

cational and motivational components for managing urinary incontinence.³⁹ More than 100 mobile applications and web platforms with diverse designs and content for urinary incontinence are already available, and most are for SUI.^{39,40} Despite this widespread use, only two randomized controlled trials (RCTs) have been published, both evaluating the same application and with conflicting evidence regarding its effectiveness.⁴¹⁻⁴⁴ Women should undergo a pelvic floor muscle (PFM) assessment prior to self-directed PFMT to mitigate the potential adverse sequelae of learning and performing the exercises incorrectly.⁴⁵

RECOMMENDATION 10

Self-directed PFMT *may* be offered to women who want to manage their symptoms on their own after initial assessment (*Weak recommendation, Weak quality of evidence*).

WHAT IS THE EVIDENCE FOR USE OF PFMT TO TREAT URINARY INCONTINENCE? SHOULD PARTICULAR METHODS BE RECOMMENDED?

Most of the literature regarding conservative management for SUI relates to PFMT.²² PFMT aims to improve PFM strength, endurance, power, relaxation, or a combination of these parameters.⁴⁶

PFMT improves FSUI by:

- Using a conscious PFM pre-contraction, prior to and during effort or exertion, preventing urine leakage (the “Knack”); and,
- Supporting the bladder neck with strong, toned PFMs, which are resistant to stretching and which limit downward movement of the bladder neck during effort and exertion.^{21,22}

The most current update of the Cochrane Collaboration’s review and recommendations from the International Consultation on Incontinence support PFMT as the first-line conservative management strategy for women with SUI.^{21,22}

PFMT is effective as a stand-alone therapy, and as part of multicomponent therapies embedding PFMT with concomitant behavioral strategies and lifestyle changes. Benefits of PFMT are shown across age cohorts and urinary incontinence type, in various cultural contexts, using several different training regimens, and assessed by multiple outcome measures.

See online Appendix for additional discussion on this question.

Table 2. Non-surgical management options for SUI²⁰⁻³¹

	Method	Strength of recommendation	Quality of evidence
Lifestyle changes			
Weight loss	Diet Exercise Behavioral modification	Strong	Moderate to high
Adjustment of fluid intake	Reduction of the volume of liquid consumed	Weak	Moderate
Smoking cessation	Behavioural intervention	Weak	Low
Exercise modification	Avoidance of high-impact exercises (jumping, straining)	Weak	Moderate
Regular bowel movements	Interventions to prevent constipation and straining during bowel movements	Weak	Low
Physiotherapy			
Supervised pelvic floor muscle training	PFMT (only) + ES + BF + VC	Strong There is no clear benefit of adding other modalities to PFMT; however, ES and/or BF may be considered for subgroups of women presenting with significant pelvic floor muscle weakness or atrophy, or reduced proprioception. Weak VC with supervised training sessions by a trained professional can be offered to women with SUI who are able and willing to use them.	High Moderate
Self-directed PFMT	Via mobile applications or web platforms	Weak	Weak
Bladder training*	Progressive voiding schedule to delay micturition ± distraction techniques	Strong	High
Alternative medicine			
	Acupuncture	Weak	Low
	Yoga, Pilates	Weak	Low

*Bladder training is mostly used for mixed or urgency incontinence. BF: biofeedback; ES: electrical stimulation; PFMT: pelvic floor muscle training; SUI: stress urinary incontinence; VC: vaginal cones.

RECOMMENDATION 11

For the index patient, providers *should* recommend a three-month individualized or group-based supervised progressive and intensive PFMT program, taught by a health professional, as first-line treatment for FSUI (*Strong recommendation, High quality of evidence*).