposes, but it is not available in Brazilian Portuguese. We aimed to validate a cross-culturally adapted Brazilian Portuguese version of the PFBQ.

Methods A pilot-tested version of the PFBQ translated from English was evaluated with Brazilian patients suffering from pelvic floor disorders. Internal reliability, test-retest reliability, validity, and responsiveness to change were assessed.

Results A total of 147 patients (mean age, 60.49 years) were enrolled in the study. The Brazilian Portuguese version of the PFBQ demonstrated good reliability ($\alpha = 0.625$; ICC = 0.981). There was strong agreement beyond chance for each item ($\kappa = 0.895$–1.00). The PFBQ correlated with stage of prolapse ($p < 0.01$), number of urinary ($\rho = 0.791$, $p < 0.001$) and fecal ($\rho = 0.78$, $p < 0.001$) incontinence episodes, and obstructed defecation ($\rho = 0.875$, $p < 0.001$).

Conclusions The Brazilian Portuguese version of the PFBQ is a reliable, valid, and user-friendly instrument that can be used for assessing the presence and severity of pelvic floor symptoms in clinical and research settings in Brazil.

Keywords Fecal incontinence · Pelvic floor disorders · Pelvic organ prolapse · Symptom assessment · Urinary incontinence · Validation studies

Introduction

Pelvic floor disorders (PFDs) encompass a wide variety of interrelated conditions, which include pelvic organ prolapse (POP), urinary incontinence, and defecatory dysfunction [1]. Because PFDs have similar pathophysiologic mechanisms and share common risk factors, it is not uncommon for several PFDs to coexist in the same patient [2].

A recent study evaluating 7924 American women reported a 25% prevalence rate of one or more pelvic floor disorders [3]. This means that one-quarter of all adult women suffer from at least one PFD [3]. It is likely that an aging population and the obesity epidemic will lead to more women being affected by these conditions. PFDs rarely result in severe morbidity or mortality; however, they can significantly impact a patient's quality of life [2].

Instruments for self-assessment of symptoms by patients are valuable because they prevent a physician or anyone else from interpreting the patients' responses. Scoring these is extremely useful to determine the most bothersome symptoms and grasp the impact of treatment.

Pelvic floor questionnaires have been proposed to provide an objective measure of the degree of bother in women with PFD. The Pelvic Floor Bother Questionnaire (PFBQ) was validated in English as an alternative short global questionnaire for use in both research and clinical practice [4]. The

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questionnaire has since been translated into other languages and used in several countries [5–9].

The field of urogynecology in Brazil has made advances in patient care and scientific research. Because most of the Brazilian population is monolingual, symptom assessment questionnaires in Brazilian Portuguese are needed. There is no simple questionnaire for a comprehensive assessment of pelvic floor symptomatology in Brazilian patients.

Objective

This study aimed to update, translate, and validate the Brazilian Portuguese version of the Pelvic Floor Bother Questionnaire (PFBQ).

Methods

The study was approved by the Research Ethics Committee (CAPPesq) at the Clinics Hospital of the University of São Paulo Medical School (HCFMUSP), São Paulo, Brazil. All participants signed an informed consent form.

The translation of the pelvic floor symptom questionnaire into Brazilian Portuguese and its adaptation included the following steps:

1. Conceptual analysis of the original Pelvic Floor Bother Questionnaire (PFBQ) in English to ensure complete comprehension of the items.
2. Translation of the PFBQ into Brazilian Portuguese by two independent translators, one of whom was a certified translator. After both translations were complete, they were integrated by common consent to form a single Brazilian Portuguese version.
3. The Brazilian Portuguese version of the PFBQ was backward translated into English by an independent translator for quality control of the forward translated version. The backward translated questionnaire was then compared with the original PFBQ for potential improvements in the translation.
4. Pilot test
    - 4.1 The questionnaire was evaluated by professionals specializing in the treatment of pelvic floor disorders to ensure a critical analysis of the relevance of the terms.
    - 4.2 The questionnaire was tested in ten patients who were asked about the clarity and readability of the questions.

The final version of the questionnaire was then drafted and psychometric tests were applied.

The study population consisted of women with PFD evaluated at the Urogynecology sector, Gynecology Discipline, and the Anorectal Physiology sector, Discipline of Digestive System Surgery and Colorectal Surgery, at the Clinics Hospital of University of São Paulo Medical School (HCFMUSP).

