



## Complete Summary

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### GUIDELINE TITLE

Conservative management of urinary incontinence.

### BIBLIOGRAPHIC SOURCE(S)

Society of Obstetricians and Gynaecologists of Canada, Robert M, Ross S, Farrel SA, Easton WA, Epp A, Girouard L, Gupta C, Lajoie F, Lovatsis D, MacMillan B, Schachter J, Schulz J, Wilkie DH. Conservative management of urinary incontinence. J Obstet Gynaecol Can 2006 Dec;28(12):1113-8. [36 references]  
[PubMed](#)

### GUIDELINE STATUS

This is the current release of the guideline.

## COMPLETE SUMMARY CONTENT

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## SCOPE

### DISEASE/CONDITION(S)

Urinary incontinence

### GUIDELINE CATEGORY

Management  
Treatment

### CLINICAL SPECIALTY

Obstetrics and Gynecology  
Urology

## **INTENDED USERS**

Physicians

## **GUIDELINE OBJECTIVE(S)**

- To outline the evidence for conservative management options for treating urinary incontinence
- To provide understanding of current available evidence concerning efficacy of conservative alternatives for managing urinary incontinence
- To empower women to choose continence therapies that have benefit and that have minimal or no harm

## **TARGET POPULATION**

Women presenting with urinary stress incontinence

## **INTERVENTIONS AND PRACTICES CONSIDERED**

1. Pelvic floor retraining (Kegel) exercises
2. Functional electrical stimulation (FES)
3. Vaginal cones
4. Continence pessaries
5. Bladder training (bladder drill)
6. Behavioral management protocols using lifestyle changes in combination with bladder training and pelvic muscle exercises

## **MAJOR OUTCOMES CONSIDERED**

- Cure rates
- Short-term subjective improvement rates
- Percent reduction in leakage episodes

## **METHODOLOGY**

### **METHODS USED TO COLLECT/SELECT EVIDENCE**

Searches of Electronic Databases

### **DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE**

The Cochrane Library and Medline (1966 to 2005) were searched to find articles related to conservative management of incontinence. Review articles were appraised.

### **NUMBER OF SOURCE DOCUMENTS**

Not stated

## **METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE**

Weighting According to a Rating Scheme (Scheme Given)

### **RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE**

#### **Quality of Evidence Assessment\***

**I:** Evidence obtained from at least one properly designed randomized controlled trial.

**II-1:** Evidence obtained from well-designed controlled trials without randomization.

**II-2:** Evidence obtained from well-designed cohort (prospective or retrospective) or case-control studies, preferably from more than one center or research group.

**II-3:** Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results from uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category.

**III:** Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

\*Adapted from the Evaluation of Evidence criteria described in the Canadian Task Force on the Periodic Preventive Health Exam Care.

### **METHODS USED TO ANALYZE THE EVIDENCE**

Systematic Review

### **DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE**

Not stated

### **METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Expert Consensus

### **DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Not stated

### **RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS**

#### **Classification of Recommendations\***

- A. There is good evidence to recommend the clinical preventive action.
- B. There is fair evidence to recommend the clinical preventive action.
- C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making.
- D. There is fair evidence to recommend against the clinical preventive action.
- E. There is good evidence to recommend against the clinical preventive action.
- I. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making.

\*Adapted from the Classification of Recommendations criteria described in the Canadian Task Force on the Periodic Preventive Health Exam Care.

## **COST ANALYSIS**

A formal cost analysis was not performed and published cost analyses were not reviewed.

## **METHOD OF GUIDELINE VALIDATION**

Internal Peer Review

## **DESCRIPTION OF METHOD OF GUIDELINE VALIDATION**

This guideline has been reviewed and approved by the Executive and Council of the Society of Obstetricians and Gynaecologists of Canada.

# **RECOMMENDATIONS**

## **MAJOR RECOMMENDATIONS**

The quality of evidence (I-III) and classification of recommendations (A-E, I) are defined at the end of the "Major Recommendations."

