The impact of pelvic floor muscle training on the quality of life of women with urinary incontinence: a systematic literature review

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Purpose: The purpose of this review was to assess the effectiveness of pelvic floor muscle training (PFMT) in the treatment of urinary incontinence (UI) in women, with a particular focus on the impact of this form of therapy on the patients’ quality of life (QoL).

Methods: The following electronic databases were searched: PubMed, Embase, and Cochrane Library (articles only in English, 1990–2017). Search terms were as follows: urinary incontinence, pelvic floor muscle training, pelvic floor exercises, quality of life. Systematic review methods were based on the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) statement.

Results: The assessment of the impact of PFMT on the QoL of women with UI was conducted among 2,394 women in 24 selected studies. After the end of treatment, the majority of patients in the experimental groups noted a statistically significant improvement in QoL.

Conclusion: The results of this literature review demonstrate that PFMT is an effective treatment for UI in women. PFMT significantly improves the QoL of women with UI, which is an important determinant of their physical, mental, and social functioning.

Keywords: urinary incontinence, pelvic floor muscle training, quality of life

Introduction
The frequency of urinary incontinence (UI) is difficult to determine, and there is no unequivocal data indicating the percentage of people suffering from this disorder. According to the data adopted during the 6th International Consultation on Incontinence (ICI), the problem of UI in the whole population ranges from 4% to 8%. It is worth noting that the number of people affected by this condition in the entire world population has been steadily growing over the last decade. In 2008, 346 million people suffered from UI, while in 2013, 383 million. At the same time, it was estimated that in 2018, the number of people with UI around the world would be ~420 million – 300 million women and 120 million men.

Based on etiology and pathophysiology, UI is classified into 3 types: Stress UI (SUI), Urge UI (UUI), and Mixed UI (MUI). SUI is defined as the involuntary leakage of urine during exertion, such as coughing, sneezing, or laughing. An increase in abdominal pressure due to physical exertion puts stress on the bladder, causing urine to leak. The basic mechanisms responsible for that reaction are poor urethral support by the pelvic floor muscles and intrinsic sphincter deficiency. Many factors predisposing to SUI are identified in the related literature, and among others, these are as follows, numerous births, previous operations, generalized weakening of connective
tissue, hormone deficiency, genital mutilation, or reduction of reproductive organs. UUI (commonly referred to as “overactive bladder”) is the involuntary leakage of urine preceded by a strong and sudden urge to urinate. This incontinence is usually caused by involuntary contractions of the detrusor muscles of the bladder wall at inappropriate times. UUI may be triggered by simple everyday occurrences, such as the sound of running water, exposure to cold temperatures, or drinking cold beverages. Idiopathic etiologic factors include myogenic, neurogenic, and urethrogenic symptoms. MUI is a mixture of SUl and UUI. Etiologic factors for MUI are also a combination of the factors described earlier.

In addition to the described somatic symptoms, problems related to urinary iodine excretion have a psychological impact and substantially reduce patients’ quality of life (QoL). They often experience discomfort, low self-esteem, mood deterioration, and the feeling of helplessness. There is a decline in quality of their personal, social, and professional life. Due to the fear of others finding out about their unfortunate condition, patients are forced to change their lifestyle, which, in turn, has a negative impact on socializing, and contributes to alienation, social isolation, changes in sexual activity, and even depression or anxiety disorder. Therefore, while assessing the effectiveness of various treatments for UI, it is essential to take into consideration the lifestyle factor, which is defined as physical, mental, and social well-being.

Physiotherapy seems to be an important part of conservative treatment of UI. Pelvic floor muscle training (PFMT) stands out among physiotherapy methods used in the treatment of UI. The scientific basis for pelvic floor muscle rehabilitation was founded by an American gynecologist Arnold Kegel, who, in the 1950s, published results of a 15-year-old study, which covered the use of pelvic floor exercises in patients with UI. Kegel pointed out that systematic muscle activity causes muscles to lose 4 times less of their mass than compared with staying inactive, and hence it is the optimal method for improving the anatomical and functional impairment of muscles. Systematic activity of contractile fragments of impaired muscles improves their coordination. This contributes to a better urethral compression, when the intra-abdominal pressure increases, during exercise. Performing pelvic floor exercises correctly, especially in sensorimotor training sessions, leads to regaining proprioception in the levator ani.