Validation of the PFBQ included the analysis of the following properties: reliability, validity, and responsiveness to change.

Inclusion criteria

Patients aged 18 years and older were included if they had any symptoms related to pelvic floor dysfunctions, such as urinary urgency and frequency, urinary incontinence, pelvic organ prolapse (POP), fecal incontinence, and/or defecatory dysfunction.

Patients who were mentally incapable of completing self-administered questionnaires or who were unable to read in Portuguese were not included in the study.

Patients who came in for a medical evaluation at the HCFMUSP urogynecology and anorectal physiology outpatient services with symptoms of pelvic floor dysfunction between February 2014 and August 2015 were invited to participate in the study.

Participants underwent a standardized evaluation that included a detailed medical history and a complete physical examination, which in turn included a pelvic organ prolapse quantification by the Pelvic Organ Prolapse Quantification (POP-Q) system. Because a full gynecologic examination is not routinely performed at the colorectal surgery service, the examinations, including the POP-Q, were conducted by a trained gynecologist (TVP). In addition, patients were instructed to complete a bowel/bladder diary. For a definitive diagnosis, additional tests, such as urodynamic testing, defecography, anorectal manometry, and endorectal ultrasonography, were required at the discretion of the attending physician without any influence from the study team.

Participants were also asked to fill out the Pelvic Floor Bother Questionnaire (PFBQ) during their initial visit. The questionnaire was self-administered, but the researcher remained available to answer the participants' questions. To assess test-retest reliability, each patient was instructed to schedule a return visit within 7 to 10 days according to patient availability. On the second visit, the patient completed the PFBQ again and returned the bowel/bladder diary. Patients referred for treatment were instructed to come in for a return visit to complete the post-treatment PFBQ.

Definitions and diagnostic criteria of lower urinary tract function and pelvic organ prolapse conform to the standards recommended by the International Urogynecology Association and International Continence Society

(IUGA/ICS). The POP quantification was determined using the POP-Q system [10].

Fecal incontinence was defined as the accidental loss of solid or liquid stool or flatulence. Defecatory dysfunction was defined as having fewer than three bowel movements per week, hard straining > 75% of time, splinting the vagina or perineum to complete defecation, digitally evacuating the rectum to complete defecation, or having a frequent feeling of incomplete evacuation. Rectal prolapse was evaluated during the physical examination as the patient performed a straining maneuver in the sitting position.

The PFBQ is a nine-item questionnaire validated to assess the presence and patient bother as related to stress urinary incontinence, urinary urgency, urinary frequency, urge incontinence, dysuria, pelvic organ prolapse, defecatory dysfunction, fecal incontinence, and dyspareunia.

Scores for each item range from 0 to 5. The total questionnaire score ranges from 0 to 45, with higher scores indicating more bother. The scores can be transformed by multiplying the mean score of the questionnaire by 20, which gives a total score varying between 0 and 100. This transformed scoring system was used throughout this study.

Reliability was assessed by internal consistency and test-retest reliability analysis. For validation of the questionnaire, the responses to the items were compared with data from the medical history and pelvic examination, including the POP-Q, the frequency of symptoms reported in the bowel/bladder diary, and the specific final diagnoses of patients.

Responsiveness to change in the PFBQ was assessed in patients who were referred directly for treatment after the first visit and who returned after the treatment and filled out the PFBQ again. Patients who underwent surgery were evaluated 90 days postoperatively, whereas patients who underwent physical therapy returned within approximately 60 days. In the post-treatment visit, patients completed the PFBQ, which was then compared with their subjective impressions—(1) worsening, (2) unchanged, or (3) improved—of the change resulting from treatment. Patients also underwent a complete physical examination that included POP quantification, loss of urine on the Valsalva maneuver, and a rectal examination for patients recruited from the anorectal physiology service.

Statistical analysis

Power analysis was performed to determine the sample size required to demonstrate the test-retest reliability of the questionnaire using the method described by Walter et al. [11]. Considering that the investigators were hoping for an intraclass correlation coefficient (ICC) of 0.80 and that an ICC greater than 0.7 would be acceptable, the required sample size was calculated to be 118 women with PFD, assuming an alpha of 0.05 and power of 80%.

The participants' characteristics were expressed as absolute and relative frequencies for qualitative variables and as summary measures (mean, standard deviation, median, and maximum and minimum values) for quantitative variables.

