Nonsurgical Management of Urinary Incontinence in Women: A Clinical Practice Guideline From the American College of Physicians

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Description: The American College of Physicians (ACP) developed this guideline to present the evidence and provide clinical recommendations on the nonsurgical management of urinary incontinence (UI) in women.

Methods: This guideline is based on published English-language literature on nonsurgical management of UI in women from 1990 through December 2013 that was identified using MEDLINE, the Cochrane Library, Scirus, and Google Scholar. The outcomes evaluated for this guideline include continence, improvement in UI, quality of life, adverse effects, and discontinuation due to adverse effects. It grades the evidence and recommendations by using ACP’s guideline grading system. The target audience is all clinicians, and the target patient population is all women with UI.

Recommendation 1: ACP recommends first-line treatment with pelvic floor muscle training in women with stress UI. (Grade: strong recommendation, high-quality evidence)

Recommendation 2: ACP recommends bladder training in women with urgency UI. (Grade: weak recommendation, low-quality evidence)

Recommendation 3: ACP recommends pelvic floor muscle training with bladder training in women with mixed UI. (Grade: strong recommendation, high-quality evidence)

Recommendation 4: ACP recommends against treatment with systemic pharmacologic therapy for stress UI. (Grade: strong recommendation, low-quality evidence)

Recommendation 5: ACP recommends pharmacologic treatment in women with urgency UI if bladder training was unsuccessful. Clinicians should base the choice of pharmacologic agents on tolerability, adverse effect profile, ease of use, and cost of medication. (Grade: strong recommendation, high-quality evidence)

Recommendation 6: ACP recommends weight loss and exercise for obese women with UI. (Grade: strong recommendation, moderate-quality evidence)

Summary for Patients: I-34

See also:

Web-Only Supplement CME quiz

* This paper, written by Amir Qaseem, MD, PhD, MHA; Paul Dallas, MD; Mary Ann Forciea, MD, MS; Melissa Starkey, PhD; Thomas D. Denberg, MD, PhD; and Paul Shekelle, MD, PhD, was developed for the Clinical Guidelines Committee of the American College of Physicians. Individuals who served on the Clinical Guidelines Committee from initiation of the project until its approval were Paul Shekelle, MD, PhD (Chair); Michael J. Barry, MD; Roger Chou, MD; Molly Cooke, MD; Paul Dallas, MD; Thomas D. Denberg, MD, PhD; Nick Fitterman, MD; Mary Ann Forciea, MD, MS; Russell P. Harris, MD, MPH; Linda L. Humphrey, MD, MPH; Tanveer P. Mir, MD; Holger J. Schünemann, MD, PhD; J. Sanford Schwartz, MD; Donna E. Sweet, MD; and Timothy Wilt, MD, MPH. Approved by the ACP Board of Regents on 25 September 2013.
Nonsurgical Management of Urinary Incontinence in Women

Diagnosis

Because most women with UI do not report it to their physicians (4), physicians should proactively ask female patients about bothersome UI symptoms as part of a routine review of systems. Clinicians should take a focused history and ask specific questions, such as the time of onset, symptoms, and frequency (4). Clinicians should also do a focused physical examination and evaluate neurologic symptoms. Asking such questions as “Do you have a problem with urinary incontinence (of your bladder) that is bothersome enough that you would like to know more about how it could be treated?” as part of a quality improvement intervention has been shown to increase appropriate care by 15% in patients aged 75 years or older (15).

Methods

This guideline is based on a systematic evidence review (11) that addressed the following key questions related to the diagnosis and nonsurgical management of UI:

1. How effective is the nonpharmacologic treatment of UI in women?
   1a. How do nonpharmacologic treatments affect continence, severity and frequency of UI, and quality of life compared with no active treatment?
   1b. How do combined methods of nonpharmacologic treatments with drugs affect incontinence, severity and frequency of UI, and quality of life compared with no active treatment or monotherapy?
   1c. What is the comparative effectiveness of different nonpharmacologic treatments?
   1d. What are the harms of nonpharmacologic treatments compared with no active treatment?
   1e. What are the comparative harms of different nonpharmacologic treatments?
   1f. Which patient characteristics, including age, type and severity of UI, baseline disease that affects UI, adherence to treatment recommendations, and comorbid conditions, can modify the effects of nonpharmacologic treatments on patient outcomes, such as continence, quality of life, and harms?

2. How effective is the pharmacologic treatment of UI in women?
   2a. How do pharmacologic treatments affect continence, severity and frequency of UI, and quality of life compared with no active treatment or combined treatment methods?
   2b. What is the effectiveness of pharmacologic treatments compared with each other or with nonpharmacologic treatments of UI?
   2c. What are the harms of pharmacologic treatments compared with no treatment?
   2d. What are the harms of pharmacologic treatments of UI compared with each other or with nonpharmacologic treatments?
   2e. Which patient characteristics, including age, type and severity of UI, baseline disease that affects UI, adherence to treatment recommendations, and comorbid conditions, can modify the effects of pharmacologic treatments on patient outcomes, such as continence, quality of life, and harms?

The systematic evidence review was done by the Minnesota Evidence-based Practice Center. The literature search included English-language studies published between 1990 and December 2011 identified using MEDLINE, the Cochrane Library, Scirus, and Google Scholar as well as manual searches of reference lists from systematic reviews. Literature was updated through December 2013, focusing on treatments most relevant to primary care (see the Supplement for details). Data were extracted using a standardized form, and study quality was assessed according to the Methods Guide for Effectiveness and Comparative Effectiveness Reviews (12). This guideline focuses on treatments most relevant to primary care clinicians; the full report (11) and published article (13) contain more details.