The purpose of the systematic review
The purpose of this review was to assess the effectiveness of PFMT in the treatment of UI in perimenopausal women, with a particular focus on the impact of this form of therapy on the patients’ QoL. The following databases were searched: PubMed, Embase, and Cochrane Library (articles only in English, 1990–2017). The search terms used were as follows: urinary incontinence “AND” pelvic floor muscle training “OR” pelvic floor exercises “AND” “OR” quality of life. Systematic review methods were based on the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) statement.

Study selections
The first and primary criterion of the review was the use of pelvic floor exercises in the treatment of UI. Then, the studies were selected based on the impact of PFMT on the QoL of women with UI. The exclusion of studies with biofeedback, electrostimulation, surgical and medical treatments was the final criterion. Quality of the selected studies was assessed using the Jadad scale. Figure 1 shows a detailed flowchart of search and exclusion strategy.

Data collection
The following data were collected from the selected studies: author name, year of publication, participants (number and age), types of UI, treatment duration, treatment type, objectivation methods of treatment outcomes, main conclusions, and the statistical analysis used. Three authors performed independent data extraction in electronic databases (AS, PubMed; MWR, Embase; and HS, Cochrane Library). One researcher collected data and conducted the data selection process (AS). Moreover, the methodological quality of the selected studies was assessed using the Jadad scale. The Jadad score is often used to assess the methodological quality of controlled trials. Studies are scored according to the presence of 3 key methodological features of clinical trials: randomization, masking, and accountability of all patients, including withdrawals. One point is added for an affirmative answer (“yes”) to each of the first 5 items, while 1 point is subtracted for an affirmative answer (“yes”) from either of the last 2 items, for an overall score from 0 to 5. The systematic analysis includes only clinical studies with a score of 3 or higher in the Jadad scale. Two authors (AS and MWR) individually assessed the methodological quality of the collected research using the Jadad scale.

Results and discussion
Study characteristics
Electronic medical databases were searched in November 2017. The search retrieved 3,680 results: a total of 464 in the Cochrane Library, 3,016 in Embase, and 208 in
PubMed. The studies were selected using a very detailed flowchart (Figure 1). Twenty-four articles were included in the final review (Table 1). There were between 30 and 446 women (a total of 2,394 patients), aged 40–85 years old in each study group. The Jadad scale showed that 19 research findings were randomized and additionally 5 of them were blinded.

**Outcome measures**

The following diagnostic tests were used in the research studies: the number of UI episodes and the pad test and urinary diary. Pelvic floor muscle strength and function were checked during palpitation, Valsalva maneuver, perinometry, and ultrasound and electromyographic investigation. Rankin Scale, Mini Mental State Examination, Visual Analog Scale, and Time Up and Go test were also used. Patients’ QoL before and after the treatment, assessed during each exam, were the study inclusion criteria. The following questionnaires were used in the QoL assessment: King’s Health Questionnaire (KHQ), Incontinence Impact Questionnaire (IIQ), Urogenital Distress Inventory (UDI), QoL Scale (QoLS), Incontinence QoL (IQoL) questionnaire, Bristol Female Lower Urinary Tract Symptoms (BFLUTS) questionnaire, Health-Related Quality of Life, ICI Modular Questionnaire (ICIQ, ICIQ-UISF; short form; ICIQ-LUTSqol; Lower Urinary Tract Symptoms QoL), Ditrovie Scale, Pelvic Floor Distress Inventory (PFDI), Pelvic Floor Impact Questionnaire (PFIQ), and Symptom Impact Index (SII). Psychometric qualities,
Table 1 Summary of studies’ assessment of pelvic floor muscle training on incontinence-specific quality of life of women with urinary incontinence