Internal consistency was measured using Cronbach's α coefficient for all items and by removing each and every item one at a time [12]. A level of 0.7 or higher was considered acceptable [13].

Test-retest reliability was measured using the intraclass correlation coefficient (ICC) with its respective 95% confidence interval [14]. The agreement of each item in the questionnaire between visits was assessed using the kappa coefficient [14].

The kappa coefficient was also used to measure the agreement between item scores and responses to the interview.

The correlation of bowel and urinary symptoms reported in the bowel/bladder diary with the questionnaire scores for the respective symptom was evaluated using Spearman's correlation coefficient (ρ) [15].

The association of each questionnaire item with final pelvic floor diagnosis was determined using the chi-square or Fisher's exact test [15].

Mean scores for each item and total scores were compared between baseline and at post-treatment using McNemar's test [15] and the Wilcoxon paired test [15], respectively.

All analyses were performed using IBM-SPSS for Windows version 20.0, and all tables were created using Microsoft Excel 2011. A p value lower than 0.05 was considered statistically significant.

Results

The translated and culturally adapted versions of the PFBQ questionnaire made by the translators were very similar, and a consensus on the final draft was easily reached. For a proper comprehension of the questionnaire, all items were translated using simple everyday words that could be understood by the population treated at HCFMUSP. The pilot test was conducted by three urogynecologists (JMH, AMP, LPG), three colorectal surgeons (RAP, ICN, LB), and two urogynecology postgraduate students (LC and SA) from our institution. Ten patients randomly selected at the urogynecology outpatient service were asked about the clarity and readability of the questions. All patients had completed primary or secondary education and had no difficulty understanding the questions.

Item 2, related to increased urinary frequency and nocturia, was modified to conform to the terminology recommended by IUGA/ICS [16]. The item in the original English version referred to nocturia as "the need to get up two or more times during the night because of a need to urinate," and it had to be modified to "Do you experience increased urinary frequency (the need to urinate more often than usual, including the need to get up one or more times to urinate)?" since IUGA/ICS

defines nocturia as "interruption of sleep one or more times because of the need to micturate."

In total, 147 patients with mean age of 60.49 ± 12.02 years and mean body mass index of 28.29 ± 4.89 kg/m^2 were included in the study. Most participants [125/147 (85%)] were postmenopausal. The majority of patients were White (n = 128; 87.1%), followed by African American (n = 17; 11.5%), and Asian (n = 2; 1.4%). Median parity was 2 (0–15). Most patients (71.5%) had completed primary education, and 9% of the patients had tertiary education. The low educational level of the women in our sample was consistent with a large proportion of the Brazilian population using public health services [17].

Seventy-seven patients (52.4%) were recruited from the urogynecology outpatient service and 70 (47.6%) from the anorectal physiology service. The mean number of pelvic floor diagnoses per patient in the initial visit was 2.03. The chief clinical complaints and the number of diagnoses per patient are summarized in Table 1.

The average length of time to complete the questionnaire was 3 min. There were no missing data. The internal consistency of the questionnaire as measured by Cronbach's α was 0.625. Test-retest reliability of the PFBQ was assessed with 137 patients who returned within 7 to 10 days after the initial visit to complete the questionnaire again. Reproducibility of the PFBQ was high with an ICC close to 1 (ICC = 0.986).

There was almost perfect agreement for each item between the initial visit and the second one 7 to 10 days later (κ > 0.8). Table 2 shows the results of the reproducibility analysis.

Table 3 shows that, for most items, there was almost perfect agreement between each item and its corresponding response at the interview (κ > 0.8). The exceptions were dysuria, fecal incontinence, and dyspareunia, whose strength of agreement was substantial (kappa = 0.61–0.8).

Mean PFBQ scores correlated strongly with the symptoms of pelvic floor dysfunction reported in the bowel/bladder diary with ρ ranging from 0.660 for number of urinations to 0.875 for hard straining (Table 4).

All PFBQ items were significantly associated with the respective final pelvic floor diagnoses, and the frequency of correct final diagnoses made by the attending physician was significantly higher in patients who reported the presence of symptoms in the questionnaire ($p < 0.05$).

The POP stage according to the POP-Q correlated strongly with the item 6 (POP symptoms) scores on the PFBQ (ρ = 0.751, $p < 0.001$).