This guideline rates the evidence and recommendations by using ACP’s guideline grading system (Table 2). Details of the guideline development process can be found in the methods paper (14).

Table 1. Nonpharmacologic Treatments for UI

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Description</th>
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<tbody>
<tr>
<td>PFMT</td>
<td>Instruction on the voluntary contraction of pelvic floor muscles (Kegel exercises)</td>
</tr>
<tr>
<td>PFMT with biofeedback using vaginal EMG</td>
<td>PFMT with EMG probe used to give patients visual feedback on when they are properly contracting the pelvic floor muscles</td>
</tr>
<tr>
<td>Bladder training</td>
<td>Behavioral therapy that includes extending the time between voiding</td>
</tr>
<tr>
<td>Continence service</td>
<td>Treatment program involving nurses and clinicians trained in identifying, diagnosing, and appropriately treating patients with UI</td>
</tr>
</tbody>
</table>

EMG = electromyography; PFMT = pelvic floor muscle training; UI = urinary incontinence.

Because most women with UI do not report it to their physicians (4), physicians should proactively ask female patients about bothersome UI symptoms as part of a routine review of systems. Clinicians should take a focused history and ask specific questions, such as the time of onset, symptoms, and frequency (4). Clinicians should also do a focused physical examination and evaluate neurologic symptoms. Asking such questions as “Do you have a problem with urinary incontinence (of your bladder) that is bothersome enough that you would like to know more about how it could be treated?” as part of a quality improvement intervention has been shown to increase appropriate care by 15% in patients aged 75 years or older (15).
**TREATMENT**

Complete continence, a clinically important improvement in UI (defined as reducing UI frequency by ≥50%), and quality of life were the primary outcomes assessed in the systematic review to evaluate the effectiveness of nonpharmacologic and pharmacologic treatments.

**Nonpharmacologic Treatment**

Appendix Table 1 (available at www.annals.org) summarizes nonpharmacologic treatments.

**Stress UI: Nonpharmacologic Treatment**

**PFMT Versus No Active Treatment.** High-quality evidence showed that PFMT is an effective UI treatment compared with no active treatment. Pooled data from studies that included women with stress UI (16–18) showed increased continence rates with PFMT compared with no active treatment (number needed to treat for benefit [NNT₉], 3 [95% CI, 2 to 5]). High-quality evidence showed that PFMT was more than 5 times as effective as no active treatment in improving UI (NNT₉, 2 [CI, 2 to 6]) (16, 19–23). In addition, studies reported improved quality of life (11).

**PFMT With Biofeedback Using a Vaginal Electromyography Probe Versus No Active Treatment.** Low-quality evidence showed that PFMT with biofeedback using a vaginal electromyography probe increased continence compared with no active treatment (16, 20). High-quality evidence showed that this treatment improved UI compared with no active treatment (NNT₉, 3 [CI, 2 to 6]) (16, 19, 20, 24).

**Other Treatments.** Evidence was insufficient to determine the effectiveness of vaginal cones and pessaries or of intravaginal and intrarectal devices versus no active treatment (11).

**Urgency UI: Nonpharmacologic Treatment**

**Bladder Training Versus No Active Treatment.** Low-quality evidence showed that bladder training improved UI compared with no active treatment (NNT₉, 2 [CI, 2 to 4]) (25, 26). However, evidence on bladder training for achieving complete continence was insufficient (11).

**Mixed UI: Nonpharmacologic Treatment**

**PFMT Versus No Active Treatment.** Pooled data from studies that included women with mixed UI (18, 20, 27) showed increased continence rates with PFMT compared with no active treatment.

**PFMT Plus Bladder Training Versus No Active Treatment.** High-quality evidence showed that PFMT combined with bladder training achieved continence (NNT₉, 6 [CI, 4 to 16]) (28–32) and improved UI (NNT₉, 3 [CI, 2 to 6]) (28, 30–32) compared with no active treatment.

**Continence Service Versus No Active Treatment.** Continence service involves nurses and clinicians trained to identify, diagnose, and appropriately treat patients with UI. Moderate-quality evidence showed that this service yielded no statistically significant improvement in continence compared with no active treatment (33–35). Low-quality evidence showed no consistent statistically significant improvement in UI (35, 36).

**Weight Loss and Physical Activity Versus No Active Treatment.** Moderate-quality evidence indicated that weight loss and exercise improved UI in obese women (NNT₉, 4 [CI, 2 to 18]) (37, 38).

**Other Treatments.** Evidence was insufficient to determine the effectiveness of behavioral modification programs, a soy-enriched diet, or acupuncture for improving UI in women with mixed UI (11).

**Comparative Effectiveness of Nonpharmacologic Treatments**

No evidence showed that one nonpharmacologic treatment was superior to another in the various comparisons assessed for stress, urgency, or mixed UI. Further details are available in the full systematic review (11) and the Supplement.

**Pharmacologic Treatment**

Appendix Table 2 (available at www.annals.org) summarizes pharmacologic treatments.