<table>
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<tr>
<th>Reference</th>
<th>Participants/age (years)</th>
<th>Type of UI</th>
<th>Treatments compared</th>
<th>Treatment duration</th>
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<th>Main findings</th>
<th>Jadad scale</th>
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<tr>
<td>Aslan et al 2008</td>
<td>50 women; aged 74–85</td>
<td>SUI, UUI, MUI</td>
<td>Supervised PFMT+BT (EG) vs CG (without exercises)</td>
<td>6–8 weeks</td>
<td>QoL (KHQ), pad test, urinary diary, Mini-mental test, Rankin scale</td>
<td>Statistically significant decrease was observed in the treatment group compared to the control group</td>
<td>2/0/1</td>
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<tr>
<td>Balmforth et al 2006</td>
<td>97 women; aged 40–60</td>
<td>SUI</td>
<td>Supervised PFMT</td>
<td>14 weeks</td>
<td>QoL (KHQ), pad test, UD, maximumValsalva maneuver, bladder neck rotationalmobility from rest to maximum excursion and maximum excursion</td>
<td>A statistically and clinically significant reduction in urine loss and improvement in condition-specific quality of life</td>
<td>2/0/1</td>
</tr>
<tr>
<td>Bø et al 2000</td>
<td>59 women; aged 40–55</td>
<td>SUI</td>
<td>PFMT (EG) vs CG (without exercises)</td>
<td>24 weeks; EG 45 min 1×week</td>
<td>QoL (QoLS-N, BFLUTS), PFM strength</td>
<td>PFMT had a statistically significant impact on QoL and PFM strength</td>
<td>2/0/1</td>
</tr>
<tr>
<td>Borello-France et al 2006</td>
<td>44 women; aged 40–55</td>
<td>SUI</td>
<td>PFMT in supine position (EG) vs PFMT in supine and standing position (CG)</td>
<td>9–12 weeks</td>
<td>QoL (IIQ), pad test, bladder diary, UD, PFM strength</td>
<td>PFMT significantly increased all test parameters; exercise position did not differentially affect treatment outcomes</td>
<td>2/0/1</td>
</tr>
<tr>
<td>Bradley et al 2010</td>
<td>344 women; aged 40–60</td>
<td>SUI, UUI, MUI</td>
<td>Supervised PFMT vs continence pessary vs combined</td>
<td>12 weeks</td>
<td>QoL (UDI), pad test, urinary diary (7 days), QUID</td>
<td>All 3-month UI outcomes significantly improved</td>
<td>2/0/1</td>
</tr>
<tr>
<td>Carneiro et al 2010</td>
<td>50 women; aged 40–60</td>
<td>SUI</td>
<td>Supervised PFMT (EG) vs CG (without exercises)</td>
<td>8 weeks; 20 min 2×week</td>
<td>QoL (KHQ), bladder diary UD, palpation bi digital, surface EMG motor activity PF</td>
<td>PMFT positively influenced the QoL in the EG group</td>
<td>2/0/1</td>
</tr>
<tr>
<td>de Oliveira et al 2009</td>
<td>60 women; aged 40–60</td>
<td>SUI</td>
<td>Group PFMT (EG) vs supervised PFMT (individual)</td>
<td>12 weeks; 2×week</td>
<td>QoL (KHQ), pad test, urinary diary (7-days)</td>
<td>There were statistically significant improvements in both muscle strength and quality of life. When the groups were compared, there were no differences in the results between them</td>
<td>2/1/1</td>
</tr>
<tr>
<td>Demain et al 2001</td>
<td>44 women; aged 60</td>
<td>SUI, UUI</td>
<td>Supervised PFMT EG (group sessions) vs CG (individual training)</td>
<td>12–14 weeks; EG 3×weeks vs CG 1×week</td>
<td>QoL (IIQ), pad test; urinary diary (7 days), incontinence impact Questionnaire, symptom severity index, VAS</td>
<td>EG results reached statistical significance</td>
<td>2/0/1</td>
</tr>
<tr>
<td>Dugan et al 2013</td>
<td>43 women; aged &gt;65</td>
<td>UI</td>
<td>Supervised PFMT (EG) vs CG (only education)</td>
<td>6 weeks</td>
<td>QoL (IIQ-7, UDI-6), self-reported bladder function, TUG</td>
<td>A group pelvic floor fitness program combined with pelvic health education improved the QoL of older women</td>
<td>2/0/1</td>
</tr>
<tr>
<td>Fan et al 2101 2013</td>
<td>372 women; aged 42–62</td>
<td>SUI, UUI, MUI</td>
<td>Supervised PFMT</td>
<td>36–42 weeks</td>
<td>QoL (UDI-6, IIQ-7), UD</td>
<td>PFMT appears to be an effective first-line intervention for improving US and QoL of women presenting with UI</td>
<td>2/0/1</td>
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### Table 1 (Continued)