Table 1 Clinical complaints and number of pelvic floor diagnoses per patient

	Frequency n (%)
Chief complaint (n = 147)	
Stress urinary incontinence	18 (12.2)
Urge urinary incontinence	9 (6.1)
Mixed urinary incontinence	28 (19)
Prolapse (POP and rectal prolapse)	26 (17.7)
Obstructed defecation	27 (18.4)
Fecal incontinence	39 (26.5)
Number of diagnoses per patient (n = 147)	
1	36 (24.5)
2	54 (36.7)
3	41 (27.9)
4	14 (9.5)
5	2 (1.4)

POP pelvic organ prolapse, *n* number of patients included in this analysis

Table 2 Test retest reliability of the items and total score of the PFBQ (n = 137)

PFBQ correlation type	Estimate	CI 95%
PFBQ total score		
Intraclass correlation	0.981	0.974 - 0.986
PFBQ items		
Kappa		
Stress urinary incontinence	0.968	0.923–1.00
Frequency	0.920	0.851–0.989
Urgency	0.951	0.896–1.00
Urge urinary incontinence	0.970	0.929–1.00
Voiding difficulty	0.895	0.795–0.995
Pelvic organ prolapse	0.984	0.953–1.00
Obstructed defecation	0.970	0.929–1.00
Fecal incontinence	0.971	0.930–1.00
Dyspareunia	1.00	1.00–1.00

PFBQ pelvic floor bother questionnaire, *CI* confidence interval, *n* number of patients included in this analysis

Table 3 Agreement analysis of PFBQ scores for each item and responses to the interview at baseline

Question (n = 147)	Kappa	CI 95%	
		Minimum	Maximum
Stress urinary incontinence	0.940	0.883	0.997
Frequency	0.806	0.706	0.906
Urgency	0.896	0.822	0.970
Urge urinary incontinence	0.876	0.798	0.954
Voiding difficulty	0.607	0.411	0.803
Pelvic organ prolapse	0.859	0.769	0.949
Obstructed defecation	0.917	0.852	0.982
Fecal incontinence	0.757	0.655	0.859
Dyspareunia	0.616	0.487	0.745

CI confidence interval; *n* number of patients included in this analysis

Table 4 Correlation of PFBQ scores with the frequency of symptoms reported in the bowel/bladder diary

Urinary and defecatory diaries ($n = 137$)	Correlation	p
Number of SUI episodes	0.791	< 0.001
Number of micturitions in toilet	0.660	< 0.001
Number of urgency episodes	0.828	< 0.001
Number of UUI episodes	0.809	< 0.001
Number of OD episodes (straining, digitation)	0.875	< 0.001
Number of episodes of FI	0.780	< 0.001

SUI stress urinary incontinence, *UUI* urge urinary incontinence, *OD* obstructed defecation, *FI* fecal incontinence, *n* number of patients included in this analysis

Forty-four patients (30% of the initial sample) returned after treatment and completed the PFQB. Chief complaints of these patients were as follows: 17 participants had urinary incontinence, 13 women had pelvic organ prolapse, 12 patients had fecal incontinence, and 2 had obstructed defecation. Of the patients with urinary incontinence, six underwent physical therapy, five underwent surgery, and two patients received anticholinergic drugs. Fifteen patients with POP underwent surgery, and two patients were fitted with pessaries. Of the patients with fecal incontinence, seven patients underwent physical therapy and five underwent surgery. Two patients with obstructed defecation underwent corrective surgery. In the post-treatment visit, all patients indicated they had "improved." Table 5 shows that mean scores and total scores improved significantly ($p < 0.05$) after treatment, with the exception of the obstructed defecation scores ($p = 0.070$).

Discussion

The prevalence of pelvic floor disorders has increased with increasing life expectancy and population aging. Because these dysfunctions are closely related, the co-occurrence of PFDs is extremely common. Thus, it is important to understand these complex interrelationships when evaluating and designing therapeutic strategies, which must often be based on a multidisciplinary and phased-treatment approach.

Instruments that directly measure the impact of PFD on women are extremely useful. Their use can help not only to reach a correct diagnosis, but also to design treatment plans aimed at alleviating the more bothersome disorders. In addition, their use is critical when evaluating the efficacy of a particular therapy.

Questionnaires have been widely used for such purposes in research studies, but not in clinical situations, where their relative length may be impractical. In the latter, only the subjective impression of the physician is used. Thus, an objective instrument would be useful because factors such as embarrassment and difficulties in verbal expression can affect the patient's description of pelvic floor symptoms.