**Stress UI: Pharmacologic Treatment**

**Nonsystemic Estrogen Therapy Versus Placebo.** Overall evidence was insufficient to determine the effectiveness of topical estrogen therapies at improving UI. Evidence showed increased continence and improved UI with vaginal estrogen formulations, but transdermal patches were associated with worsened UI. Studies used a range of estrogen applications.

Urinary incontinence improved with vaginal estrogen tablets (39) and vaginal ovules (40) compared with placebo. Vaginal estrogen tablets increased continence compared with placebo (NNT₉, 5 [CI, 3 to 12]) (39–42). An...
estradiol implant did not improve UI compared with placebo (41).

\**Intravaginal Estriol Plus PFMT Versus Intravaginal Estriol.** Low-quality evidence from 1 study showed that a combination of intravaginal estriol plus PFMT more effectively achieved continence than intravaginal estriol alone (NNT\(_B\), 1 [CI, 1 to 2]) (43).

\**Duloxetine Versus Placebo.** Low-quality evidence showed that continence was reduced less with duloxetine than placebo (44, 45). High-quality evidence showed that duloxetine did not statistically significantly improve UI compared with placebo (NNT\(_B\), 13 [CI, 7 to 143]) (44, 46–49). Low-quality evidence showed that duloxetine improved quality of life (45, 49, 50). However, quality of life did not improve in women with severe stress UI or overactive bladder (46, 51).

**Urgency UI: Pharmacologic Treatment With Antimuscarinics**

\**Darifenacin Versus Placebo.** High-quality evidence showed that darifenacin improved UI compared with placebo (NNT\(_B\), 9 [CI, 6 to 18]) (52–54). Achieving complete continence was not studied as an outcome with darifenacin treatment. High-quality evidence also showed that darifenacin improved quality of life (11).

\**Fesoterodine Versus Placebo.** Moderate-quality evidence showed that fesoterodine achieved continence more than placebo (NNT\(_B\), 8 [CI, 6 to 11]) (55–57). High-quality evidence also showed an improvement in UI (NNT\(_B\), 10 [CI, 7 to 18]) (56, 58–60). Low-quality evidence showed that fesoterodine also improved quality of life (11).

\**Oxybutynin Versus Placebo.** High-quality evidence showed that oxybutynin achieved continence more than placebo (NNT\(_B\), 9 [CI, 6 to 16]) (61–65). Moderate-quality evidence showed that this agent also improved UI (NNT\(_B\), 6 [CI, 4 to 11]) (24, 61, 62, 64, 66–73).

\**Propiverine Versus Placebo.** Low-quality evidence showed that propiverine achieved continence more than placebo (NNT\(_B\), 6 [CI, 4 to 12]) (74, 75), and moderate-quality evidence showed that it improved UI (NNT\(_B\), 5 [CI, 4 to 8]) (74–76) compared with placebo.

\**Solifenacin Versus Placebo.** High-quality evidence showed that solifenacin achieved continence more than placebo (NNT\(_B\), 9 [CI, 6 to 17]) (77–81), and low-quality evidence indicated that it resolved UI compared with placebo (NNT\(_B\), 6 [CI, 4 to 10]) (81, 82). Low-quality evidence from 1 study showed that higher doses of solifenacin (10 mg/d vs. 5 mg/d) did not decrease the frequency of UI episodes and were associated with increased risk for adverse effects (83).

\**Tolterodine Versus Placebo.** High-quality evidence showed that tolterodine achieved continence (NNT\(_B\), 12 [CI, 8 to 25]) (55, 56, 84, 85) and improved UI (NNT\(_B\), 10 [CI, 7 to 24]) (55, 56, 59, 86–90) more than placebo. Low-quality evidence showed that tolterodine improved quality of life (11).

**Tolterodine Versus Placebo.** High-quality evidence showed that trolspium achieved continence more than placebo (NNT\(_B\), 9 [CI, 7 to 12]) (91–94). Low-quality evidence did not show a statistically significant improvement in UI compared with placebo (94, 95). Individual studies showed that trolspium improved quality of life (11).

**Urgency UI: Pharmacologic Treatment With \(\beta_3\)-Adrenoceptor Agonists**

\**Mirabegron Versus Placebo.** Moderate-quality evidence showed that mirabegron achieved continence more than placebo (NNT\(_B\), 12 [CI, 7 to 29]) and improved UI compared with placebo (NNT\(_B\), 9 [CI, 6 to 17]) (96). Low-quality evidence showed that higher doses of mirabegron improved treatment satisfaction and quality of life compared with lower doses (150 mg/d vs. 100 mg/d) (97).

\**Solabegron Versus Placebo.** Evidence was insufficient to determine the effect of solabegron on continence or improving UI, but low-quality evidence showed that it decreased the frequency of UI episodes in a dose-dependent manner (98).

**Urgency UI: Other Pharmacologic Treatments**

Evidence was insufficient to determine the clinical effectiveness of resiniferatoxin or nimodipine compared with placebo for treatment of UI (11).

**Urgency UI: Comparative Effectiveness of Pharmacologic Treatments**

\**Fesoterodine Versus Tolterodine.** Moderate-quality evidence showed that fesoterodine achieved continence more often than tolterodine (NNT\(_B\), 18 [CI, 11 to 52]) (55, 56, 99). High-quality evidence showed that fesoterodine improved UI more than tolterodine (NNT\(_B\), 36 [CI, 17 to 100]) (55, 56, 59, 90).