<table>
<thead>
<tr>
<th>Reference</th>
<th>Participants/age (years)</th>
<th>Type of UI</th>
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<th>Main findings</th>
<th>Jadad scale</th>
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<tbody>
<tr>
<td>Felicissimo et al₂⁰ 2010</td>
<td>62 women; aged 45–60</td>
<td>SUI</td>
<td>Supervised PFMT (EG) vs CG (training at home)</td>
<td>8 weeks</td>
<td>QoL (ICIQ-SFF), urogynecological history, urodynamic study</td>
<td>Both intensive, supervised PFMT and unsupervised PFMT are effective to treat female SUI if training is provided ICIQ improved in both groups but EG &gt; CG</td>
<td>2/0/1</td>
</tr>
<tr>
<td>Ferreira and Santos₂³ 2012</td>
<td>34 women; aged 50</td>
<td>SUI</td>
<td>Supervised PFMT (EG) vs CG (training at home)</td>
<td>24 sessions</td>
<td>QoL (Bariofrage scale), number of incontinence episodes</td>
<td>PFM training resulted in significant improvement in the QoL of women with UI</td>
<td>2/0/1</td>
</tr>
<tr>
<td>Fitz et al²⁴ 2012</td>
<td>36 women; aged 46–64</td>
<td>SUI</td>
<td>Supervised PFMT vs CG</td>
<td>12 weeks</td>
<td>QoL (KHQ), urinary diary (7-days), PFM function</td>
<td>More aspects of quality of life improved significantly in the training group than in the control group</td>
<td>2/0/1</td>
</tr>
<tr>
<td>Hung et al²⁵ 2010</td>
<td>70 women; aged 50–60</td>
<td>SUI, MUI</td>
<td>Supervised PFMT (EG) vs CG (training at home)</td>
<td>16 weeks</td>
<td>QoL (SII), number of incontinence episodes, PFM function, 20 min pad test; 3-day voiding diary</td>
<td>ICIQ score has a significant difference between the 2 groups</td>
<td>2/0/1</td>
</tr>
<tr>
<td>Jahromi et al²⁶ 2015</td>
<td>50 women; aged 60–74</td>
<td>SUI</td>
<td>PFMT (EG) vs CG (without exercises)</td>
<td>8 weeks</td>
<td>QoL (ICIQ), number of incontinence episodes, QUID, self-esteem questionnaires</td>
<td>High-intensity PFMT combined with BT is more effective than BT alone in the short term for treating UI or SUI</td>
<td>2/0/1</td>
</tr>
<tr>
<td>Kaya et al²⁷ 2015</td>
<td>108 women; aged 40–60</td>
<td>SUI, UUI, MUI</td>
<td>PFMT+BT (EG) vs BT (CG)</td>
<td>6 weeks</td>
<td>QoL (IQ-7, UDI-6), number of incontinence episodes, PFM strength and endurance</td>
<td>High-intensity PFMT combined with BT is more effective than BT alone in the short term for treating UI or SUI</td>
<td>2/0/1</td>
</tr>
<tr>
<td>Kenton K et al²⁸ 2012</td>
<td>446 women; aged 40–60</td>
<td>SUI</td>
<td>Pessary therapy vs PFMT vs CG (combination therapy)</td>
<td>12 weeks</td>
<td>QoL (PFDI, PFIQ), number of incontinence episodes, urinary diary (7 days), QUID</td>
<td>There was no difference in pelvic floor symptom bother and HRQoL between the pessary and behavioral therapy arms in women undergoing conservative treatment for SUI</td>
<td>2/1/1</td>
</tr>
<tr>
<td>Konstantinidou et al²⁹ 2013</td>