In addition, the presence of a PFD may not be directly related to its degree of bother; hence, the importance of instruments that use scales and scores. The PFBQ score can range from 0 to 45 or from 0 to 100, as shown in the results. In the present study, we used the latter alternative, which is preferred by the authors, since it provides the degree of discomfort in percentages.

The PFBQ was designed as a tool capable of concisely addressing most disorders of the pelvic floor. Since its development, the PFBQ has demonstrated relevant clinical significance, and today it is used routinely.

Table 5 Comparison of PFBQ items and total scores between baseline and post-treatment in 44 patients who underwent treatment

Question	Basal		Post-treatment		p
	n	%	*n*	%	
Stress urinary incontinence	23	16.8	14	10.2	0.012
Frequency	29	21.2	16	11.7	0.011
Urinary urgency	28	20.4	15	10.9	0.001
Urge urinary incontinence	24	17.5	10	7.3	0.001
Voiding difficulty	9	6.6	0	0	0.003
Pelvic organ prolapse	22	16.1	1	0.7	< 0.001
Obstructed defecation	17	12.4	11	8.0	0.070
Fecal incontinence	23	16.8	14	10.2	0.004
Dyspareunia	13	9.5	5	3.6	0.021
PFBQ total score[a], median (min;max)	34.4 (6.7; 95.6)		5.6 (0; 46.7)		< 0.001*

McNemar's test, *Wilcoxon paired test

PFBQ Pelvic floor Bother Questionnaire, *n* number of patients who referred to this condition when filling out the PFBQ questionnaire

[a] PFBQ transformed scoring system varying from 0 to 100

The current study evaluated the degree of bother caused by the most common PFDs. To achieve a sample representative of the broad array of PFDs, 52.4% of patients were recruited from the urogynecology sector and 47.6% from the anorectal physiology sector. Most patients had multiple PFDs (24.5% of the sample had only one complaint, 36.7% had two, and 38.8% had three or more), which confirms the importance of a comprehensive questionnaire for measuring the degree of bother of women with a PFD.

The use of terminology familiar to Brazilian women was crucial for designing the Portuguese version of the PFBQ in view of the wide variety of terms used in the various regions of the country and in different cultural settings. Patients had no difficulty understanding the questions, and the fact that the study was conducted with participants from widely different regions encourages us to support the adoption of this Brazilian Portuguese version of the PFBQ countrywide.

The psychometric evaluation showed that the Portuguese version of the PFBQ is as valid and reliable as the versions in other languages. To date, the PFBQ has been translated into Arabic, Turkish, and Thai and has been used in the countries where these languages are spoken [5, 6, 8, 9].

In 2013, Bazi et al. [5] published a validated Arabic version of the PFBQ. The Arabic PFBQ was completed by 130 women, 65 with PFD and 65 healthy controls, and reliability evaluated by ICC was greater than 0.7 for all items.

In 2016, Dogan et al. [6] translated and validated the Turkish version of the PFBQ with 130 women with PFD. The Turkish PFBQ proved to be a psychometrically valid and reliable instrument, which strongly correlated with the Pelvic Floor Distress Inventory (PFDI) and the Pelvic Floor Impact Questionnaire (PFIQ).

The utility of the PFBQ in research studies has been demonstrated in some studies. In 2015, using the PFBQ, Lipschuetz et al. [7] evaluated the degree of bother from PFD in Israeli women 1 year after their first delivery. In 2016, Ghandour et al. [9] used the PFBQ to assess the prevalence and degree of bother caused by pelvic floor disorder symptoms among women treated at primary care and specialty clinics in Lebanon. Also in 2016, Manonai et al. [8] investigated the correlation between pelvic floor symptoms and POP severity using the PFBQ and the POP-Q.

The Portuguese version of the PFBQ was found to have adequate psychometric properties. Its reproducibility proved to be as high as the original English version and the other validated versions (Table 6).

Because the PFBQ was designed to be self-administered, we chose not to include patients who could not read. In the test-retest analysis, patients completed the questionnaire at HCFMUSP rather than over the telephone to prevent the questions from being misunderstood.

A potential disadvantage of self-administered instruments is that they may be returned with fully or partially unanswered items and may have a low response rate. There were no missing data in any items in the PFBQ, which confirms the convenience of its short length and readability.