\**Oxybutynin Versus Tolterodine.** Low-quality evidence showed no difference between oxybutynin and tolterodine for achieving continence (100). Moderate-quality evidence showed no difference for improving UI (66, 68, 100, 101).

\**Tolterodine Versus Tropium.** Low-quality evidence from 1 study showed that tolterodine and tropium were similarly effective at treating urgency UI (100).

\**Solifenacin Versus Tolterodine.** Evidence was insufficient to compare solifenacin with tolterodine for effects on continence or improvement of UI (11).

\**Tropium Versus Oxybutynin.** Low-quality evidence showed no differences between tropium and oxybutynin for effects on continence or improvement of UI (11).

**Other Comparisons.** Evidence was insufficient to determine the comparative effectiveness on continence or improvement of UI for darifenacin, propiverine, solifenacin, or flavoxate versus oxybutynin; solifenacin versus darifenacin; or tolterodine or solifenacin versus propiverine (11).
Comparative Effectiveness of Pharmacologic Versus Nonpharmacologic Treatments

Low-quality evidence from 1 study showed that PFMT plus bladder training improved UI more than tolterodine alone (102).

Role of Patient Characteristics on Outcomes of Pharmacologic Treatments

Age. Moderate-quality evidence showed that age did not modify clinical outcomes associated with pharmacologic treatment (11). High-quality evidence showed that trospium, oxybutynin, and darifenacin effectively improved UI and quality of life in older women (52, 71, 92). High-quality evidence also showed that solifenacin achieved continence more often than placebo, regardless of age (77).

Race. Evidence was inconclusive about differences among various racial groups.

Baseline Frequency of UI. Low-quality evidence showed that the baseline frequency of UI was not associated with statistically significantly different clinical outcomes for any drugs examined (11). However, women with more frequent UI episodes had slightly greater benefits with active pharmacologic treatment than placebo (103, 104).

Prior Treatment Response. High-quality evidence showed that solifenacin achieved continence more than placebo regardless of the response to previous treatments; a larger dose did not improve an initially poor response (77).

Concomitant Treatments. Moderate-quality evidence indicated that trospium reduced the number of urgency UI episodes regardless of whether the patient was receiving other drugs. Patients receiving 7 or more concomitant medications had more adverse effects than those receiving fewer than 7 (105).

Obesity. Evidence did not show any difference in effectiveness of trospium in achieving continence in obese or nonobese patients (106).

Adverse Effects

Nonpharmacologic Treatments

The risk for adverse effects associated with nonpharmacologic treatments was low.

Pharmacologic Treatments

Appendix Table 2 summarizes the adverse effects associated with pharmacologic treatments, which were similar within drug classes. The most commonly reported adverse effects associated with antimuscarinics included dry mouth, constipation, and blurred vision. Evidence showed that fesoterodine (high-quality; number needed to treat for harm [NNTH], 7 [CI, 5 to 9]) (56, 57, 60, 107, 108), solifenacin (high-quality; NNTH, 6 [CI, 4 to 12]) (78, 79, 82, 109), tolterodine (high-quality; NNTH, 12 [CI, 8 to 21]) (56, 66, 85, 107, 109–116), and tropismide (moderate-quality; NNTH, 8 [CI, 6 to 11]) (91–93, 112, 117) had higher rates of adverse effects than placebo. Moderate-quality evidence showed that adverse effects, including dry mouth and headache, were more common with fesoterodine than with tolterodine (NNTH, 11 [CI, 8 to 17]) (99). Dry mouth and insomnia were more frequently reported for oxybutynin than for tolterodine (100).

Dizziness was more frequently reported for tropium, and dry mouth and insomnia were more frequently reported for oxybutynin (100). Tolterodine has also been associated with increased risk for hallucinations (118). Nasopharyngitis and gastrointestinal disorders were more frequent with mirabegron than placebo (96, 97).

Discontinuation of treatment due to adverse effects was common. Evidence showed that discontinuation due to adverse effects was higher for fesoterodine (high-quality; NNTH, 33 [CI, 18 to 102]) (55, 56, 58–60, 119), oxybutynin (high-quality; NNTH, 16 [CI, 8 to 86]) (65–68, 72, 120), propiverine (low-quality; NNTH, 29 [CI, 16 to 77]) (75, 121), solifenacin (high-quality; NNTH, 78 [CI, 39 to 823]) (77–80, 82, 121–123), and trospium (high-quality; NNTH, 56 [CI, 30 to 228]) (92–94, 117, 124) than for placebo. High-quality evidence showed no statistically significant difference in treatment discontinuation rates due to adverse effects between darifenacin (52–54, 125–127) or tolterodine and placebo (55, 56, 59, 66, 87, 107, 110, 111, 113, 115, 123, 128, 129).

Discontinuation due to adverse effects was higher with fesoterodine than tolterodine (moderate-quality; NNTH, 58 [CI, 33 to 206]) (55, 56, 59, 107) and with oxybutynin than tolterodine (high-quality; NNTH, 14 [CI, 7 to 145]) (67, 68, 101, 110, 130–135). Discontinuation of treatment due to adverse effects did not differ between solifenacin and tolterodine (moderate-quality) (123, 136–138) or between trospium and oxybutynin (low-quality) (100, 139, 140).

Summary

Nonpharmacologic therapies were effective at managing UI, had a large magnitude of benefit for increasing continence rates, and were associated with a low risk for adverse effects. Pelvic floor muscle training alone and in combination with bladder training or biofeedback and weight loss with exercise for obese women were effective at achieving continence and improving UI. Evidence was insufficient to compare nonpharmacologic therapies with one another or with pharmacologic therapies; head-to-head comparisons would be useful.