<td>46 women; aged 40–60</td>
<td>SUI</td>
<td>EG (TrA+PFMT) vs CG (PFMT)</td>
<td>12 weeks</td>
<td>QoL (KHQ), 7-day bladder diary, vaginal assessment of the PFM strength using the Oxford grading, 24-hour pad test</td>
<td>The protocol to strengthen the PFM used by the EG was effective to improve the UI, QoL function and pressure of PFM contraction. PFMT and VG both treatments are effective in UI</td>
<td>2/0/1</td>
</tr>
<tr>
<td>Nascimento-Correia et al³⁰ 2012</td>
<td>30 women; aged 50–69</td>
<td>UI</td>
<td>PFMT (EG) vs CG (without exercise)</td>
<td>12 weeks</td>
<td>QoL (KHQ), number of incontinence episodes, PFM function</td>
<td>Both groups showed a significant improvement in most QoL domains measured with ICIQ and LUTS</td>
<td>2/0/1</td>
</tr>
<tr>
<td>Pereira et al³¹ 2012</td>
<td>41 women; aged 50–60</td>
<td>SUI</td>
<td>PFMT EG (group sessions) vs VG (vaginal cones) vs CG (without exercises)</td>
<td>6 weeks</td>
<td>QoL (KHQ), pressure perineometry, PFM strength by digital palpation</td>
<td>Both groups showed a significant improvement in most QoL domains measured with ICIQ and LUTS</td>
<td>2/0/1</td>
</tr>
<tr>
<td>Ptak et al³² 2017</td>
<td>140 women; aged &gt;50</td>
<td>SUI</td>
<td>EG (TrA+PFMT) vs CG (PFMT)</td>
<td>12 weeks</td>
<td>QoL (ICIQ-LUTSQol), Gaudenz questionnaire, physical examination, and urodynamic testing</td>
<td>Both groups showed a significant improvement in most QoL domains measured with ICIQ and LUTS</td>
<td>2/1/0</td>
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</tr>
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<tbody>
<tr>
<td>Sar and Khorshid et al. 2009</td>
<td>41 women; aged 40–55</td>
<td>SUI, MUI</td>
<td>PFMT (EG) vs CG (without training)</td>
<td>8 weeks; 3 sets daily</td>
<td>QoL (I – QoL), number of incontinence episodes, pad test, PFM strength</td>
<td>PFMT significantly increased PFM strength, QOL and reduced the frequency of UI episodes</td>
<td>2/0/1</td>
</tr>
<tr>
<td>Sherburn et al. 2011</td>
<td>83 women; aged &gt;65</td>
<td>SUI</td>
<td>Supervised PFMT vs PFMT (training at home) vs CG (bladder training)</td>
<td>20 weeks</td>
<td>QoL (ICIQ-SF), Urine loss on a stress test; UD,VAS, urinary diary (7 days), 5-point global rating of change; TUG test</td>
<td>High intensity PFMT is effective in managing stress urinary incontinence and is more effective than BT in healthy older women</td>
<td>2/2/1</td>
</tr>
<tr>
<td>Zanetti et al. 2007</td>
<td>44 women; aged 53–57</td>
<td>SUI</td>
<td>Supervised PFMT (EG) vs PG (training at home)</td>
<td>12 weeks; EG 2×week, 45 min; CG 1×4 week</td>
<td>QoL (I-QoL), pad test, urinary diary (7-days), PFM strength</td>
<td>There was a significant increase in the QoL of patients after treatment.</td>
<td>2/0/1</td>
</tr>
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</table>