### **Pelvic Floor Retraining**

1. Pelvic floor retraining (Kegel) exercises should be recommended for women presenting with stress incontinence. **(I-A)**
2. Proper performance of Kegel exercises should be confirmed by digital vaginal examination or biofeedback. **(I-A)**
3. Follow-up should be arranged for women using pelvic floor retraining, since cure rates are low and other treatments may be indicated. **(III-C)**
4. Kegel exercises may be offered as an adjunct to other treatments for overactive bladder (OAB) syndrome, but they should not be the only treatment offered for these symptoms. **(I-B)**

## **Functional Electrical Stimulation (FES)**

5. Although FES has not been studied as an independent modality, it may be used as an adjunct to pelvic floor retraining, especially in patients who have difficulty identifying and contracting the pelvic muscles. **(III-C)**
6. FES should be offered as an effective option for the management of OAB. **(I-A)**

## **Vaginal Cones**

7. Vaginal cones may be recommended as a form of pelvic floor retraining for women with stress incontinence. **(I-A)**

## **Mechanical Devices for Urinary Incontinence**

8. Continence pessaries should be offered to women as an effective, low-risk treatment for both stress and mixed incontinence. **(II-B)**

## **Bladder Training**

9. Bladder training (bladder drill) should be recommended for symptoms of OAB, since it has no adverse effects **(III-C)**, and it is as effective as pharmacotherapy. **(I-B)**
10. Behavioral management protocols using lifestyle changes in combination with bladder training and pelvic muscle exercises are highly effective and should be used to treat urinary incontinence. **(I-A)**

## **Conclusion**

The practice of the conservative management of urinary incontinence is widespread and should be encouraged. All modalities appear to be more effective than no therapy. Unlike surgical treatment of urinary incontinence, which carries a significant risk of complications and poor long-term outcomes, conservative management is associated with minimal adverse outcomes. For a significant number of patients, the results of conservative management are satisfactory and may obviate the need for medical or surgical interventions.

## **Definitions:**

### **Quality of Evidence Assessment\***

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**Classification of Recommendations\*\***

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- C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making.
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\*The quality of evidence reported in these guidelines has been adapted from the Evaluation of Evidence criteria described in the Canadian Task Force on the Periodic Preventive Health Exam Care.

\*\*Recommendations included in these guidelines have been adapted from the Classification of Recommendations criteria described in the Canadian Task Force on the Periodic Preventive Health Exam Care.

**CLINICAL ALGORITHM(S)**

None provided

**EVIDENCE SUPPORTING THE RECOMMENDATIONS**

**TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS**

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

**BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS**

**POTENTIAL BENEFITS**

Conservative management is associated with minimal adverse outcomes, and for a significant number of patients, the results are satisfactory and may obviate the need for medical or surgical interventions.

## POTENTIAL HARMS

Not stated

## QUALIFYING STATEMENTS

### QUALIFYING STATEMENTS

This guideline reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. Local institutions can dictate amendments to these opinions. They should be well documented if modified at the local level. None of these contents may be reproduced in any form without prior written permission of the SOGC.

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Getting Better

### IOM DOMAIN

Effectiveness  
Patient-centeredness

## IDENTIFYING INFORMATION AND AVAILABILITY

### BIBLIOGRAPHIC SOURCE(S)

Society of Obstetricians and Gynaecologists of Canada, Robert M, Ross S, Farrel SA, Easton WA, Epp A, Girouard L, Gupta C, Lajoie F, Lovatsis D, MacMillan B, Schachter J, Schulz J, Wilkie DH. Conservative management of urinary incontinence. J Obstet Gynaecol Can 2006 Dec;28(12):1113-8. [36 references]  
[PubMed](#)

### ADAPTATION

Not applicable: The guideline was not adapted from another source.

### DATE RELEASED

2006 Dec

**GUIDELINE DEVELOPER(S)**

Society of Obstetricians and Gynaecologists of Canada - Medical Specialty Society

**SOURCE(S) OF FUNDING**

Society of Obstetricians and Gynaecologists of Canada

**GUIDELINE COMMITTEE**

Urogynaecology Committee

**COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE**

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**FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST**

Not stated

**GUIDELINE STATUS**

This is the current release of the guideline.

**GUIDELINE AVAILABILITY**

Electronic copies: Available in Portable Document Format (PDF) from the [Society of Obstetricians and Gynaecologists of Canada Web site](#).

Print copies: Available from the Society of Obstetricians and Gynaecologists of Canada, La société des obstétriciens et gynécologues du Canada (SOGC) 780 promenade Echo Drive Ottawa, ON K1S 5R7 (Canada); Phone: 1-800-561-2416

**AVAILABILITY OF COMPANION DOCUMENTS**

None available

**PATIENT RESOURCES**

None available

## **NGC STATUS**

This NGC summary was completed by ECRI Institute on March 18, 2009. The information was verified by the guideline developer on March 25, 2009.

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