Pharmacologic therapies were effective and equally efficacious at managing urgency UI and had a moderate magnitude of benefit in achieving continence rates but were associated with adverse effects. In addition, evidence showed that some patients were likely to discontinue pharmacologic treatment because of adverse effects. Solifenacin was associated with the lowest risk for discontinuation due to adverse effects, whereas oxybutynin was associated with the highest risk.

Only darifenacin and tolterodine had risks for discontinuation due to adverse effects similar to placebo. Evi-
Summary of the American College of Physicians guideline on nonsurgical management of urinary incontinence in women.

**Interventions Evaluated**

- **Nonpharmacologic:**
  - Pelvic floor muscle training (PFMT), bladder training, vaginal cones, medical devices, continence services, and weight loss and physical activity
- **Pharmacologic:**
  - Antimuscarinics: Darifenacin, fesoterodine, oxybutynin, propiverine, solifenacin, tolterodine, trosplum
  - β3-Adrenoceptor agonists: Mirabegron and solabegron
- **Other:** Duloxetine and estrogen

**Outcomes Evaluated**

- Continence, improvement in UI, quality of life, and adverse effects
- Continence, ≥50% reduction in the frequency of UI episodes

**Benefits**

- Continence, improvement in UI, quality of life, and adverse effects

**Harms**

- Nonpharmacologic: Low risk for adverse effects
- Pharmacologic: The most commonly reported adverse effects included dry mouth, constipation, and blurred vision for antimuscarinics; nasopharyngitis and gastrointestinal disorders were associated with the β3-adrenoceptor agonist mirabegron

**Recommendations**

- **Recommendation 1:** ACP recommends first-line treatment with PFMT in women with stress UI. (Grade: strong recommendation, high-quality evidence)
- **Recommendation 2:** ACP recommends bladder training in women with urgency UI. (Grade: weak recommendation, low-quality evidence)
- **Recommendation 3:** ACP recommends PFMT with bladder training in women with mixed UI. (Grade: strong recommendation, high-quality evidence)
- **Recommendation 4:** ACP recommends against treatment with systemic pharmacologic therapy for stress UI. (Grade: strong recommendation, low-quality evidence)
- **Recommendation 5:** ACP recommends pharmacologic treatment in women with urgency UI if bladder training was unsuccessful. Clinicians should base the choice of pharmacologic agents on tolerability, adverse effect profile, ease of use, and cost of medication. (Grade: strong recommendation, high-quality evidence)
- **Recommendation 6:** ACP recommends weight loss and exercise for obese women with UI. (Grade: strong recommendation, moderate-quality evidence)

**High-Value Care**

UI is a common and important health care problem in women that is underreported and underdiagnosed. Clinicians should take a detailed history and ask specific questions about UI, such as the time of onset, symptoms, and frequency. Clinicians should use nonpharmacologic management for UI, such as PFMT for stress UI, bladder training for urgency UI, and PFMT with bladder training for mixed UI, because they are effective, have few adverse effects, and are cheaper than pharmacologic therapies. Although pharmacologic therapy can improve UI and provide complete continence, many patients discontinue medication because of adverse effects.

**Clinical Considerations**

Vulnerable populations include women aged >65 years, nursing home residents, and women receiving Medicare home care services. At least one half of women with UI do not report the issue to their physician. Pharmacologic treatment should be based on harms, because most drugs are similarly efficacious. Identifying and managing conditions that may cause UI, such as urinary tract infections; metabolic disorder; excess fluid intake; and impaired mental conditions, such as delirium, are important. Clinicians should identify whether patients are receiving medications that may cause or worsen UI.

PFMT = pelvic floor muscle training; UI = urinary incontinence.

**Recommendations**

**Recommendation 1:** ACP recommends first-line treatment with PFMT in women with stress UI. (Grade: strong recommendation, high-quality evidence)
Pelvic floor muscle training increased continence rates and improved UI and quality of life in women with stress UI. Nonpharmacologic therapy with PFMT should be first-line treatment for women with UI.

Recommendation 2: ACP recommends bladder training in women with urgency UI. (Grade: weak recommendation, low-quality evidence)

Bladder training improved UI for women with urgency UI. The addition of PFMT to bladder training did not improve continence compared with bladder training alone for urgency UI.

Recommendation 3: ACP recommends PFMT with bladder training in women with mixed UI. (Grade: strong recommendation, high-quality evidence)

Pelvic floor muscle training combined with bladder training improved continence and UI in women with mixed UI.

Recommendation 4: ACP recommends against treatment with systemic pharmacologic therapy for stress UI. (Grade: strong recommendation, low-quality evidence)

Treatment of stress UI with standard pharmacologic therapies used for urgency UI has not been shown to be effective. Vaginal estrogen formulations improved continence and stress UI, but transdermal estrogen patches worsened UI.

Recommendation 5: ACP recommends pharmacologic treatment in women with urgency UI if bladder training was unsuccessful. Clinicians should base the choice of pharmacologic agents on tolerability, adverse effect profile, ease of use, and cost of medication. (Grade: strong recommendation, high-quality evidence)

Pharmacologic therapies were effective and equally efficacious at managing urgency UI and had a moderate magnitude of benefit in achieving continence rates. However, they were associated with adverse effects and evidence showed that some patients were likely to discontinue pharmacologic treatment because of these effects. For urgency UI, oxybutynin, tolterodine, darifenacin, solifenacin, fesoterodine, and trospium increased continence rates and improved UI.