Abbreviations: BFLUTS, Bristol Female Lower Urinary Tract Symptoms Questionnaire; BT, bladder training; Contr, contractions; CG, control group; EG, experimental group; EMG, electromyography; HRQoL, Health-Related Quality of Life; ICIQ, International Consultation on Incontinence Questionnaire; ICIQ LUTS-QoL, International Consultation Incontinence Questionnaire Lower Urinary Tract Symptoms Quality of Life; ICIQ-SF, International Consultation on Incontinence Questionnaire-Short Form; IIIQ, Incontinence Impact Questionnaire; IQoL, Incontinence Quality of Life Questionnaire; KHQ, King’s Health Questionnaire; MUI, mixed urinary incontinence; PFDI, pelvic floor distress inventory; PFDI, Ditrovie Scale, Pelvic Floor Distress Inventory; PFIQ, pelvic floor impact questionnaire; PFMT, pelvic floor muscle training; PFM, pelvic floor muscle; QoL, quality of life; QoLS-N, Norwegian version of the Quality of Life Scale; QUID, Questionnaire for Urinary Incontinence Diagnosis; SII, Symptom Impact Index; UIQ, Incontinence Impact Questionnaire; VAS, visual analog scale; VG, vaginal cones.

The most commonly used questionnaire was the KHQ; it was mentioned in 8 out of 24 studies. KHQ is a patient self-administered self-report and has 3 parts consisting of 21 items. Part 1 contains general health perception and incontinence impact (1 item each). Part 2 contains role limitations, physical limitations, social limitations (2 items each), personal relationships, emotions (3 items each) and sleep/energy (2 items), as well as severity measures (4 items). Part 3 is considered as a single item and contains 10 responses in relation to frequency, nocturia, urgency, urge, stress, intercourse incontinence, nocturnal enuresis, infections, pain, and difficulty in voiding. KHQ is a tool recommended by the European Clinical Practice Guidelines.

In 5 out of 24 studies, the QoL was evaluated by the use of IIQ. This questionnaire was used in 2 versions: the full version – IIQ and the abbreviated one IIQ-7. In 3 out of 24 studies, the full version of the questionnaire was used, while in 2 out of 24 tests, a short form – IIQ-7 was used. The IIQ was designed by Shumaker et al. to assess the impact of UI on activities and emotions in women. Thirty self-administered questions cover 4 domains: physical activity, social relationships, traveling, and emotional health.

In 4 out of 24 studies, the ICIQ was applied. The ICIQ-SF consists of 3 items (Frequency, Amount, and Impact), and a group of 8 questions related to the type of UI, which are not part of the questionnaire score. The purpose of the 8 questions is to describe a given type of urinary incontinency. The total score is the sum of the first 3 items and it ranges from 0 to 21 points. A score of 21 – the worst possible QoL, and 0 – the best possible QoL. The ICIQ LUTS QoL is based on KHQ. ICIQ LUTS measures the impact of UI on physical and mental activities, changes in interpersonal relations, and in everyday life. The global score can range between 19 and 79 points – the higher the score, the worse the QoL. The conversion of points of ICIQ LUTS QoL is carried out on the basis of the instructions by Hebbar based on KHQ.

In 2 out of 24 tests, the IQoL questionnaire was implemented. The IQoL questionnaire is composed of 20 questions evaluating limitations on behavior, the psychosocial impact, and the social embarrassment that UI causes. The scales, which have only been used in 1 study are as follows, The Norwegian version of the QoL Scale (QoLS-N), The BFLUTS questionnaire, PFIQ, SII, and Ditrovie scale. The QoLS-N is adapted and modified for use in the chronic illness population, by Burckhardt et al.; this scale applies to general health and QoL. The Norwegian version uses a 7-point satisfaction scale. The BFLUTS questionnaire was designed to assess a wide range of symptoms, including incontinence, and the impact on sexual function and QoL. The PFDI comprises a urinary scale (UDI;
score range 0–300), including 3 subscales (Stress, Irritative and Obstructive; score range 0–100), prolapse (POPD; score range 0–300), and colorectal (CRADI; score range 0–400) scales. Higher PFDI scale and subscale scores reflect increasing symptoms. The PFIQ includes 3 scales, urinary (UIQ), prolapse (POPIQ) and colorectal (CRAIQ) ones, each with score range of 0–300. Higher PFIQ scores — greater daily impact on pelvic symptoms. The Ditrovie scale consists of 10 items: activity (4 items), emotional impact (2 items), self-image (2 items), sleep (1 item), and general welfare (1 item). The higher the score, the worse the QoL. The SII measures women’s views on stress incontinence severity, as well as the impact or discomfort caused by the symptoms.

Therapy comparison and treatment duration
The studies compared supervised and unsupervised PFMT, group and individual training, PFMT and bladder training (also with the use of vaginal cones), as well as training groups and a control group (no training). Treatment duration was between 6 and 42 weeks; a majority of the therapy sessions were held 1–3 times per week, and lasted 45 minutes each.

Pelvic floor muscles training and types of UI
The evaluation of the impact of PFMT on the QoL of women with incontinence was carried out in all of the presented studies. In 16 studies, the study population concerned women with SUI. Moreover, in studies where the authors compared the effects of pelvic floor muscle exercises on incontinence depending on the type of urinary incontinence, a statistically highest improvement in QoL occurred in SUI, then a lower result was achieved in UUI, and no significant differences were found in the impact of PFMT on MUI. In the case of 2 studies, the type of UI in the study population was not reported.