Table 6 Test-retest reproducibility of the different versions of the PFBQ

Item	Test-retest reliability			
	USA[a]	Brazil[a]	Lebanon[b]	Turkey[b]
SUI	0.897	0.968	0.812	0.981
Urinary frequency	0.837	0.920	0.962	0.985
Urinary urgency	0.765	0.951	0.774	0.993
UUI	0.841	0.970	0.967	0.979
Voiding difficulty	0.850	0.895	0.951	0.920
Pelvic organ prolapse	0.914	0.984	0.976	0.985
Obstructed defecation	0.884	0.970	0.972	0.993
Fecal Incontinence	0.889	0.971	0.900	0.990
Dyspareunia	0.888	1.00	0.844	0.992
Total score	0.941[b]	0.981 [b]	–	0.996 [b]

a kappa, *b* intraclass correlation, *SUI* stress urinary incontinence, *UUI* urge urinary incontinence

Seven items had almost perfect agreement with responses from the medical history interview ($\kappa > 0.8$), whereas voiding difficulty, fecal incontinence, and sexual dysfunction demonstrated only substantial agreement ($\kappa = 0.6$-0.8). More patients reported these symptoms when answering the self-administered questionnaire than when answering the attending physician. This finding indicates that the Brazilian Portuguese version of the PFBQ is a useful instrument that can reveal symptoms often neglected because of shame, fear of exposure, or difficulties in verbal expression.

Internal consistency evaluates the overall correlation between items within a scale or subscale of a questionnaire and is a very important measurement property for questionnaires measuring a single concept using multiple items. In contrast, in questionnaires like the Apgar score [18], in which the items are merely different aspects of a complex clinical phenomenon, internal consistency is less relevant and thus the items do not need to be correlated. It is no surprise that the internal consistency of the Brazilian Portuguese version of the PFBQ measured by Cronbach's alpha was not high, given that the questionnaire contains only nine items addressing different disorders. For this reason, internal validity was not assessed in the studies that validated the Arabic and Turkish versions of the PFBQ. Internal consistency was similarly questionable in the original version of the questionnaire (Cronbach alpha 0.61).

Responsiveness to change in the PFBQ was assessed by comparing the PFBQ scores of only 44 participants (30% of the initial sample) before and after treatment. This low response rate to the second questionnaire resulted mainly from the fact that many patients had multiple comorbidities,

hindering the prompt initiation of certain treatments and postponing diagnosis until a treatment interval. Because these delays and intervening treatments could affect the presence and severity of PFD, possibly biasing the analysis, we chose not to include patients who did not receive treatment immediately after the initial visit.

We were encouraged to report our results because similar sample sizes were reported in other studies assessing responsiveness to change using pelvic floor questionnaires. In 2016, Arouca et al. [19] included 22.7% of their initial sample in the responsiveness analysis when validating the Portuguese version of the Pelvic Floor Distress Inventory PFDI-20 and PFIQ-7, and Tamanini et al. [20] used 40% of the initial sample to assess responsiveness in the Brazilian version of the International Consultation on Incontinence Questionnaire-Vaginal Symptoms (ICIQ-VS).

After the completion of their treatment, all patients indicated they had improved, and pre- and post-treatment PFBQ scores reflected this clinical change.

It should be noted that this is the first study to assess responsiveness to change in the PFBQ, a property that was not tested in the original English version or in other translated versions.

The present study has both strengths and limitations. The main pelvic floor dysfunctions were represented in the sample, which consisted of two virtually equal-numbered groups of patients, one of which was referred for gynecologic treatment and the other for colorectal surgery care. This design allowed all of the main pelvic floor disorders (complaints of urinary and fecal dysfunctions and of pelvic organ prolapse) to be represented.

The Brazilian Portuguese version of the PFBQ was not compared with other questionnaires for assessment of the presence and degree of bother from pelvic floor disorders because no validated versions of similar questionnaires in Brazilian Portuguese were available at the time of the study. Its internal consistency measured with Cronbach's alpha was questionable. The number of patients included in the responsiveness to change analysis was low, which may have affected our analysis. Nevertheless, the Brazilian Portuguese version has shown it is adequately valid and reliable in comparison with the original version and the versions validated in other languages.

Conclusions

The Brazilian Portuguese version of the Pelvic Floor Bother Questionnaire is a valid and reliable instrument for assessing the presence and severity of symptoms associated with pelvic floor disorders. Also, it can be useful in clinical practice and research studies because of its short length and readability.

Compliance with ethical standards

Conflicts of interest None.

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