Evidence was insufficient to evaluate the comparative effectiveness of different drugs and to determine the long-term safety of pharmacologic treatments for UI. Patient characteristics, such as age, race, comorbid conditions, or baseline UI, did not affect the outcomes of the various pharmacologic medications. However, adherence to pharmacologic treatments for UI was poor.

Adverse effects were a major reason for treatment discontinuation. Clinicians and their patients should compare the risk for pharmacologic adverse effects with the severity and bothersomeness of the patient’s symptoms. Appendix Table 2 shows the quality of evidence for outcomes of continence and improvement of UI as well as the adverse effects for the various drugs.

Evidence was insufficient to evaluate the comparative effectiveness of nonpharmacologic versus pharmacologic treatments for UI, and nonpharmacologic treatment should be considered first-line therapy. Evidence showed that nonpharmacologic treatments were better than no treatment in achieving continence and improving UI with a large magnitude of effect and are associated with a low risk for adverse effects. Pharmacologic treatments are associated with adverse effects that may be intolerable and lead to discontinuation of treatment. Clinicians and patients should keep in mind the costs of treatment, especially long-term costs, when choosing treatment.

Recommendation 6: ACP recommends weight loss and exercise for obese women with UI. (Grade: strong recommendation, moderate-quality evidence)

Weight loss and exercise improved UI in obese women with no evident harms. In addition, the benefits of weight loss in obese women extend beyond improvement of UI.

ACP High-Value Care

Urinary incontinence is a common and important health care problem in women that is underreported and underdiagnosed. Clinicians should take a detailed history and ask specific questions, such as the time of onset, symptoms, and frequency. Clinicians should use nonpharmacologic management for UI, such as PFMT for stress UI, bladder training for urgency UI, and PFMT with bladder training for mixed UI, because these therapies are effective, have few adverse effects, and are cheaper than pharmacologic therapies. Although pharmacologic therapy can improve UI and provide complete continence, many patients discontinue medication because of adverse effects.

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Note: Clinical practice guidelines are “guides” only and may not apply to all patients and all clinical situations. Thus, they are not intended to override clinicians’ judgment. All ACP clinical practice guidelines are considered automatically withdrawn or invalid 5 years after publication or once an update has been issued.

Disclaimer: The authors of this article are responsible for its contents, including any clinical or treatment recommendations. No statement in this article should be construed as an official position of the U.S. Department of Veterans Affairs.

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**Clinical Guideline**


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ANNALS PERSONAE PHOTOGRAPHS FOR ACP’S CENTENNIAL

In recognition of the American College of Physicians’ 100th anniversary, Annals of Internal Medicine is seeking photographs of internal medicine physicians to feature on each issue of the journal during 2015, the ACP’s centennial year. In choosing from among submitted photographs, we will seek photos that capture personality and celebrate the diversity of individuals who devote their professional lives to the practice of internal medicine. Readers and others are encouraged to submit photographs of internal medicine physicians for consideration. In an effort to bring people to the pages of the Annals of Internal Medicine, the editors began publishing photographs of people in 1999. Annals published photographs in a section of the journal called “Personae” from 1999 to 2000, and photographs have appeared on the cover since 2000.

Written permission to publish the photograph from the subject (or subjects) of the photograph or the subject’s guardian or next of kin must accompany submissions. The subject must understand that, if selected for publication, the photograph will not only appear on the cover of the journal but also in digital versions of the journal and associated publications. Photographs can be published without the subject’s permission only under the following circumstances: 1) the subject is unidentifiable in the photograph or 2) the photograph was taken in a public venue, is not potentially damaging to the subject, and is accompanied by a written statement from the photographer vouching that the photograph was taken in a public venue with the subject’s consent. A cover letter ensuring no prior publication of the photograph and providing permission from the photographer for Annals to publish the image should accompany all submissions. In addition, the letter should indicate the name and specialty of the internist depicted and the photographer’s name, academic degrees, institutional affiliation, mailing address, telephone number, and e-mail address. Photographers must relinquish copyright to the American College of Physicians before publication. Pictures from photographers unwilling to do so will not be considered.

Please submit high-resolution, digital copies of photographs to Nicole Briglia at nbriglia@acponline.org for consideration in our special 100th-anniversary issues. We look forward to receiving your photographs.
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Collection and assembly of data: A. Qaseem, M. Starkey.

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<td><strong>PFMT with biofeedback using vaginal EMG probe vs. PFMT</strong></td>
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<tr>
<td>Continence</td>
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<td><strong>PFMT vs. vaginal cones</strong></td>
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<td>Continence</td>
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<tr>
<td>Improved UI</td>
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<tr>
<td><strong>Comparative effectiveness of treatments for urgency UI</strong></td>
</tr>
<tr>
<td><strong>PFMT combined with bladder training vs. bladder training</strong></td>
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<tr>
<td>Continence</td>
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</tbody>
</table>

EMG = electromyography; NA = not available; NNT<sub>b</sub> = number needed to treat for benefit; NS = no significant difference based on relative and absolute risk; PFMT = pelvic floor muscle training; UI = urinary incontinence. Clinically important improvement in UI was defined as a ≥50% reduction in UI frequency. Adapted from reference 11. Relative risk/absolute risk where noted. “Improve” signifies that the treatment provided benefit vs. the comparator.
### Appendix Table 2. Pharmacologic Treatments for UI