Compared treatment methods
A PFM training group and a control group (no training) were compared in 5 out of the 24 studies which qualified for the analysis (223 patients). In all referenced studies, statistically significant improvement in the QoL in the PFMT group was observed compared with the control group.

In 5 out of the 24 studies (a total of 253 women) qualified for the analysis, a PFM training group was divided into a supervised PFMT group and a control (home-exercise) group. Fan et al study results showed a significant improvement of the UDI total result ($p<0.01$) and the IIQ ($p<0.01$) in the experimental group compared with the control group after a 6-week training program. Whereas Ferreira et al showed that 6 months following the treatment, the QoL improved in both groups. However, the outcome was better in women in the supervised PFMT group than in women who exercised at home ($p=0.04$). Similar study results were obtained by Sherburn et al and Jahromi et al. Felicissimo et al showed there were no differences between the supervised group and the home-exercise group, with regard to the QoL ($p=0.76$). The study authors concluded that both supervised PFMT and unsupervised PFMT are effective in UI treatment, if a proper training session is provided.

The effectiveness of group and individual training was compared in 2 out of the 24 selected studies (104 patients). No significant differences were found between both studies in terms of group and individual training effectiveness.

In 1 out of the 24 selected studies (44 women), PFMT in supine position (KG) was compared with PFMT in supine and standing position (CG). The study results have shown the effectiveness of PFMT, but various training positions had no impact on its effectiveness.

In 8 out of the 24 selected studies, the effectiveness of PFMT was compared with other methods. In studies conducted by Pereira et al, a group of 45 women was divided into 3 distinct groups – a vaginal cone group (VG), a PFMT group, and a control group (no therapy). After 6 weeks of therapy, a significant improvement ($p<0.01$) in terms of QoL was observed in both the VG group and the PFMT group, compared with the control group. The following 2 studies (186 women) compared abdominal muscle training (TrA) to PFMT monotherapy. Konstantinidou et al found that improvement in QoL was observed in both groups, and no significant differences were found between them. Whereas, Ptak et al observed better results in the combined therapy group (TrA+PFMT).

In 3 out of the 24 selected studies, bladder training (BT) was compared with PFMT. A total of 238 women participated in the study. Sherburn et al showed an improvement in QoL in both groups ($p=0.01$), without any significant differences between the groups. The next study compared a combined PFMT/BT with a BT monotherapy. After treatment, all of the studied women had an improvement in QoL (IIQ-7 $p=0.01$; UDI-6 $p<0.01$). The following study (790 patients) compared the effectiveness of combined PFMT/BT (the study group) to no treatment (the control group). After therapy, there was a statistically significant improvement in QoL in the study group, compared with the control group ($p=0.05$).
In 2 out of the 24 selected studies (790 women), QoL was evaluated after PFMT, pessary therapy, and combined therapy (PFMT-pessary therapy). After a 3-month treatment, a statistically significant improvement in QoL ($p<0.01$) for all women was observed in both studies, and no significant differences were observed between the groups.

In 3 out of the 24 selected studies (505 women), patients received PFMT monotherapy and there was no control group. Each study showed a statistically significant improvement in QoL after PFMT.

Limitations
The limitation of this analysis is primarily the methodical variability in the analyzed studies. The search criteria should be narrowed further, taking into account the methodological homogeneity of the conducted therapy.

Conclusion
The results of this literature review demonstrate that PFMT is an effective treatment for UI in women. PFMT appears to be an effective non-surgical intervention, particularly for women with SUI. It could also be recommended as the first-line conservative treatment for elderly women. PFMT significantly improves the QoL of women with UI, which is an important determinant of their physical, mental, and social functioning. The duration of PFMT should not be shorter than 6 weeks. It is advised to provide supervised PFMT. PFMT can be used either as a monotherapy or as a combined therapy for the treatment of UI in women. The KHQ is useful for following up on the QoL of women with UI in many different clinical settings and in controlled clinical trials.

Author contributions
All authors contributed toward data analysis, drafting and critically revising the paper, gave final approval of the version to be published, and agree to be accountable for all aspects of the work.

Disclosure
The authors report no conflicts of interest in this work.

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