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<tr>
<th>Outcome, by Treatment*</th>
<th>Effect on Outcome†</th>
<th>Studies, n</th>
<th>Patients, n</th>
<th>Relative Risk (95% CI)</th>
<th>Absolute Risk Difference (95% CI)</th>
<th>Attributable Events (95% CI), n</th>
<th>NNTb/NNTM (95% CI)</th>
<th>Adverse Effects</th>
<th>Quality of Evidence</th>
<th>Reference</th>
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<tbody>
<tr>
<td><strong>Treatment of stress UI</strong></td>
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<td>Duloxetine vs. placebo</td>
<td>Conti-worsen/NS</td>
<td>2</td>
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<td>0.92 (0.86 to 0.98)</td>
<td>-0.03 (-0.12 to 0.06)</td>
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<td>NA</td>
<td>Nausea, somnolence, insomnia, dizziness, headache, fatigue, diarrhea, constipation</td>
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<td>44, 45</td>
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<td>Improved UI</td>
<td>Improve/NS</td>
<td>4</td>
<td>1138</td>
<td>1.68 (0.94 to 3.00)</td>
<td>0.08 (0.01 to 0.14)</td>
<td>75 (7 to 142)</td>
<td>13 (7 to 143)</td>
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<td>High</td>
<td>44–46, 46–49</td>
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<tr>
<td>Discontinuation due to adverse effects</td>
<td>Worsen/NS</td>
<td>9</td>
<td>3252</td>
<td>4.40 (3.24 to 5.86)</td>
<td>0.13 (0.06 to 0.19)</td>
<td>129 (64 to 193)</td>
<td>8 (5 to 16)</td>
<td></td>
<td>High</td>
<td>44–46, 48, 50, 158–161</td>
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<td>Intravaginal estril plus PFMT vs. intravaginal estril</td>
<td>Conti-improve 1</td>
<td>206</td>
<td>8.1 (4.1 to 14.7)</td>
<td>0.69 (0.59 to 0.79)</td>
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<td>1 (1 to 2)</td>
<td>Low</td>
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<td>43</td>
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<td><strong>Treatment of urgency UI</strong></td>
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<td>Darifenacin vs. placebo</td>
<td>Improved/NS</td>
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<td>1011</td>
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<td>117 (57 to 177)</td>
<td>9 (6 to 18)</td>
<td>Constipation, dry mouth, dyspepsia, headache</td>
<td>High</td>
<td>52–54</td>
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<tr>
<td>Discontinuation due to adverse effects</td>
<td>NS</td>
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<td>0.00 (0.00 to 0.02)</td>
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<td>NA</td>
<td></td>
<td>High</td>
<td>52–54, 125–127</td>
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<tr>
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<td>NS</td>
<td>4</td>
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<td>-0.01 (-0.02 to 0.01)</td>
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<td>Moderate</td>
<td>53, 126, 127</td>
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<td>Fesoterodine vs. placebo</td>
<td>conti-improve 3</td>
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<td>0.13 (0.09 to 0.17)</td>
<td>132 (90 to 174)</td>
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<td>Moderate</td>
<td>Dry mouth, constipation, abdominal pain</td>
<td>55–57</td>
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<td>Improve/NS</td>
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<td>1.3 (1.2 to 1.5)</td>
<td>0.10 (0.06 to 0.15)</td>
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<td>10 (7 to 18)</td>
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<td>0.15 (0.11 to 0.19)</td>
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<td>4433</td>
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<td>55, 56, 58–60, 119</td>
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<tr>
<td>Discontinuation due to failure</td>
<td>NS</td>
<td>2</td>
<td>1896</td>
<td>0.6 (0.2 to 2.5)</td>
<td>-0.01 (-0.03 to 0.02)</td>
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<tr>
<td>Oxybutynin vs. placebo</td>
<td>Improved/NS</td>
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<td>1.7 (1.3 to 2.1)</td>
<td>0.11 (0.06 to 0.16)</td>
<td>114 (64 to 163)</td>
<td>9 (6 to 16)</td>
<td>Dry mouth, constipation, dyspepsia</td>
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<td>61–65</td>
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<tr>
<td>Improved UI</td>
<td>Improve/NS</td>
<td>9</td>
<td>1244</td>
<td>1.5 (1.2 to 1.9)</td>
<td>0.17 (0.10 to 0.24)</td>
<td>167 (95 to 240)</td>
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<td>Moderate</td>
<td>24, 61, 62, 64, 66–73</td>
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<td>Worsen/NS</td>
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<td>16 (8 to 86)</td>
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<td>65–68, 72, 120</td>
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<td>Propiverine vs. placebo</td>
<td>Improved/NS</td>
<td>3</td>
<td>985</td>
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<td>0.19 (0.13 to 0.25)</td>
<td>192 (132 to 252)</td>
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<td>Improve/NS</td>
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<td>0.03 (0.01 to 0.06)</td>
<td>34 (13 to 61)</td>
<td>29 (16 to 77)</td>
<td></td>
<td>Low</td>
<td>75, 121</td>
</tr>
</tbody>
</table>

*Outcome, by Treatment* indicates the outcome of the treatment compared to the control group.

†Effect on Outcome† indicates whether the outcome improved or worsened.

Studies, n represents the number of studies for each treatment.

Patients, n represents the total number of patients in each study.

Relative Risk (95% CI) represents the relative risk of the treatment effect compared to the control group.

Absolute Risk Difference (95% CI) represents the absolute difference in risk between the treatment and control groups.

Attributable Events (95% CI), n represents the number of attributable events.

NNTb/NNTM (95% CI) represents the number needed to treat/benefit.

Adverse Effects list the adverse effects associated with the treatment.

Quality of Evidence indicates the level of evidence for the treatment.

Reference list the references for the treatment data.

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<th>Outcome, by Treatment*</th>
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<th>Relative Risk (95% CI)</th>
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<td>Improve</td>
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<td>0.11 (0.06 to 0.16)</td>
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<td>Improve</td>
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<td>Worsen</td>
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<td>7</td>
<td>9080</td>
<td>1.3 (1.1 to 1.7)</td>
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<td><strong>Tolterodine vs. placebo</strong></td>
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<td>Improve</td>
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<td>3404</td>
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<td>85 (40 to 129)</td>
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<td>Autonomic nervous system disorders, constipation, dyspepsia, abdominal pain, dry mouth</td>
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<td>Adverse events</td>
<td>Worsen</td>
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<td><strong>Trospium vs. placebo</strong></td>
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<td><strong>β3-Adrenoreceptor agonist Mirabegron vs. placebo</strong></td>
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*Studies, n
†Patients, n
‡Relative Risk
§Absolute Risk Difference
||Attributable Events, n
||NNTb/NNTth
||Adverse Effects
|Quality of Evidence
||Reference

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<th>Patients, n</th>
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<th>Absolute Risk Difference (95% CI)</th>
<th>Attributable Events (95% CI), n</th>
<th>NNTB/NNTH (95% CI)</th>
<th>Adverse Effects</th>
<th>Quality of Evidence</th>
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<td><strong>Fesoterodine vs. tolterodine</strong></td>
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<tr>
<td>Continence Improve 2 2756</td>
<td>1.10 (1.04 to 1.16)</td>
<td>0.06 (0.02 to 0.09)</td>
<td>56 (19 to 92)</td>
<td>18 (11 to 52)</td>
<td>Moderate</td>
<td>55, 56, 99</td>
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<tr>
<td>Improved UI Improve 3 4425</td>
<td>1.06 (1 to 1.2)</td>
<td>0.03 (0.00 to 0.06)</td>
<td>28 (1 to 57)</td>
<td>36 (17 to 1000)</td>
<td>High</td>
<td>55, 56, 59, 90</td>
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<tr>
<td>Discontinuation due to adverse effects Worsen 4 4440</td>
<td>1.54 (1.21 to 1.97)</td>
<td>0.02 (0.01 to 0.03)</td>
<td>17 (5 to 31)</td>
<td>58 (33 to 206)</td>
<td>Moderate</td>
<td>55, 56, 59, 107</td>
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<td><strong>Oxybutynin vs. tolterodine</strong></td>
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<td>Improved UI NS 3 947</td>
<td>1.11 (0.94 to 1.31)</td>
<td>0.05 (0.03 to 0.13)</td>
<td>NA</td>
<td>NA</td>
<td>Moderate</td>
<td>66, 68, 101</td>
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<td>Discontinuation due to adverse effects Worsen 6 2323</td>
<td>1.9 (1.1 to 3.3)</td>
<td>0.07 (0.01 to 0.15)</td>
<td>72 (7 to 154)</td>
<td>14 (7 to 145)</td>
<td>High</td>
<td>67, 68, 101, 110, 130-135</td>
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<td><strong>Solifenacin vs. tolterodine</strong></td>
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<tr>
<td>Discontinuation due to adverse effects NS 3 2755</td>
<td>1.28 (0.86 to 1.91)</td>
<td>0.01 (0.00 to 0.03)</td>
<td>NA</td>
<td>NA</td>
<td>Moderate</td>
<td>123, 136-138</td>
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<td><strong>Trospium vs. oxybutynin</strong></td>
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<tr>
<td>Discontinuation due to adverse effects NS 2 2015</td>
<td>0.75 (0.52 to 1.1)</td>
<td>0.00 (0.03 to 0.05)</td>
<td>NA</td>
<td>NA</td>
<td>Low</td>
<td>139, 140</td>
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</table>

GI = gastrointestinal; NA = not available; NNTB = number needed to treat for benefit; NNTH = number needed to treat for harm; NS = no significant difference based on relative and absolute risk; PFMT = pelvic floor muscle training; UI = urinary incontinence; UTI = urinary tract infection.

* Clinically important improvement in UI was defined as a ≥ 50% reduction in UI frequency.
† Adapted from reference 11. Relative risk/absolute risk where noted. “Improve” signifies that the treatment provided benefit versus the comparator. “Worsen” signifies that the treatment resulted in harm versus the comparator.
**CORRECTION: NONSURGICAL MANAGEMENT OF URINARY INCONTINENCE IN WOMEN**

In a recent guideline (1), recommendations 2 and 3 should read as follows. Recommendation 2: ACP recommends bladder training in women with urgency UI. (Grade: weak recommendation, low-quality evidence). Recommendation 3: ACP recommends pelvic floor muscle training with bladder training in women with mixed UI. (Grade: strong recommendation, high-quality evidence).

This has been corrected in the online version.

**Reference**